



# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE STATE OF NEW YORK

---

---





# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 1

NEW YORK, N Y

JANUARY 16, 1925

## THE GRAM-POSITIVE ANAEROBES IN APPENDICITIS AND ITS COMPLICATIONS \*†

By JOHN E JENNINGS, M D, F A C S,

BROOKLYN, N Y

WE are accustomed to think of appendicitis as a disease rather well under surgical control and if the diagnosis be made early and the interference timely, this may be admitted, in theory at least. Unfortunately, in practice, it still takes its toll of lives, and although the complicating peritonitis is no longer so hopeless as it was, it is still a dreaded condition, and in no small number of cases does not yield to the measures at our command. The mortality of diffuse peritonitis secondary to gangrenous or suppurative appendicitis in the best of hands, is not below 20 per cent.

The association of this localized gangrenous process in the appendix with the gram-positive anaerobic organisms, which are found with putrid gas gangrene in contaminated gunshot wounds, has been noted by several observers. The opinion has prevailed, however, that this contamination, if one may so call it, was due to a gross perforation of the bowel wall and that, save in rare instances, it was not to be considered as of clinical import. This opinion, however, has not been by any means established.

Simonds, writing in 1915, in his monograph on the *Bacillus Welchii*, says "The relation of anaerobes in general and of *Bacillus Welchii* in particular, to appendicitis is still unsettled." His review of the literature of *Bacillus Welchii* infection up to that time is extensive and complete.

Veillon and Zuber made a valuable contribution in 1898 in which they first definitely noted the presence of *Bacillus Welchii*, which they called *Bacillus Perfringens*, in infections of the appendix. Their conclusions are worth translating and transcribing. The suppurative infections of the appendix, in which the organ is gangrenous, perforated or on the point of being so, in which the pus has a markedly fetid odor, contain in abundance anaerobic micro-organisms which we have been able to isolate and describe.

When they contain streptococci and colon bacilli, which is not absolutely constant, these latter organisms are always present in infinitesimal quantity in proportion to the others.

Welch records thirteen cases of diffuse peritonitis in which *Bacillus Welchii* was found. Ten of these were perforative and three non-perforative cases and he also notes the presence in two cases of circumscribed gas containing intra-peritoneal abscesses resulting from perforation of the appendix verimormis.

Flexner made cultures at various times post-mortem, from sixty cases of endogenous peritonitis and found *Bacillus Welchii* in eight cases, usually in mixed cultures. His work done in 1898 seems quite primitive and not at all complete.

Wright and Stokes isolated the organism in pure culture from peritonitis complicating typhoid as did also Hitschmann and Lindenthal and Von Hibler, and a number of other observers have found it in cases of peritonitis of various types.

Dudgeon and Sargent made a study of the bacteriology of appendicitis in England in 1905, in which they came to the conclusion that the *Bacillus coli* was the most frequent cause. They did not believe that anaerobic bacteria played any important rôle in appendicitis or peritonitis. They believed that if *Bacillus Welchii* was frequently present in cases of appendicitis, emphysematous gangrene of the bowel should be a common lesion instead of an interesting curiosity, and that foaming viscera should be seen very frequently at autopsies on patients dead from appendicitis. Instead there was only one case of foaming organs in such cases among the autopsies at St. Thomas' Hospital in one year, 1905. They found themselves quite unable to grow streptococci, but cultivated staphylococci and pyocyanus with their colon bacilli. Their work would be negligible were it not that it would seem to have diverted attention from the study

\* Read before the Annual Meeting of the Medical Society of the State of New York at Rochester, N Y, April 23, 1924.

† From the Surgical Department of the Brooklyn Hospital.

of the significance of the anaerobes in this disease

On the other hand, Lanz and Tavel found in 138 cases of appendicitis bacillus edematis maligni in forty-nine, classing under bacillus edematis maligni various anaerobes, including bacillus Welchii

Runeberg in 1908 found bacillus Welchii once in fourteen cases of appendicitis. He believed that anaerobes played an important part in appendicitis and peritonitis by the production of toxins rather than by actually taking part in the infection

Heyde, of Frederick's clinic in Marburg, in 1911 published a monograph on the anaerobes in appendicitis. He concluded that anaerobic bacteria were present in one hundred out of 102 cases studied and that they were present in greater profusion than anaerobes in all stages of appendicitis and peritonitis, and attributed to them the direct causation of inflammation, of gangrene and of toxemia. He found that the perfringens group (bacillus Welchii) outstripped all others in rapidity of growth

Grigoroff studied eighteen normal and thirty-one diseased appendices. In the normal appendices, aerobes and anaerobic specimens were present in approximately equal proportions, or aerobic organisms were more abundant. In the inflamed appendices, however, the strictly anaerobic bacteria were strikingly predominant. In the thirty-one cases of appendicitis bacillus perfringens (bacillus Welchii) was found nine times

It seems quite clearly demonstrated that the gram-positive anaerobes are unable to attack living healthy tissues, although they grow with vigor in devitalized structures

Cramer and Gye found that anaerobic organisms freed from toxins were unable to set up an infection in an animal of a susceptible species

A mixture of a sublethal dose of toxin and an emulsion of these organisms, on the other hand, invariably caused death. The defense is due to

- 1 Extra-cellular lysis
- 2 Phagocytosis

and is sufficient to prevent the bacteria from developing their pathological action, namely, secreting a toxin

In order to produce the specific disease from the toxin free bacteria, it is necessary to make a breach in the defenses of the body, which can be done by the injection of definite chemical substances such as calcium salts, organic or inorganic colloids or distilled water. Their observations were directed to wound infection, as, indeed, are most studies of these infections and

emphasize the influence of contamination with calcium-containing soils

Lardenais and Baumel, discussing gangrenous infection of war wounds, say: "These organisms may exist alone, but in practice and especially in severe cases they are associated with one another or with aerobic organisms"

The most serious association is undoubtedly that which occurs with the streptococcus. This combination with the streptococcus, and anaerobic association, is extremely interesting from the point of view of general pathology. In fact the streptococcus alone, even in very great abundance, is much less serious than the association of streptococcus plus anaerobic bacilli

This fact struck us immediately and it is manifested especially in certain phases of Infections Gangrenous on which, in our opinion, insufficient emphasis has been laid

An aerobic microbe, in possessing itself of the oxygen of the tissues and diverting toward itself the phagocytic activity, permits the multiplication of an associated anaerobe. By their association these microbes may be functionally modified both in their zynogenic and in their toxico-genic actions. The fact is well known for tetanus, and it has been proven that the streptococcus induces the bacillus diphtheriae, for example, to secrete a greater quantity of toxin

The streptococcus increases the virulence of the anaerobes which produce gangrene. As Grasset has very truly said: "One must not consider microbic association as a simple collaboration in an inert and impartial subject. The reaction of an organism to a mixed infection is not the sum of the respective reactions of that organism to each of the microbes present. It is a new ensemble of reactions, it is a new disease"

It has been usual to consider the streptococcus as the more common invading organism in appendicitis, with the colon bacillus, staphylococcus and pneumococcus less frequent offenders

In appendicitis, however, we have a contaminated infection from the first and it seemed reasonable to suspect that given an invading organism, like the streptococcus and a breach in the mucous membrane which separates the physiologic exterior of the body, the lumen of the gut from the interior, that the anaerobes might well be found as invaders themselves, and in fact we have been able to demonstrate that this is the case. We have found, in sections of appendices, the seat of gangrene gram-positive organisms showing the characteristic forms of these organisms invading tissue not as yet gangrenous, and have isolated them by cultivation of tissue removed from without in such a way as to avoid contamination from the lumen of the organ

Several questions have arisen, i.e.

1 To what extent may gangrene producing organisms be considered responsible for gangrene of the appendix? It has been the rule to consider this lesion as due to the strangulation of the organ by the oedema of the inflammation caused by the infection and the actual putrid gangrene with or without gross perforation, as a secondary affair. We are prepared to say that our studies lead us to consider gangrenous appendicitis as an infection by the gas gangrene producing organism superimposed on the so-called catarrhal or suppurative appendicitis due to streptococci or other invasion.

2 What is the relation of the anaerobes to the local, walled-off suppurative process, the so-called appendicular abscess? We have limited our studies, for the most part, to the bacillus Welchii for several reasons. *First*, we had available an antitoxin against it and our aim was in the beginning, to evaluate its use. *Second*, we believed that the bacillus Welchii to be the most numerous and probably the most common organism with which we had to deal, and *third*, we were able, with the means at our command, to recognize its presence more promptly than other organisms, such as the vibrios septique, the oedematiens, etc. We have fully realized the limited scope of such an approach, but it seemed a practical method of attack.

We have found the bacillus Welchii almost constantly present in the gangrenous abscess and except in massive collections it has, as a rule, seemed a quite harmless contamination. In several very large abscesses, however, we have noted profound intoxication associated with its presence in great numbers.

It is to be emphasized that its presence is not necessarily associated with gas formation.

It may be interesting, in this connection, to note the results of studies made by Lardenais and Baumel on the Gangrenous Infections of the Extremities in War Wounds. They noted the following varieties of anaerobic infections.

1 Anaerobic infections which cause swelling of the muscles and which kill the patient in 24 hours without producing any special odor of gangrene, without the apparent existence of tissue destruction or of gas at autopsy, after the most careful search.

2 White, odorless oedema without gas which infiltrate an extremity and which carry off the patient although one can find no important muscular lesion.

3 Circumscribed infections with gangrenous muscle covered with a yellowish necrotic membrane separating it in sheets, liquified and foul smelling, although the general condition seems relatively slightly affected.

4 Purulent gas containing abscesses circumscribed plugmous so often benign.

All of which may merge into the most characteristic diffuse gas gangrene.

It is evident that the natural history of these infections of the intestinal wall and the peritoneal cavity, presents quite a different picture from that of wounds of the extremities.

In cases of a leaking abscess or spreading peritonitis there are found at operation two different sorts of fluid in the peritoneal cavity, a free fluid, varying from serous, straw-colored, more or less turbid fluid in greater or less amount, and a local, more or less walled-off cavity containing foul, gray or dark colored pus. We have found cases in which the bacillus Welchii was present in both fluids, cases in which it was present only in the abscess cavity and a few cases in which it was present in neither.

What is the relation to diffuse peritonitis?

1 We have found it present in large numbers in fatal cases associated with toxic symptoms not unlike those associated with fatal gas gangrene of the extremities.

2 We have found it present in peritoneal fluid with symptoms of intoxication and have noted the relief of the toxic symptoms on administration of the antitoxin available.

3 We have found it present in the peritoneal fluid and have noted the remission of toxic symptoms following the use of antitoxin, but have been unable to control the peritonitis with the classical fatal issue.

4 We have noted its presence, given the antitoxin and found it quite useless. An intoxication apparently due to another toxin.

The cases of diffuse peritonitis in which the anaerobes are present in numbers show a more or less typical clinical picture. The temperature is not as a rule much elevated, the pulse rate out of ratio, they are cyanotic and the pupil is dilated. A dusky flush may be present.

At section the fluid may be foul or not. A dark colored or coffee ground fluid is sometimes seen. One may find in the region of the base of the cecum an emphysematous retro-peritoneal cellulitis, spreading and sometimes extending to the anterior abdominal wall. The progress of such a case may be quite favorable for from 24 to 48 hours when with comparatively little distension and little or no regurgitant vomiting the pulse becomes rapid and thready, cyanosis becomes more profound, the skin grows clammy, respiration becomes more rapid and death occurs.

One may say that every patient who develops a gangrenous appendicitis is affected with a local process which may spread, allowing the development of toxins, and ending fatally.

Henry and Lacey studied the precipitation of bacillus Welchii toxin.

*Bacillus Welchii* toxin reaches its maximal value in young cultures 12-24 hours old, after which it depreciates very rapidly

The potency of *bacillus Welchii* toxin is much less than that of diphtheria or tetanus. A good *bacillus Welchii* toxin, when grown on meat broth, is one with a lethal dose for mice of 0.1 cc. By precipitation with ammonium sulphate and alcohol and re-solution a concentration of from 50 to 250 mouse minimal lethal doses per 1 cc. were obtained. Stored in amber colored bottles with rubber corks a room temperature. No deterioration in over 11 months.

De Krief showed that the toxin of the bacillus exercised a very definite aggressive action on the bacilli. As the bacteria multiply, the symptoms of intoxication become manifest and are the same as those observed when sub-lethal doses of toxin are injected into the circulation of susceptible animals. They act on the nervous system, producing tremor, slight convulsion, hic-cough, bristling of hair, constipation by paralysis of the bowel. They affect the circulatory system, as evidenced by the extreme rapidity of the pulse. Before death, paralysis of the hind legs occur and the animal refuses food. It remains hunched up and motionless and its respirations are markedly increased. Death intervenes by respiratory failure rather than by cardiac paralysis.

The lesions are those referable to the muscles, the blood vessels and the fat of the subcutaneous connective tissue. The muscles are first rendered necrotic by contact with the toxin which is a protoplasmic poison. The carbohydrates of the necrotic muscle are then attacked in turn by the saccharolytic ferments of the bacilli which produce gas and acids. The gas infiltration results from this change. The oedema which occurs, has been ascribed by some authors to the acid produced, whereas others maintain that it is due to the pressure of the infiltrating gas. The toxin seems to exert a specific effect on the muscle fibres of the media coat of the blood vessels, with a tendency to rupture of the blood vessels and consequent hemorrhage. The exuded blood is hemolyzed by the hemolytic substance secreted by the *bacillus Welchii*. This diffusion of caked blood is particularly noticeable with toxic strains.

Exactly what is the relation of the presence of the gram-positive anaerobes to toxemia?

In many instances, in fact in most of the cases of appendicitis, they would seem to be comparatively innocent bystanders. Present in the lumen of practically all appendices removed at operation and in the pus of gangrenous abscesses almost without exception. They are found with fair regularity in the foul pus of drained cases without any evidence of toxic effect.

They may however be found in the free fluid of a disseminated peritonitis, in sacculated and

undrained collections of pus within the abdomen and associated with other organisms, notably the streptococcus, in a retroperitoneal cellulitis, such numbers and accompanied with such a degree of intoxication as to very strongly suggest a causal relation. The symptomatology of a perforative peritonitis advancing to a fatal issue, simulates quite closely the picture of a case of gas gangrene and of the intoxication produced by the experimental injection of the toxin in guinea pigs.

The surgeon enters a race with death. He knows this. He has known it now many years, and in the amputation of the appendix he removed the focus, if it is still limited to the organ. If the anaerobes have spread beyond the appendix, the process may be localized or general in the peritoneal cavity and the degree of virulence has evidently a wider range.

### CLINICAL

We believe that the greater number of patients who die of peritonitis secondary to appendicitis, die of an intoxication and not of an adynamic ileus which has not time to develop, and that the clinical manifestation of this intoxication is not unlike the classical descriptions of gas gangrene.

We believe that the development of such an intoxication may be prevented by prompt and proper surgery and that a certain number of cases in which surgical relief would be unavailing alone may be saved by early and vigorous use of serum treatment.

The treatment of such cases has only served to emphasize what we already knew, namely, the necessity for

- 1 Prompt recognition of appendicitis and prompt appendectomy
- 2 Operative measures carried out so as not to spread the infection
- 3 Adequate drainage
- 4 The Fowler posture with free tube drainage in generalized cases
- 5 Measures to guard against acidosis, and
- 6 The recognition, so far as possible, of the degree of diffusion of anaerobic infection and the use of such antitoxin means as we possess

In a previous paper I have reported a series of cases in which a serum antitoxin to the *Welchii* bacillus was used.

It is evident that this can be but a feeble weapon when a number of equally if not more dangerous organisms may be quite as responsible. It was and is, however, the only one at our command and the measure of its usefulness only, serves to emphasize the need for more work in that direction.

The subject calls for further bacteriologic and clinical study and for more serologic armament than we now possess

### Discussion

LOUIS NERB, BROOKLYN HOSPITAL

In cases of gangrenous appendices, a very important factor is the identification of the different aerobic and anaerobic bacteria. After careful investigation the conclusion was reached that most important among these is the *B. Welchii* or *Bacillus Aerogenes Capsulatus*, commonly known as gas bacillus. The great handicap in such cases was found to be the long process needed to bring about the identification of this anaerobe. Our aim was to shorten as much as possible the time necessary to definitely prove the presence of the *B. Welchii*.

At first the identification was made according to the standard method, by injecting a rabbit with the suspicious material.

Anaerobic agar cultures were run parallel by applying the Wright's Pyrogallic Acid method.

With this method it is impossible to make a definite diagnosis of *B. Welchii* in less than eighteen or twenty-four hours.

Anaerobic milk cultures were then substituted for agar cultures. It was found that the culturing time could be lessened and purer cultures could be depended upon.

At the same time this particular method of culturing can be used for the differentiation of *B. Welchii* and the anaerobic bacillus *Vibrio Septique* or *Bacillus of Malignant Oedema*. This latter type of anaerobe grows under practically the same condition as *B. Welchii*, except that it does not show the violent explosion in the milk, but forms an almost solid coagulum in the clear whey. In acute appendices, separate cultures were taken from the lumen, the mucosa, and the submucosa of the appendix, also from the peritoneal fluid nearest the gangrenous lesion. Most important is the discovery of the presence of the *B. Welchii* in the peritoneal fluid in the shortest possible time.

The first experiment in the attempt to shorten the time was to inject into the livers of five guinea pigs, an active, live culture of *B. Welchii*. The pigs were killed and placed in the incubator. After three hours an autopsy was performed on one pig and then on the others at intervals of one hour.

Smears and cultures were taken from the liver, the bloody peritoneal fluid and the heart's blood of each animal. The *B. Welchii* were found in all these smears and cultures, but there were no

marked changes in the organs of the animals. This experiment proved that *B. Welchii* could be found in as short a time as three hours after the injection in the liver. To prove that the *B. Welchii* in the heart's blood was the *B. Welchii* that was injected in the liver and not the result of a ruptured intestine or a post mortem result, the following experiment was made.

The same number of animals were injected individually with sterile saline, different kinds of staphylococci, *B. Coli*, and streptococci. Autopsies were performed as before—the first after three hours and the others at intervals of one hour. The *B. Welchii* could not be detected in smears or cultures from these animals.

The next step was the injection of animals with different dilutions of a live culture of *B. Welchii* mixed with a twenty-four hour culture of *B. Coli*.

The dilutions were made in concentrations of one hundred, one thousand, and ten thousand organisms per cc. The pigs were injected in the liver with these dilutions, and autopsies performed after two hours. The *B. Welchii* could be easily seen in smears taken from the liver, the bloody peritoneal fluid, and from the heart itself. Pure anaerobic cultures of *B. Welchii* were obtained in this experiment. The bacteria were most numerous in the bloody peritoneal fluid. The conclusion was therefore, that by producing a trauma in the liver with a twist of the needle, making a more bloody exudate, the bacteria would be more numerous.

The actual work was done as follows. Suspicious material, especially from acute appendices, was emulsified with sterile broth, part injected with a hypodermic syringe and a twenty-gauge needle into both lobes of the liver of a guinea pig, and part cultured in the described way. The guinea pig was killed and placed in the incubator. An autopsy was performed two hours later and smears were taken from the bloody peritoneal fluid, the liver itself and from the heart. In positive cases the *B. Welchii* could be easily seen. According to our records there were 97 per cent positive findings in animals after two hours, compared with the positive anaerobic milk cultures. This slight difference may be explained by an error of the proper technique, in as much as the animal injections were not always made by the same person.

Using the anaerobic milk culture as a check on the smear from the peritoneal fluid, the conclusion is that the presence of *B. Welchii* may be definitely proven within two hours after receiving the suspicious material.

# THE CONVULSIVE TOXEMIA OF PREGNANCY AND ITS TREATMENT\*

By ROSS McPHERSON, M.D., F.A.C.S.,

NEW YORK CITY

A REQUEST from the chairman of a section for a paper on a definite subject is, of course, tantamount to a command, so that when the chairman of this section asked me to read on the Convulsive Toxemia of Pregnancy and its treatment, I could not well refuse, although I am sure that many of my audience are already weary of hearing me talk on this subject. Since the publication in 1916 of my first paper on the conservative treatment of convulsive toxemia of pregnancy, there has been in this country such a rapid spread of this method of handling the complication, that it is a great source of gratification to the reader to feel that, in some small measure, at least, he has been responsible for the more general adoption of the less radical procedures, with the consequent lowering of maternal and fetal morbidity and mortality. Indeed, at a large medical meeting held in New York City only two weeks ago, where the subject for the evening was the same as the one with which we are dealing today, and where prominent obstetricians from three different cities were present—Philadelphia, Baltimore and New York—the general and practically unanimous opinion was in favor of the adoption of the more conservative methods, and the elimination of radical methods in dealing with the convulsive toxemias of pregnancy, except in a very few cases.

There still remain in every community, however, a few practitioners, who, either from timidity (for it requires courage to depart from the beaten path into unknown territory in treating a condition as terrifying to physician and lay observer alike as in a convulsive toxemia), or lack of initiative or some other equally invalid reason, refuse to adopt either the careful prophylaxis that should be practiced during the prenatal state, thus avoiding the toxemia later, or the conservative method of treatment which should prevail when the complication has arisen, and it is these last few prodigals that the reader wishes to gather into the family circle.

Quoting from an article on this subject read by me at the annual meeting of the Massachusetts Medical Society at Pittsfield, Mass., in June, 1923:

Eclampsia, otherwise and more correctly known as the conservative toxemia of the pregnant woman, has always been regarded as one of the most baffling conditions with which the physician has had to deal. Coming on with its lightning-like suddenness and, as was formerly supposed, in the absence of premonitory signs—

signs which we have lately learned are present and usually can be recognized both by means of better methods of diagnosis and a more accurate and thoughtful study of the complication—it was, and still is, enough to strike terror into the mind not only of the lay observer but also of the medical attendant, and, as with the introduction of modern surgical methods it became easier and more simple to empty the uterus with speed, it is small wonder that operative intervention in these cases became the accepted and approved method of handling them. Appearing in the pregnant state, what could be more natural and reasonable than the theory that the pregnancy must be the cause of the condition and that, therefore, to help the patient, the provoking cause must be removed, a theory which seems sound and to a certain extent undoubtedly is.

Whether or not, however, the practice in popular vogue is always the best for obtaining this result is the matter before us for consideration today, and with your permission, I would like to take up the subject in the following order: 1 Frequency of occurrence of eclampsia, 2 symptoms, 3 the pathology, 4 the treatments commonly in vogue, both past and present, with the idea of placing the complication on a more rational basis.

Williams<sup>1</sup> in his textbook considers that an eclampsia occurs once in 130 cases, Cragin<sup>2</sup>, once in 79 cases, and other authors in about the same proportion. At the New York Lying-In Hospital, in 120,000 cases we had 890 eclampsias. This shows that we may expect in hospital practice to see a case of this description once in about 185 patients. The season of the year apparently has some importance in this connection, as the cases are noted more frequently in the early spring than at other times, and also greater numbers are seen some years than others. Its occurrence is almost twice as common in primiparae as in multiparae (64.4 per cent and 35.6 per cent respectively), and as might be expected, much more frequent in antepartum than in postpartum or intrapartum patients.

The greatest number of cases are noted between the ages of 20 and 25 years, which is in accord with the statement that the greater number occur in primiparae.

The symptoms may be divided into (a) the premonitory or pre-eclamptic, and (b) those occurring after the convulsive seizure has taken place. Of these the pre-eclamptic warnings are the most important, as like storm signals at sea, if properly noted in time, preparation for the approaching tempest can be made, and often a port reached, which will frequently though not

\* Read at the annual meeting of the Medical Society of the State of New York at Rochester, April 23, 1924.

always, as some authors have said, enable us to avoid the storm altogether

It is difficult to put in the proper order of their importance the pre-eclamptic signs and symptoms, many authorities disagreeing markedly on this point, but to the reader it seems that by far the most constant and most significant warning of an impending toxic state in the pregnant woman is found in the blood pressure. In an otherwise normal patient, a sudden and permanent rise in the blood pressure is to be looked on with alarm and is never of slight importance.

Next in order we have the condition of the urine, not so much from the standpoint of the kidneys themselves, as an index of the degree of toxemia from which the patient is suffering, and, thirdly, the results of the ophthalmoscopic examinations of the eyes, which, as they are becoming more common, seem to point out to us a very important piece of information. Edema of the extremities, or of the body in general, tenderness over the gall-bladder, nasal hemorrhage, various digestive disturbances, constipation and so on, are undoubtedly of importance and when present should be carefully noted and if possible treated and corrected, but the increasing blood pressure, the urine examination, both regarding the increase of albumin and the presence of casts, and possibly the nitrogen coefficient (though this is of doubtful value) and the presence of progressive changes noted by the skilled use of the ophthalmoscope, are all that the skilled obstetrician needs to put him on his immediate guard for the onset of the eclamptic seizure. These, when present, with the convulsion, the coma, the cyanosis, the rolling eyes, clenched teeth and other familiar features, need no further description, and we will now proceed to consider the pathology of the complication, in the light of what knowledge we have been able to accumulate during the last few years.

For a long time the disease was thought to be of renal origin, and as such was considered a uremia. More careful and extended observation, however, has shown that the kidney involvement is entirely secondary, as evinced by the fact that we frequently see cases in which, although typical in every other respect, clinically the kidney is not involved, or not until late.

The typical lesions found are those of a degeneration of the parenchymatous organs, notably the liver, followed by the kidney, less commonly by the spleen and pancreas, this takes the form of an albuminous change known as cloudy swelling, passing on to fatty degeneration early in the disease, and later, in the more aggravated forms, extending to all the tissues. In the other toxemias of the non-convulsive type, we find zonal necroses in the liver lobules. These necroses have been described by Schmorl<sup>2</sup> of Germany and Williams<sup>4</sup> in this country.

In eclampsia, on the contrary, we usually find extensive hemorrhages in and about the portal spaces, with very little zonal necrosis in the outer space of the lobule. The hemorrhages are general in character, usually being especially marked in the brain, about the corpus striatum and pons, rupturing into the fourth ventricle.

Welch<sup>5</sup>, formerly pathologist to the New York Lying-In Hospital, explains these hemorrhages by suggesting that there is circulating in the blood a poison which causes agglutination of the red cells, forming emboli, and when the solution of the endothelium of the blood into the tissues. The blood pressure is usually high, especially during the convulsions, a condition which increases the brain hemorrhages occurring in these young subjects who are usually free from arteriosclerosis. Welch believed that the poison causing the intoxication is probably an enzyme or a combination of enzymes which attack the cells and cause their destruction, the process being known as autolysis, this statement is particularly applicable to the liver.

Concerning the immediate sources of the poison, they have been regarded as four in number: the food, fermentations in the intestine, cell metabolism, and the fetus and placenta, with a possible fifth in the kidney. It is a well-known fact that the autopsy reports always invariably show dilated ureters in women dying in advanced pregnancy, and from retention there may be some contributory share. With regard to the part played by the fetus and placenta, little is yet known, and whether they furnish a portion of the enzymes which attack the maternal organism, as has been declared by some, is a question which the biological chemist has not yet answered.

Hunter<sup>6</sup> states that eclampsia is due to a toxin, but what that toxin is has not yet been shown. McGarrison<sup>7</sup>, in his work on the thyroid, gives the following suggestion. Spinal anæsthesia is produced by injecting a local anæsthetic, such as stovaine, into the spinal canal, that is, bringing a paralyzing substance, into contact with the spinal cord. If instead of a paralyzing substance an irritant, like the toxin of eclampsia, is mingled with the cerebrospinal fluid, we would expect the results of irritation, namely, convulsions, as in eclampsia.

If it be true that the eclamptic toxin is to be found in the cerebrospinal fluid, it must get there through the choroid plexus which normally secretes the fluid. The choroid plexus is a true secreting gland, and in health has a selective action which prevents toxic bodies passing from the blood to the cerebrospinal fluid. If from disturbed function this selective action is lost, toxins will pass through the gland to the spinal cord, and those toxins may be the toxins of eclampsia. McGarrison mentions two classes of toxins: (1) Those resulting from endogenous



metabolism and (2) toxins of bacterial action. Possibly the first class, by their presence in the cerebrospinal fluid, is responsible for the symptoms of eclampsia. The kidneys under normal conditions would secrete these toxins. In pregnancy they are much increased in quantity.

From McGarrison's<sup>7</sup> work it seems reasonable that the bacterial toxins may bring about a disordered condition of the thyroid, and that they are originated in the alimentary canal. He mentions the frequency of the enlarged thyroid in pregnancy. The fetus causes increased activity of the thyroid which is more easily disturbed on account of acting under greater pressure. Most obstetricians believe that the toxin of eclampsia is elaborated in the alimentary canal of the mother.

McGarrison<sup>7</sup> concludes that the bacterial toxins elaborated in the alimentary canal are absorbed into the blood and carried to the thyroid apparatus upon which they act injuriously and cause insufficient hormone production. This leads to choroid plexus insufficiency with loss of selective action which permits (toxic) endogenous products of metabolism to enter the cerebrospinal fluid, where they act upon the central nervous system and produce the condition of eclampsia. If this view be correct, the rational treatment would be

- 1 To remove the organisms which form the toxins from the blood
- 2 To remove toxins, both bacterial and metabolic, from the blood
- 3 To remove toxins from the spinal canal
- 4 To supply hormones to activate the choroid plexus
- 5 To treat symptoms as they arise

LaVake<sup>8</sup> states that in the field of obstetrics there is not a more interesting or more important problem than that of the etiology of pre-eclamptic toxemia and eclampsia. He groups the principal theories into 1, bacterial, 2, auto-intoxication, 3, nephritic, 4, liver, 5, ovular and placental.

*The bacterial theory* was presented as early as 1884. The main advocate of this theory has been Stroganoff, and his reasons for advocating are well worth citing. 1 General disease affecting all parenchymatous organs. 2 Acute infection commencing explosively or after a prodrome. 3 Fever accompanies it. 4 One attack confers immunity. 5 Marked genus epidemicus. In 1897, 25 per cent died. In 1898, he had nineteen cases with a zero mortality. 6 It is impossible to explain the increase of eclampsia in populous centers otherwise than by accepting the infection theory. 7 As an argument against the uremic and fetal theories he mentions 126 cases, 10 of which occurred in the early months of pregnancy, and after the cessation of eclamptic seizures the

pregnancy continued to normal termination. This could scarcely occur if eclampsia were due to toxins generated by the fetus. Early eclampsia usually affords the worst prognosis.

*The auto-intoxication theory* was brought forward by Bouchard, laying stress upon the toxins generated in intestinal stasis. He believes this view is tenable only from the standpoint of direct infection or absorption of toxic products resulting from the colon or other intestinal organisms.

*The nephritic theory* lays stress upon the presence of albuminuria and concomitant signs of nephritis with insufficient kidney function, the products of maternal or fetal metabolism being the offenders.

*The liver theory* accounts for the condition by the derangement of the liver structure and function as evidenced by anatomic and functional pathology.

*The ovular and placental theories* maintain the condition to be due to the generation of toxins from the products of conception or to infarcts of chorionic villi, and bring to their standard the force of the necessity of pregnancy in obtaining the condition.

LaVake states that in his experience the great majority of thromboses are caused by infection. For the past six years he has been interested in following cases with general pathologic conditions due to infections and trying to find the possible portal of entry. Obscure cases which clear up after the eradication of foci of infection are heard of every day. It has been proved that muscular pains have disappeared after the removal of infected teeth and tonsils. Cases of neuritis have improved under the same procedure.

Also, the author has been especially impressed by the cases of nephritis which clear up and remain so, after thorough eradication of dental and tonsillar infection.

Instances have been reported of eclampsia in the mother and nephritis in the child. Many have adduced from this that the products of the fetal metabolism causing the nephritis in the child were the cause of the eclampsia in the mother. It has been shown that organisms can pass from mother to child and it is possible that an infection was the cause of both conditions. Streptococci are the most common bacteria found in tooth and tonsillar infections, and their presence turns attention to those portals of entry in history-taking and in making complete physical examinations. The author calls attention to the absence of data regarding dental infection in many obstetrical histories and examinations. He presents 13 case histories of pre-eclamptic toxemia which came under his observation, cases which were typical, and he dwells especially upon the histories of infection, where obtainable, and the evidence of infection. The data obtained in

these patients point to the fact that it is important to eradicate foci of infection as soon as a case of pregnancy presents, or, if this is not possible, especial care should be exercised in determining the approach of toxemia. Every case should have a thorough dental examination and should be under the care of a dentist throughout pregnancy. The author disregards the belief of the laity and some of the medical profession that any dental procedure at this time is dangerous. He has never seen a case resulting in the disaster of an abortion from this cause, and he has the assurance of many leading dentists that such an occurrence has never come under their observation, although such men would undoubtedly use their judgment in avoiding long, tiring, painful operations. The author concludes that adherence to the infection theory offers the best prospect of success in the prophylaxis of pre-eclamptic toxemia.

Thus it will be seen that while the etiology of the disease is by no means clear or settled, we still have made a marked advance over a few years ago, and are headed in the right direction. What the pathologist has done for us is to furnish the results of the findings postmortem, so arranged as to give us more definite ideas on which to work, and we believe that the time is not far distant when the actual toxin, enzyme or organism which causes the complication, and its method of operation, will be discovered.

Analyzing the situation, then, we are dealing with a woman who in the pre-eclamptic stage is just on the edge of being out of balance, and who, in the convulsive stage, has lost her balance, so that in the first condition we must devote our efforts toward preventing the pathology from getting worse, thus allowing the convulsions to occur, and in the second to preventing them from recurring after they have occurred once, and incidentally only, of relieving the patient of the cause of her complication, namely the pregnancy, this latter, however, to be done without imposing on her a strain which will be greater than the one to which she is already being subjected.

I lay a great deal of stress on the convulsions, because I firmly believe that practically all of these cases die of brain hemorrhage due to rupture of the cerebral blood vessels, and that while it is not universally true that the higher pressure during the convulsion is the causative factor in the rupture of the vessel, it undoubtedly is the main one, as shown by treatment, of which more later.

It is acknowledged that we occasionally see cases which, while otherwise presenting most of the features of the convulsive type, pass away without any actual convulsions, but autopsy reveals the same brain hemorrhages as those present in the patients in whom convulsions did occur. These, however, are more profoundly

toxic than the others and are apt to run a much higher continuous pressure which does not, therefore, affect our premise in the net result.

With these thoughts and facts before us then, let us proceed to take up the final subdivision of our subject, namely, the treatment. This may be divided into

(1) Prophylaxis in the pre-eclamptic state

(2) Treatment of the actual condition when it has occurred. Both of these may be subdivided into (a) medical or conservative, and (b) surgical or radical.

Prophylaxis means watchful waiting. Watchful of small indicative symptoms, always suspicious that the blow is about to fall, yet not rushing into operative procedures too hurriedly, but waiting for a definite indication in short, preparedness, in the most marked sense of the word. Every pregnant woman should be regarded as potentially pre-eclamptic, and that suspicion should not disappear until she has passed through her puerperium. Routine blood pressure, urine examinations and ophthalmoscopic inspections, together with general and special physical examinations should be made at frequent intervals, these to be increased generously if anything occurs which calls attention to any abnormal thing in the economy and it is only by this constant care that results will be obtained. It is often tiresome to physician and patient alike, especially to the latter, who cannot understand the necessity for such proceedings, and it is rarely wise to communicate to the patient the thought which makes us feel the desirability of these frequent visits. Still, the thing must be done, and faithfully, unless we are willing to take the chances of a severe catastrophe, which when in spite of these precautions, occasionally does overtake us, is apt to reflect severely upon our professional judgment and skill, if all means possible for prevention have not been employed.

The diet should be regulated, meat and eggs largely discontinued, fluids given freely, proper exercise ordered and seeing that it is performed, sufficient sleep obtained, and elimination by means of the bowels, bladder and skin secured. The teeth should be inspected and attended to. Printed instructions to patients are never given by the reader, as he prefers to consider each as an individual to be treated especially for the conditions suitable for her alone and not as one of a general class.

In the large majority of cases, if watched and handled in the above manner, no symptoms of toxemia will develop. Occasionally, however, in spite of this care, we shall one day, usually toward the latter part of the pregnancy, note a rise in blood pressure, possibly slight, possibly considerable, the urine may contain a trace of albumin, and an occasional cast and eye changes may occur, slight but distinct.

We now come to the turn in the road. The signs point in two ways, shall we institute medical treatment, and if so, how rigid shall it be, or shall we terminate the pregnancy, and if so, by what means? What shall be the determining factor for the one or the other treatment? The writer confesses that he knows of no positive rule which should be applied in every case and the only thing that can be done is to be guided by one's experience and the judgment based on that experience. If rest in bed, low diet, possibly with an increase in the carbohydrate unit, elimination, etc., do not produce an amelioration of the symptoms or if they rapidly grow worse, termination of the pregnancy should be considered before the patient has reached the point where the eclamptic seizures take place, and this termination, if decided upon after such consideration, should be brought about by some one of the gentler means, in order to avoid the intense shock which otherwise may and usually does occur if the more forcible means are employed. Chloroform should never be used and rough manual dilation is absolutely not to be tried. Cases properly watched and cared for will rarely arrive at this stage, however, and we fortunately shall not often be called on to make the decision.

So much for the prophylaxis. We have seen that by its efficient use, the convulsive cases will be far less numerous than they have heretofore been. Nevertheless, there will always unavoidably remain the uncalculated few who, either from personal indifference or ignorance on their part, neglect on the part of the medical advisor, or a combination of both, or the very small proportion, who, though adequately and conscientiously cared for, still develop convulsions, and who will demand all the resources we can bring to bear to suitably handle their complication.

As already stated at the beginning, the general feeling is still strong that the removal of the uterine contents is the most important step to be taken in the way of relief for the condition, and with the advent of modern surgical technic many operative procedures for this purpose have been employed. Rough manual dilation followed by internal podalic version, with its resultant laceration and marked shock, vaginal hysterotomy, abdominal hysterotomy, have all been exploited and freely tried, and so firmly fixed are these maneuvers in the minds of most obstetricians that until comparatively recently they have been practically universally employed. The reader pleads guilty to having been one of the surgical enthusiasts until within the past five years.

Careful study of the results obtained, both for mother and child, by these operative measures, compels thoughtful reflection, and when we consider that accouchement force gave a maternal mortality of about 30.8 per cent, with

an accompanying fetal mortality of 30.35 per cent, that Cesarean section gives a high percentage of dead mothers with only a slightly improved fetal mortality, it makes one wonder whether or not these means of delivery are after all so efficacious as they would seem.

With this idea in mind, in 1916, the writer made up his mind to at least try out the Rotunda method of treating the actual convulsive cases, giving the method a fair trial, and then to compare the results with the operative method, with the idea of ascertaining if there was not some way in which at least an improvement in the maternal mortality could be made.

Since that time he has had 116 cases in which this method has been definitely followed, 17 mothers have died, or 14.6 per cent. Excluding those who were actually moribund when first seen, 7 in number, and in whom no treatment of any sort would have availed, this leaves a corrected mortality of 8.6 per cent for the net result, with a stillbirth mortality of 22.6 per cent. Certainly a startling difference when compared with the operative method, which showed 30.8 per cent in 250 cases reported by the writer in 1909.

After this time a somewhat modified treatment was instituted which brought the mortality down to 17.4 per cent in 890 cases occurring in 120,000 confinements at the New York Lying-In Hospital up to January 1, 1921. This, however, includes 104 cases of the author's treated in the conservative manner, which reduced the mortality figures considerably.

We now come to the conservative treatment, so called. This procedure was consistently carried out in all cases and, unless the patients gave evidence of prompt delivery when the head reached the pelvic outlet, low forceps were permitted.

It is understood that all of the reported cases were pregnant or recently so, that they all had had one or more convulsions and represented true obstetrical convulsive toxemias.

Immediately on entrance to the hospital the patient's blood pressure is taken, a catheterized specimen of urine secured, and she is put into an isolation room which is darkened, and as much quiet as possible obtained. She is then given by hypodermic injection, one-half gram morphine sulphate, her stomach is washed out, two ounces of castor oil is poured down the tube at the end of the lavage, and she is given a colonic irrigation of five gallons of 5 per cent glucose solution.

If the blood pressure is over 175 systolic, phlebotomy is done, and a sufficient quantity of blood is extracted to bring the pressure down to 150, normal saline is not injected. In the experience of the writer, it is unwise to bleed the patient if the pressure is lower than 175 systolic, as, if for any reason, a good deal of blood is

lost during the delivery, the pressure will be reduced so low that the patient may die from shock. The same objection applies to the antepartum administration of large doses of veratrum viride.

She is now kept quiet and one-fourth grain morphine administered every hour until the respirations drop to eight per minute. At this time convulsions have usually ceased, the patient will have fallen into labor, and, as has happened in practically all of our cases, will be delivered normally or by an easy low forceps in a short time. Occasionally the use of a little ether is necessary to control the convulsions while waiting for the effect of the morphine. The convalescence is treated in the usual manner, as indicated by the symptoms, and has been in our patients significantly uncomplicated.

Summarizing our results, then, we see that

1 The convulsive toxemia of pregnancy is a condition of whose exact cause we are unaware

2 The toxemia is divided into two groups (a) The pre-eclamptic stage, (b) The stage of convulsive seizures

3 We can by careful watchfulness and intelligent supervision, largely prevent the condition from becoming severe, or from occurring at all

4 When it does occur, rough operative procedures do not give as satisfactory results, either for mother or child, as does more conservative medical treatment judiciously combined with the gentler and less traumatic forms of operation

## REFERENCES

- 1 Williams Text-book of Obstetrics
- 2 Cragin Text-book of Obstetrics
- 3 Schmorl *Arch f Gynäk* 1902, lxx, 504-529
- 4 Williams Text-book of Obstetrics
- 5 Welch *Bull Living-In Hosp*, New York, December, 1909
- 6 Hunter *Brit Med Jour*, March, 1920, p 469
- 7 McGarrison *Ibid*
- 8 LaVae *Jour Lancet*, 1916, xxvi, 600

## THE ETIOLOGY AND TREATMENT OF TONSILLAR HEMORRHAGE\*

By GERARD HUTCHISON COX, MD, F.A.C.S.,

GLEN COVE, N. Y.

THE tonsil operation today is performed so frequently in all localities that the dangers connected with it are often overlooked. Not the least of these, both in frequency and severity, is tonsillar hemorrhage, a complication which often leads to a fatal termination. With a proper understanding of this condition and the methods for its prevention and control, this danger may be reduced to a small minimum.

A survey of the literature made by the author in 1912<sup>1</sup> shows a considerable number of fatalities from hemorrhage alone. Nearly fifty years ago, in 1875, Bardeleben<sup>2</sup> reported two fatal cases in which the cause of death was injury to the carotid artery. Downie<sup>3</sup> in 1886 and Casselberry<sup>4</sup> in 1893 each reported a fatality from hemorrhage following tonsillotomy. Damianos and Hermann<sup>5</sup> in 1902 reported the case of a man twenty-three years old, operated in the Vienna Clinic for hypertrophied tonsils, who died sixteen days later from secondary anemia. Autopsy demonstrated an eroded vessel. Digital and instrumental compression, and ligation of the carotid had failed to control the hemorrhage. Johnston<sup>6</sup> mentions the case of a boy seventeen years old, a bleeder, who died from hemorrhage two weeks after the application of a galvanocautery to the tonsil. Hurd<sup>7</sup> in 1910 reported a fatal hemorrhage in a child operated with a tonsillotome. A tonsillar clamp and ligation of the carotid failed to save

the patient's life, death ensuing before transfusion could be performed. Harmon Smith<sup>8</sup> records six additional fatalities, one in a child eight and one-half years of age, who had an anomalous internal carotid artery which was wounded with the tonsillotome. Holinger, Mackellar, and Barkan have each recorded a death from tonsillar hemorrhage and Stucky a bleeder of fifteen years who died from a continuous venous oozing. Chase<sup>9</sup> mentions eight unpublished cases of fatal hemorrhage following tonsillectomy. In reply to Hill's<sup>10</sup> questionnaire, one operator recorded twelve cases of fatal hemorrhage, while another operator reported four fatal cases. One reported three deaths and four, two deaths each.

In 1920 Douglas reported that there had been four fatalities from tonsillectomy in three years at the Post Graduate Hospital.

In 1922 Loeb<sup>11</sup> collected statistics of death following operations on the throat and nose, including only cases not reported elsewhere. Among these deaths were forty-three fatalities from hemorrhage after tonsillectomy. An analysis of the reports of these forty-three cases shows that in sixteen there was lack of post-operative control, while in four cases there was a fatal hemorrhage in spite of thorough ligation of the vessels. In one case the fatal hemorrhage occurred three weeks after the operation. In two cases there was an anomalous branch of the carotid artery, while in still another there was extremely high blood pressure.

\* Read before the Nassau County Medical Society, October 28 1924

Bailey<sup>11</sup> in 1922 sent out a questionnaire and received replies from 350 laryngologists in the United States. Twenty-seven operators each reported a death from tonsillar hemorrhage. In Panse's fatal case (see table) the source of bleeding was apparently blood vessels in an enlarged salivary gland, injured during the tonsil operation. In Macleod's fatal case (see table) the patient died from hemorrhage and shock although the pillars were sutured. In the fatal case autopsied by Sebeleanu (see table) there was a piece torn from the wall of the internal carotid artery. The hemorrhage was so sudden and severe that nothing could be done to stop it and the child died within a few minutes.

Coming now to the cases of alarming tonsillar hemorrhage, the outcome of which was not fatal, we find a report by J. Wright<sup>12</sup> in 1890 of thirty-one serious hemorrhages, and another report by Harmon Smith in 1903 of twenty-four additional cases. In a search of the literature from 1904 to 1912 made by me, thirty-five additional cases were reported. I have recently looked up the literature from 1912 to date and have uncovered thirty-four cases of alarming tonsillar hemorrhage in addition to the fatalities enumerated above. These reports are given in the annexed table.

Thus we find ourselves confronted with a series of 261 cases of alarming tonsillar hemorrhage, with fatal outcome in 125 instances. Such an array of figures may well make us pause and take measures to improve our technic.

### ETIOLOGY

The bleeding in tonsillar hemorrhage comes from the arteries and veins which supply the tonsil. The normal blood supply of the tonsil is given by Coakley<sup>14</sup> as follows:

"The superior pole of the tonsil is supplied from the descending palatine branch of the internal maxillary, and the middle and external portion from the ascending pharyngeal and the ascending palatine arteries, the lower part of the tonsil and part of the lateral pharyngeal wall are supplied from the *dorsalis linguae*."

The return venous supply is composed of a rather large plexus of veins which seem to be assembled partly between the outer layers of the capsule and partly between the capsule and superior constrictor of the pharynx lying just external to the capsule. This plexus drains into the internal maxillary vein above, into the lingual anteriorly and into the palatine below. There is a confluence of veins towards the lower pole of the tonsil. Poynter states that "From this point a large vein leads outward to join the pharyngeal plexus or opens directly into the internal jugular vein." Thus we see that the entire arterial supply of the tonsil comes from the external carotid artery and we also note that the posterior and

lower pole of the tonsillar fossa is the danger zone for tonsillar hemorrhage.

1 Abnormalities in the distribution of the blood vessels supplying the tonsil are often accountable for bleeding.

2 Traumatism, especially injury of the tonsillar pillars and extra tonsillar tissue (particularly the superior constrictor muscle) as well as neglect to tie all bleeding points, is naturally a prolific source of hemorrhage.

3 Acute inflammation of the tonsils is a contraindication to operation until several weeks after the subsidence of the inflammatory process. Moure<sup>13</sup> reports a case of hemorrhage after tonsillotomy during active inflammation of the tonsils.

4 Anemia is a frequent cause of bleeding, and should always be looked for. The writer has noticed that flabby, pale children at the age of puberty are especially apt to bleed profusely.

5 Menstruation and pregnancy are two conditions which especially predispose to post-operative bleeding. Marschik and Otto J. Stein each report cases of alarming hemorrhage occurring in menstruating women.

6 Arteriosclerosis and nephritis naturally predispose to hemorrhage. It must be remembered, in this connection, that the former condition sometimes occurs in young adults. The writer has seen two advanced cases of arteriosclerosis in young adults in the third decade, one in a man and the other in a young woman.

7 Fibroid tonsils, if operated upon, are more likely to be followed by severe hemorrhage than the simple hypertrophied variety. The fibroid tissue interferes with the contraction of the arterioles.

8 Acute infectious diseases sometimes cause tonsillar bleeding if the patient is operated upon just before the onset. F. E. Hopkins reports a case of severe bleeding on the first and second day after operation. The child developed measles on the third day.

9 Syphilis may be a cause of tonsillar bleeding. Operations on people with active syphilis are naturally contra-indicated.

10 Age. Our statistics show that post-operative tonsillar hemorrhage is more frequent in adults than in children.

11 Sex. Alarming bleeding is more common in males than in females. Of thirty-one cases in one series where the sex was mentioned, twenty occurred in males. In Smith's report, among fifty-four cases only eight were women.

12 Sloughing of a vessel wall from a low grade infection not infrequently causes late secondary tonsillar hemorrhage. The writer was recently called to two such cases who had moved to Long Island to recuperate from the tonsil

operation, the bleeding in each taking place seven days after the original operation. Such hemorrhages occur not infrequently two and even three weeks after operation.

13 Hemophilia is a much discussed cause of post-operative tonsillar hemorrhage. One frequently encounters the statement that hemophilia may be ignored provided a careful operation is done and all bleeding points thoroughly ligated. While there is considerable merit in this assertion, yet one who has had a case of hemophilia under his care is usually not disposed to dismiss the subject so lightly.

A case of nose bleed in an eighteen year old hemophile, which I treated in Dr Chappell's service at the Manhattan Eye, Ear and Throat Hospital in 1912, well illustrates the gravity of this unfortunate disease. (Reported by Chappell in the *Transaction of the American Laryngological Association* in 1912.) During the past six years, the patient had repeated attacks of nose bleed every three or four months, principally from the left nostril. After the bleeding had continued for some time, the right nostril also began to bleed. The hemorrhage usually lasted three or four hours.

On February 5, 1912, the boy was admitted to the Manhattan Hospital bleeding profusely from the left nostril. He stated that this bleeding had continued for one month, every second or third day, and that immediately before entering the institution, he had been bleeding continuously for thirty-two hours.

The patient's face was blanched and white as paper. Pulse 120.

Examination of the nose showed a continuous oozing from the whole anterior portion of the septum and from a spot on the anterior end of the inferior turbinate, and from a third spot further back on the floor of the nose. No bleeding vessel could be seen. The left nostril was packed with gauze, saturated with fresh human blood serum. This controlled the bleeding in about fifteen minutes. 20 cc. of the freshly prepared blood serum of the brother was injected into the patient's arm intravenously.

The blood pressure on admission was 110, the haemoglobin 35 per cent and the red blood cells 2,784,000.

The packing, which had been in the nose for almost twenty-four hours, was removed the next day and three hours later the patient began to bleed again, and at 6 p m it was again necessary to pack the nose with gauze. 18 cc of human blood serum was injected intravenously.

For the next four days he was given 18 to 20 cc of fresh rabbit serum twice a day.

The bleeding practically ceased on the fifth day after admission but on the seventh day the patient began to bleed very profusely from the

left nostril, the blood welling out as fast as it could be wiped away and it was necessary to pack the nose with gauze.

Five days later there was profuse bleeding from the whole left side of the septum, which was controlled for a short time by gauze packing, but which recurred again and again until the patient's condition became desperate.

On February 22nd a transfusion operation was performed by Dr George E Brewer, consulting surgeon. The blood was run from the donor's artery into the patient's vein for twenty-eight minutes. The haemoglobin increased from 30 per cent to 65 per cent and marked improvement resulted.

On March 30th, six weeks after admission, he was discharged from the hospital cured.

Although the period at which this patient was treated antedates modern laboratory methods and modern technique for blood transfusion, the case is of considerable interest inasmuch as it illustrates the difficulties with which the treatment of hemophilia is surrounded.

Nowadays, with ordinary care in taking the patient's history, and particularly if the coagulation time and bleeding time are estimated before operation, there should be no difficulty in diagnosing a bleeder beforehand. In this connection it is well to remember, when taking the history, that true hemophilia occurs only in males and is transmitted through the female to the male. Particular attention should be directed to ascertaining the occurrence of umbilical hemorrhage at birth, and hemorrhage from circumcision.

In a personal conversation, Dr F E Sondern told me that in his experience, in the case of bleeders, there are no borderline abnormal cases as far as coagulation time is concerned. For instance, if the normal coagulation time is 6-8 minutes in the Bifi-Brooks platinum loop method which he employs, there are no cases with a coagulation time of say 9 to 10 or 10 to 11 minutes. With bleeders, the clotting time will be prolonged to 16 or 18 minutes, or even longer. In this connection it is well to remember that in true hemophilia the bleeding time is normal, although of course, as stated above, the coagulation time is markedly prolonged.

Fortunately in blood transfusion, we have a means of raising the coagulation time in advance of operation, in addition to transfusion being a most efficacious method of treating post-operative hemorrhage. I am indebted to Dr Rufus E Stetson of New York for notes on cases of tonsillar hemorrhage where he was called in consultation to perform transfusion.

Case 1. Male child seven years of age. Hemorrhage following tonsillectomy. Child in extremis at time of transfusion. 300 cc of whole blood given. Recurrence of hemorrhage two days later easily controlled, second transfusion not

necessary History of bleeding in this case suspicious of true hemophilia

Case 2 Female child between three and four years of age Hemorrhage following tonsillectomy At time of transfusion child was very pale, restless and fretful Rapid pulse Unable to retain nourishment 250 cc of whole blood given Recovery uneventful

Case 3 Male adult about 45 years of age Profuse and uncontrollable hemorrhage occurring a few hours after tonsillectomy Patient's condition at time of transfusion was critical 700 cc of whole blood given Hemorrhage controlled Patient left hospital in two days

Case 4 Male child seven years of age Profuse hemorrhage a few hours following tonsillectomy Child's condition very grave at time of transfusion Almost exsanguinated, unconscious, pulse barely perceptible, air hunger This case was complicated by an acute acidosis, to combat which, the donor was administered large doses of bicarbonate of soda before giving blood 500 cc of whole blood used Recovery uneventful (The four cases are also listed in the table which follows)

Case 5 Male child, five years of age True hemophilic *Pre-operative* transfusion of 500 cc of whole blood given from mother in preparation for tonsillectomy Operation successfully performed without undue bleeding

Dr Stetson writes me that "The use of whole blood intravenously in these cases may be considered as near a specific cure as any therapeutic measure which we can employ Other coagulants such as horse serum, rabbit serum, and thromboplastin often fail to control the hemorrhage, and the delay involved in their trial is often dangerous, and may be fatal to the patient"

#### TREATMENT

What measures may be taken to prevent tonsillar hemorrhage? In the first place the tonsil operation, no matter whether performed under a local or general anaesthetic, is essentially a hospital operation The practice of operating in an office or dispensary and sending the patient home directly afterwards, is, in my opinion, absolutely unjustifiable The heart, lungs, kidneys and arteries should be examined before operation, while in adults the blood pressure should be taken Where the temperature is elevated, the operation is postponed Avoid operating in the presence of, or directly after, acute tonsillitis Do not operate in early pregnancy or during the menstrual period If there is a history of bleeding and a prolonged coagulation time, give a preliminary blood transfusion

Calcium lactate is employed by many surgeons as a routine prophylactic measure for three days preceding operation in doses of 15 grains by mouth tid for adults and grains  $7\frac{1}{2}$  for children

In this connection, a recent article by Bowler and Walters<sup>16</sup> of the Mayo Clinic is of interest These observers have used, in cases of obstructive jaundice requiring operation, pre-operative intravenous injections of calcium chloride daily for three days preceding operation, giving 5 cc of a 10 per cent aqueous solution per dose The results have been gratifying as evidenced by the lowering of the blood coagulation time and the absence of post-operative hemorrhage

I personally believe that a great many so-called post-operative tonsillar hemorrhages are really primary hemorrhages where the bleeding is not thoroughly controlled before the patient is allowed to leave the operating table Too much stress cannot be placed upon the importance of securing a thoroughly dry operative field Use good electric illumination, a good suction apparatus, and a retractor for the tonsillar pillars If the bleeding does not promptly cease when a cotton ball or a sponge holder is held for a moment in the tonsillar fossa, carefully inspect the fossa and pick up the bleeding point or points with artery clamps Ligate with a catgut slip-noose, or transfix with a Seiffert tonsil needle and tie Some surgeons advise their patients to suck ice or gargle with ice-water directly after the tonsil operation I am convinced that these measures are harmful, and tend to increase, rather than inhibit bleeding

There is a tendency among some surgeons in post-operative hemorrhage, to lay too much stress upon general measures for the control of the bleeding The operator will probably order a hypodermic of morphine, an ice-coil to the neck, and perhaps will allow the patient to slowly but steadily bleed, drop by drop, under a clot in the tonsillar fossa In this way valuable time is lost, and the patient loses more and more blood until his condition finally becomes precarious It is far better, if any unusual bleeding takes place after the patient is returned to the ward to inspect carefully the tonsillar fossae under good illumination, boldly wipe away the clot, and immediately take the patient back to the operating room, where the bleeding points may be ligated

Under unfavorable conditions, without sufficient assistance, and where there is need of extreme haste, the Wagner-Michel metal tonsillar clamps are useful aids These resemble the metal skin suture clips, and are sold in special sets with an instrument for introduction and another for removal When using these clips, a small gauze pad is first placed in the tonsillar fossa, and the pillars are brought together and clamped over the pad A small thread is attached to each clamp and fastened with adhesive plaster to the side of the patient's mouth These metal clips should be removed the following morning They have the disadvantage of producing considerable traumatism and tearing of the tonsillar

pillars, and I have discarded them in favor of ligation and suture

In closing, mention should be made of carotid artery ligation as an extreme measure. Either the external carotid may be ligated, or, if there is urgent need of haste, the common carotid may be tied. Jackson ligates the external carotid, and has performed this operation seven times to arrest tonsillar hemorrhage.

Henking<sup>17</sup> in 1905, stated that ligation of the common carotid on account of uncontrollable hemorrhage from tonsillotomy has been practiced by Guntner, Hada Siden, Sands, Fuller, Arbuthnot Lane, Downie and Mosetig-Moorhof.

In the first five cases cited the hemorrhage definitely ceased after ligation, and the patients recovered, although two were apparently hemophiles (Guntner's and Fuller's cases). One of the fatal cases (Mosetig-Moorhof's) died of sepsis sixteen days after the operation. In the other fatal case (Downie's) the cause of death could not be ascertained.

In all of these cases the common carotid was tied, apparently because it is more easily and quickly reached than the external carotid. In none of these seven cases did the ligation of the common carotid have any unfavorable influence upon the brain function.

TABLE OF CASES OF SEVERE TONSILLAR HEMORRHAGE REPORTED 1913 TO JULY 1, 1924  
(Paper by DR. G. H. COX)

REPORTED BY	Patient's Age	Sex	Disease	Instruments Used	Result	Reference and Remarks	Methods Used for Control of Hemorrhage
O'Malley, J. F.	25	Female		Gullotine	Recovery	Clin. J., 43 49, 1914	No Special Treatment.
O'Malley, J. F.	11	Male	Deafness and Obstruction	Gullotine	Recovery	Clin. J., 43 49, 1914	Hemorrhage beginning 24 hours after operation spontaneously arrested by the time patient reached hospital.
Hurd, Lee M.	27	Male	Recurrent Tonsillitis	Dissection and Snare	Recovery	Laryngoscope 25 856, 1915	Repeated hemorrhages, treated by horse serum, coagulose, pressure, metal clips.
Agnew, F. F.	6	Female	Enlarged Tonsils	Blunt separation of pillars and cold snare	Recovery	Ann. Otol. Rhinol. and Laryngol. 24 44, 1915 The internal carotid was in an abnormal position.	Hemorrhage 2 hrs after operation controlled by application of adrenalin to fossa, compression of carotid artery, and tonsil clamp. Secondary hemorrhage 9 days after operation, was treated by ligation of the common carotid.
Amsden, H. H.	9	Male			Recovery	Boston M. A. S. J., 177 594 1917 Secondary Hemorrhage in a patient operated in another clinic.	Inspection of the tonsil showed a large button-hole of the right anterior pillar from which bleeding occurred, controlled by catgut stitch.
Laboure, J.	22	Male		Ruault forceps	Recovery	Presse Med. 26 396 1918	Hemorrhage after operation controlled by pressure, secondary hemorrhage on 8th day stopped by ligation of the ascending pharyngeal artery.
Laboure, J.	25	Female		Cold Snare	Recovery	Presse Med. 26 396 1918	Hemorrhage immediately after operation, controlled by ligation of external carotid.
Laboure, J.	39	Male	Infected Tonsils	Cold Snare	Recovery	Presse Med. 26 396, 1918	Hemorrhage began after removal of one tonsil not controlled by injections of ergotin, or serum, by pressure or suture of pillars. Ligation of external carotid successful.
Yergen, C. F.	12	Female	Rheumatic Fever	Sluder Method	Recovery	Illinois M. J., 35 142 1919 Hemorrhage apparently caused by erosion of a small vessel.	Secondary hemorrhage on 9th day, severe but ceased spontaneously, a small clot covered the site of bleeding vessel.



REPORTED BY	Patient's Age	Sex	Disease	Instruments Used	Result	Reference and Remarks	Methods Used for Control of Hemorrhage
Dabney, V	18	Female	Recurrent Peri-tonsillar abscess	Mackenzie Tonsillotome	Recovery	Ann Otol, Rhinol and Laryngol 28 697, 1919	Capillary hemorrhage two days after operation controlled by ice held firm'y in the fossa.
Dabney, V	25	Male		Mackenzie Tonsillotome	Recovery	Ann Otol Rhinol and Laryngol 28 697, 1919	Repeated hemorrhage six hours and 10 days after operation, later stopped when the patient fainted Method treatment not stated
Dabney, V (not operated by author)	Adult	Male			Recovery	Ann Otol Rhinol and Laryngol 28 697, 1919	Hemorrhage 7 days after operation finally stopped by clamping the posterior pillar in which the bleeding point was found
Dabney, V	19	Female		Blunt dissection & snare	Recovery	Ann Otol Rhinol and Laryngol 28 697 1919	Hemorrhage six days after operation, controlled by packing fossa with soft gauze sponge
Whales, H L	13	Female		Dissection	Recovery	Brit M J, 1 637, 1919 Hemorrhage probably due to an abnormal tonsillar blood supply	Bleeding during removal of right tonsil Clamping failed, external carotid ligated
Panse, R	17	Male	Enlarged tonsils and cervical glands	Cooper scissors and snare	Fatal	Passows Beitr 12 51, 1919	Tamponade and infusion of salt solution camphor
McKinney, R.	32	Female	Attacks of tonsillitis and kidney infection	Sluder Method	Recovery	Laryngo-scope 30 430, 1920	Hemorrhage four days after operation, ceased without special method of treatment.
McKinney, R	19	Male	Attacks of tonsillitis and nephritis	Sluder Method	Recovery	Laryngo-scope 30 430, 1920	Hemorrhage beginning the fifth day after operation, controlled by suture of the pillars
Macleod, A L	6	Female	Enlarged tonsils and adenoid	Sluder Method	Fatal	Proc. Roy Soc. Med 14 Sect. Laryngol 31, 1921	Hemorrhage two hours after operation, adrenalin dropped in nose, morphin, left tonsillar pillars stitched under second anaesthesia
Sebileau, P (not operated by author)	Child	Male		Morcellation with Ruault forceps	Fatal	Bull et mem Soc. de Chir de Paris 47 109, 1921	Severe hemorrhage during the last part of the operation, pressure did not control it. Wall of internal carotid artery was torn by the operator
Fuller, T E (not operated by author)	8	Male		Beck Instrument	Recovery	Ann Otol, Rhinol. and Laryngol 30 205, 1921	Packing of tonsillar fossa and clamping bleeding vessel
Fuller, T E.	25	Male		Matthews technic	Recovery	Ann. Otol, Rhinol and Laryngol 30 205, 1921	Hemorrhage a few hours after operation controlled by pressure with a sponge
Fuller, T E	23	Female		Matthews technic	Recovery	Ann Otol, Rhinol and Laryngol 30 205, 1921	Hemorrhage 12 hours after operation, pituitrin had no effect Suture of pillars
Fuller, T E	20	Male		Matthews technic	Recovery	Ann. Otol, Rhinol and Laryngol 30 205 1921	Hemorrhage at first controlled by horse serum, recurred, suture of pillars
Fuller, T E	30	Male		Matthews technic	Recovery	Ann Otol, Rhinol and Laryngol 30 205, 1921	Hemorrhage five days after operation controlled by pressure and hypodermic of emetin

REPORTED BY	Patient's	Age	Sex	Disease	Instruments Used	Result	Reference and Remarks	Methods Used for Control of Hemorrhage
Lavton T B	32		Male		Dissection	Fatal	J Laryngol 36 177, 1921	Oozing after operation necessitated suture of pillars recurrence treated by pressure, painting fossa with turpentine, clamping morphin and saline infusion
Just, T H (operated by Harmer)	Child		Female	Enlarged tonsils and adenoids	Tonsil lotine	Gul- Fatal	Brit M J 2 431, 1921 (abnormal loop of internal carotid artery severed)	Pressure.
Hawkins, A D	23		Female	Submerged necrotic tonsils	Not Stated	Recovery	Journal Lancet, 42 449, 1922 (day after operation patient developed mumps)	Oozing of blood began immediately after operation, pressure clamping, suture of pillars failed to control, 5 cc of a hemostatic serum preparation given subcutaneously with good results
Martin C E	16		Female		Scissors and snare	Recovery	J Laryngol 37 80, 1922 Second tonsil was not removed	Hemorrhage occurred at operation after dissection of right tonsil Bleeding points caught with artery forceps, clamp applied
Ramey, J J	43		Male		Scissors and snare	Recovery	Laryngo-scope 33 446, 1923	Ligation of vessel in the left tonsillar fossa, vessel in right fossa ligated at operation.
Ramey, J J	14		Male	Tonsillitis and rheumatic fever	Scissors and snare	Recovery	Laryngo-scope 33 446, 1923 Hemorrhage from vessels in lower pole. Those in upper pole ligated at operation	Pressure three or four minutes with sponge dipped in adrenalin.
Callison J G	19		Male	Enlarged tonsils, rheumatism		Recovery	Laryngo-scope 34 354 1924 Coagulation and bleeding time normal, but platelet count low	Recurrent bleeding for 11 days after operation Transfusion, sodium citrate injections and a preparation of thyroid pituitary-spermin extract used
Stetson R. E	7		Male	Tonsile case			Personal communication from Dr Stetson	History of bleeding suspicious of hemophilia Transfusion with 300 cc of whole blood
Stetson, R. E	3		Female	Tonsile case			Personal communication from Dr Stetson.	At time of transfusion child was pale, restless, and unable to retain nourishment. 250 cc. of whole blood given
Stetson R. E	45		Male	Tonsile case		Recovery	Personal communication from Dr Stetson Oct, 1924	Uncontrollable hemorrhage a few hours after operation Patient in critical condition 700 cc. of whole blood given. Discharged from hospital in 2 days

Reported by	Patient's Age	Sex	Disease	Instruments Used	Result	Reference and Remarks	Methods Used for Control of Hem
Stetson, R E	4	Male	Tonsile case		Recovery	Personal communication from Dr Stetson Oct, 1924	Profuse hemorrhage a few hours after operation. Patient unconscious and almost exsanguinated, air hunger This case was complicated by an acute acidosis, to combat which the donor was administered large doses of soda bicarbonate before 500 cc of whole blood was given Uneventful recovery

### CONCLUSIONS

1 The most frequent causes of tonsillar hemorrhage are traumatism at operation, and neglect to secure a dry field by ligating all bleeding points

2 The majority of tonsillar hemorrhages are operative and not post-operative

3 Hemophilia, while rare as a cause of tonsillar hemorrhage, presents serious difficulties in treatment Early transfusion is the only efficient means of control In pre-operative tonsil cases with prolonged coagulation time, the latter should be brought to normal by transfusion before operation

4 Late secondary hemorrhage is usually due to infection

5 The treatment of tonsillar hemorrhage is surgical—the ligation of all bleeding points in a dry, clean, well illuminated field

### REFERENCES

1 G H Cox "Tonsillar Hemorrhage Causes, Prevention and Treatment" *The Medical Record*, June 1, 1912

2 Bardeleben *Lehrbuch der Chirurgie und Operationslehre*, 1875, 7 Ausgabe, Bd 113

3 Downie "Hemorrhage Following Tonsillectomy," *Edin Med Journal*, 1886-87, XXXII.

4 W E Casselberry "Abcission of the Tonsil Report of a Fatal Case," *Chicago Med Recorder*, January, 1893

5 Damianos und Hermann *Wien. klin. Wochen*, 1902, p 225

6 Johnston *Rev hebdomadaire de Laryngologie*, 1906, p 545

7 Hurd *Laryngoscope*, 1910, p 674

8 Harmon Smith "Alarming Hemorrhage Following Tonsillotomy," *Laryngoscope*, February, 1904

9 Chase *Northwest Med*, 17 173, 1918.

10 Hill *Lancet* 39 170, 1919

11 Bailey *Journal Iowa Med Soc*, 12 222, 1922

12 Wright *N Y Med Journal*, August 30, 1890

13 Moure *Journal of Laryngology*, No 8, 1890

14 Coakley "Hemorrhage During and After Tonsillectomy, Surgical Principles and Methods for its control," *Journal of Laryngology and Otology*, January, 1922

15 Loeb *Ann Otol, Rhinol & Laryngol*, 31 273, 1922

16 Bowler and Walters "Effect of Intravenous Injections of Calcium Chloride on the Kidney," *Journal of American Medical Association*, October 18, 1924

17 E Henking *Archiv fur Laryngologie und Rhinologie*, 1905, p 64

## A SIMPLE AUSCULTATORY METHOD OF PHYSICAL DIAGNOSIS

By R BURTON-OPITZ, M D,

NEW YORK CITY

AS a rule the heart and other organs of the body are outlined by the method of percussion, as first practiced by the Austrian physician, Auerbruger, in 1761 This method has been greatly amplified since then and now includes several procedures, namely

(a) Direct percussion with the index or middle finger of one hand, and

(b) Indirect percussion, when the index or middle finger of the left hand is interposed between the part to be mapped out and the percussing finger of the right hand The place of the amplifying finger may be taken by a plate of rubber (pleximeter of Piorry), and the percussing finger by a small hammer made of the same material (Barry)

These methods of percussion may also be combined with that of auscultation A stethophone

is placed over the organ to be mapped out while the neighboring regions are lightly tapped upon with the finger or hammer of the pleximeter

I should like to call attention to a simple method of auscultatory stroking which has given excellent results as proven by means of the fluoroscope and Roentgen photographs While I have used this procedure principally in mapping out the heart, it may be applied with equal accuracy to other organs, such as the liver and kidneys

The bell of the stethophone is placed over the sternum at the second interspace By means of a blunt colored pencil short vertical strokes are then made from without inward, beginning about three inches to the right of the sternum As the pencil is moved inward a line will eventually be reached when the sound suddenly increases in its intensity This point is marked with the pencil The stethophone is then lowered about an inch

each time and this process repeated, until the entire right border of the heart has been charted in this manner

The stethophone is now raised to its former level at the second intercostal space, while stroking movements are made with the pencil beginning at a point three inches to the left of the sternum. The point at which a sudden increase in the intensity of the sound is noted, is again marked. The stethophone is then moved downward and this process repeated. At about the fourth rib the stethophone is shifted towards the left so that it comes to lie over the main mass of the ventricles. Sweeping oblique strokes are then made, beginning about four inches above the bell of the stethophone. This process is repeated in successive radial lines until the entire left border of the heart has been outlined.

The lower border of the heart is ascertained by placing the stethophone over the ventricles

two inches to the left of the sternum, and by making short horizontal strokes from below upward, beginning at a point about three inches below the bell.

The accuracy of this method may be tested in the following manner. A paste made of mucilage and barium sulphate is applied with a camel's hair brush in such a way that the different colored marks are joined with one another in the form of a line about three millimeters in width. The patient is then fluoroscoped. If the outlining has been correctly done the barium line cannot be differentiated from the dark borders of the heart. Furthermore, if the patient moves the tip of his index finger along the barium line, it can readily be noted whether this line corresponds with the fluoroscopic findings. Additional proof of the accuracy of this method has been obtained by the taking of numerous X-ray plates showing the barium line superimposed upon the boundary of the heart shadow.

## A CASE OF INFECTIOUS JAUNDICE\*

By E S McDOWELL, M D,

PLATTSBURG N Y

**I**NFECTIOUS jaundice is a common disease in Japan. It is caused by spirochetes which are often found in rats, although the animals do not seem to be particularly affected by the organisms. The spirochetes reach man by means of food infected by the excretions of rats.

Many outbreaks of infectious jaundice have been reported in widely separated parts of New York State, and many attempts have been made to discover and isolate the organism in the patients, but the cases have been mild and the onset of the disease insidious, and the organisms have disappeared by the time that the nature of the illness is suspected. No fatal cases have previously been reported in New York State. The following case is therefore of interest because the typical history was confirmed at autopsy and the spirochetes were identified in the tissues.

The patient was a man aged 43, working and sleeping in a kitchen that was infested with rats, but he gave no history of a rat bite. He suddenly became sick about July 1, 1924 with fever 103, and severe pains in his joints, back, and abdomen. After three days he had a total anuria which was followed within 24 hours by a cardiac collapse, his pulse running from 140-160, and being totally irregular in rate and rhythm with frequent extra systoles. He soon became very deeply jaundiced. Following this he vomited bloody material and passed blood by rectum. He de-

veloped a persistent hiccough and died in a convulsion about one week after the onset of the disease.

The urine obtained by catheterization, which was only one dram in amount, showed red and white cells, bile, hyaline and epithelial casts, and 3 plus albumin. His Wasserman was negative.

Autopsy showed a deeply jaundiced man. The autopsy findings showed no evidence of liver atrophy, the kidneys were large and swollen, and there was evidence of petchial hemorrhages through the gastro-intestinal tract. The microscopic examination of autopsy material showed acute glomerular nephritis, and extensive destruction of liver cells, and the spirochetes were demonstrated in the liver and kidneys. There was intense hemorrhagic congestion of the lungs.

One rat from the premises was obtained alive, and its blood was inoculated in guinea pigs. The guinea pigs developed all the symptoms of Weil's disease and the spirochetes were obtained from their blood stream, re injected, and the disease reproduced, and the spirochetes reobtained.

Infectious jaundice is likely to occur in the practice of any physician, and may assume a virulent type. It is a disease to be considered when an attack of stomach ache and backache is followed by jaundice.

The common occurrence of the disease is a strong argument for the eradication of rats and for the proper control of garbage heaps, which are their great breeding places.

\* Abstract of a paper read before the Medical Society of the County of Clinton in Plattsburg on November 18 1924



# EDITORIALS



The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the Journal. Views expressed in the various departments of the Journal represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

**Editor-in-Chief**—NATHAN B VAN ETEN, M.D.,  
New York  
**Associate Editor**—ORRIN SAGE WIGHTMAN, M.D.,  
New York  
**Executive Editor**—FRANK OVERTON, M.D.  
Patchogue

### COMMITTEE ON PUBLICATION

E ELIOT HARRIS, M.D., *Chairman* New York  
ORRIN SAGE WIGHTMAN, M.D. New York  
EDWARD LIVINGSTON HUNT, M.D. New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

**President**—OWEN E. JONES, M.D. Rochester  
**First Vice-President**—GEORGE A. LEITNER, M.D. Piermont  
**Second Vice-President**—LUZERN COVILLE, M.D. Ithaca  
**Speaker**—E. ELIOT HARRIS, M.D. New York  
**Vice-Speaker**—GEORGE M. FISHER, M.D. Utica  
**Secretary**—EDWARD LIVINGSTON HUNT, M.D. New York  
**Assistant Secretary**—WILBUR WARD, M.D. New York  
**Treasurer**—CHARLES GORDON HEYD, M.D. New York

### CHAIRMEN, STANDING COMMITTEES

**Arrangements**—FREDERICK H. FLAHERTY, M.D. Syracuse  
**Public Health and Medical Education**  
JOSHUA M. VAN COTT, M.D., Brooklyn  
**Scientific Work**—ANDREW MACFARLANE, M.D. Albany  
**Medical Economics**—HENRY LYLE WINTER, M.D. Cornwall  
**Legislation**—JAMES N. VANDER VEER, M.D. Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex-President and the Councilors of the District Branches

**First District**—EDWARD C. RUSHMORE, M.D. Tuxedo Park  
**Second District**—FRANK H. LASHER, M.D. Brooklyn  
**Third District**—ARTHUR J. BEDELL, M.D. Albany  
**Fourth District**—CHARLES C. TREMBLEY, M.D. Saranac Lake  
**Fifth District**—NELSON O. BROOKS, M.D. Oneida  
**Sixth District**—GEORGE H. FOX, M.D. Binghamton  
**Seventh District**—WILLIAM I. DEAN, M.D. Rochester  
**Eighth District**—HARRY R. TRICK, M.D. Buffalo

### COUNSEL

GEORGE W. WHITESIDE, Esq., 27 William St. New York  
Telephone, Broad 1744

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St. New York

### EXECUTIVE OFFICER

JOSEPH S. LAWRENCE, M.D. 51 Chapel Street, Albany

### SECTION OFFICERS

**Medicine**  
**Chairman**—ROBERT L. LEVY, M.D. New York  
**Secretary**—L. WHITTINGTON GORHAM, M.D. Albany  
**Surgery**  
**Chairman**—MARSHALL CLINTON, M.D. Buffalo  
**Secretary**—EDWARD S. VAN DUYN, M.D. Syracuse  
**Obstetrics and Gynecology**  
**Chairman**—HAROLD C. BAILEY, M.D. New York  
**Secretary**—NATHAN P. SEARS, M.D. Syracuse  
**Pediatrics**  
**Chairman**—JOSEPH C. PALMER, M.D. Syracuse  
**Vice-Chairman**—ROGER H. DENNETT, M.D. New York  
**Secretary**—ARTHUR W. BENSON, M.D. Troy  
**Eye, Ear, Nose and Throat**  
**Chairman**—ARTHUR G. BENNETT, M.D. Buffalo  
**Secretary**—EUGENE E. HINMAN, M.D. Albany  
**Public Health, Hygiene and Sanitation**  
**Chairman**—PAUL B. BROOKS, M.D. Albany  
**Secretary**—ARTHUR D. JACQUES, M.D. Lynbrook  
**Neurology and Psychiatry**  
**Chairman**—EUGENE N. BOUDREAU, M.D. Syracuse  
**Secretary**—CLARENCE O. CHERNEY, M.D. Utica

For a list of the officers of the county medical societies, see October issue, advertising page XXVI

## THE JOURNAL DURING 1924

We have often been asked what we were doing with the JOURNAL. We were unable to tell with any degree of accuracy, and so we have patiently compiled a statistical array of figures regarding the material which we have published. Our philosophically inclined readers who may be interested in the ideals which actuated us at the beginning of the year, will find a statement of our aspirations on page 24 of the January issue. Then on page 999 of the December issue they will find a statement of our policies after they had undergone a year's evolution and crystallization.

Last year's JOURNAL is numbered Volume 24, which indicates that the JOURNAL has been published during twenty-four years. Twenty-one

numbers were issued in 1924. One number was issued each month, except from February 1st to April 18th, inclusive, when the JOURNAL was issued weekly. The work of the editorial staff during the weekly issues was like that on a daily paper. The work had to be done quickly, and the editor often had to play the part of Procrustes as he either stretched or amputated the articles to fit the space that was available for them.

We printed 1,034 pages of text during the year, as compared with 514 pages during 1923, and 594 during 1922. Scientific articles occupied 409 pages, or about 40 per cent of the space. The number of articles was 102, covering nearly every phase of medicine. The amount

of space given to medical papers was governed by the number and length of the papers which are read at the annual meeting, but in addition we have been able to publish a few others which had a special timeliness

We have run 83 pages of editorial matter, on 87 topics. The subjects have been predominantly educational

Mr George W Whiteside, our Counsel, has contributed 42 pages, consisting of 29 reports of lawsuits against physicians, and thirteen educational articles upon the legal aspects of the work of medical societies and practising physicians. Mr Whiteside's department is an excellent storehouse of legal lore for the practising physician

Dr James N Vander Veer, the chairman of the legislative committee, contributed 165 pages to the Legislative Department of the JOURNAL last year. This exceeds the amount of space used by any other contributor, including the editor. When we consider that Dr Vander Veer wrote or edited this as a by-product of his legislative experience, we admire his earnestness, sincerity, and spirit of self-sacrifice, and wonder how he got time to practice medicine at all

Medical Surveys of nine sections of New York State have filled 26 pages. These are the first attempts that have been made to list the public activities of physicians in distinction to their individualistic work of treating cases of sickness. While the primary object of the surveys was to secure information for the benefit of the State Medical Society, an effect of still greater value has been to stimulate local interest in all forms of the practice of civic medicine

Studies of the medical items that have appeared in the daily press have filled 37 pages of last year's JOURNAL. It is gratifying to note the friendliness of the editors toward physicians and preventive medicine, and the high medical standard of the items. Our study confirms our opinion that the daily press is of great importance in the medical education of the people

The New York State Department of Health has used 22 pages of the JOURNAL and has filled

them with announcements of its policies and news of public health developments

Items of Medical News have been given a prominent place in every issue. We have made a special effort to obtain full reports of the meetings of the County Medical Societies, and to print them in a form which would be both interesting and instructive. The sixty County Medical Societies in New York State (Dutchess and Putnam are united in one Society), hold 172 meetings annually. We have printed 58 reports of the meetings of 27 County Societies. Albany County has sent seven reports, and Bronx County five, Richmond, Rockland, Tompkins and Washington have each supplied four reports, and Livingston three. We have received two reports from Cattaraugus, Columbia, Nassau, Queens, Saratoga, Suffolk, and Wayne, and one from Cayuga, Clinton, Delaware, Essex, Greene, Jefferson, Kings, Oneida, Ontario, Oswego, Otsego, Schoharie, and Schuyler

The percentage of meetings reported last year was thirty-three. Let's double it this year

Book reviews occupied 35 pages last year, and 148 medical books were reviewed. The reviews have been prepared with great care by competent specialists whose names are signed to their articles. The news about new books is as important as items concerning any other phase of medical activity

A page of Prunes appeared in 17 issues of the JOURNAL last year. It is always difficult to get the unbiased opinion of sedate medical men regarding this department of the JOURNAL. We passed out advance copies of the December issue to the twenty-two members assembled at a meeting of the Council. Nineteen members opened the JOURNAL at the back and hesitated at the beginning of the index, and ten of them inquired where the Prunes were. We will continue the department this year

Our prognostications went astray in one respect. We had expected that the physicians would demand considerable space for correspondence, but very few letters were received for publication. Controversies carried on in a monthly journal are too much like a slow game of chess to suit this active age.

F O

## ORGANIZATION

A State Society, especially of medical men, succeeds in its endeavors only as the thoughts and principles of proper type are instigated and carried through by a well organized body, and the effort of that body can succeed only to that extent where these thoughts and principles are put into active practice

The standing of a body of citizens in any profession is considered in general conversation or debate only by reason of accomplishments slowly but surely gained through concerted effort and through the prestige of individuals in that body being given over to the advancement of the body as a whole

The Medical Society of the State of New York has ever stood for that which is right toward the people of the State from a broad viewpoint of the questions under consideration. Its plans and its principles have been inclusive of all scientific discoveries when they have been proven of value

It has seldom erred in narrow or limited ways for the advancement of the group of physicians which compose it, or of those members of the profession who have not seen fit to enter into its membership

It has constantly striven to develop its younger members along the lines of scientific research and desire for more knowledge in the alleviation of individual and public ills of medical nature

It has slowly though surely taken these newer ideas unto itself and adopted them wholeheartedly, when proven of worth

At times it has been threatened by dissensions within its ranks concerning new thoughts in the questions of the diagnosis and treatment of old and new diseases, or matters political within its own ranks, but with the broadminded attitude that physicians should have in relation to each other and to the questions at issue, it has thrashed out these differences to the betterment of the Society as a whole

It is the duty of your officers to see that all questions of import pertaining to the individual in the Society are thoroughly discussed within the ranks of the Society before decisions are arrived at

Too often the criticism has been that the individual County Society or the Council of the State Society has acted hastily on matters without allowing freedom of discussion, but in contravention it may be said that too often a small group tends toward endless discussion for the purpose of delaying a decision on a question which in some cases must needs be met promptly

With this in mind your Society has created the position of Executive Officer, and among others of his duties it is delegated to him to disseminate by word of mouth the ideas originating from individuals or groups who have the welfare of the Society at heart

It is to be hoped that through his efforts, questions which may recur or new ones which may appear can be the more thoroughly discussed with advantage to all of the members of the Society and decisions arrived at more quickly than in the past

J N V V

---

## KEEP THE OLD SECRETARY

In these days of business efficiency, no concern would think of hiring a secretary and then, just as soon as he learned his job, let him go. That, however, is just what a great many of the County Societies do

If you have a good secretary, why not keep him? There are a good many reasons for this. The job of Secretary is different from the presidency of the Society, which should change every year. The secretary must know the doctors of the County and what their opinions on various subjects are, and what they are willing to do for the Society. He must also have a working knowledge of the doctors' likes and dislikes, so that the best results may be accomplished in the appointment of committees and assignment of work. He is the custodian of the books and records of the Society. In some counties these are becoming of much value from an historic standpoint. He is the "whole works" of the County Society between meetings. He keeps the

bearings greased and makes the machine run smoothly. He does all the work and gets little thanks for it. Why change just when he is learning his job? That is not good business. It does not make for efficiency. It is wasteful. There is no good reason for getting rid of a good secretary, except death.

He should be paid. That doesn't mean that the salary should be large enough to make a prize of the position, but a small honorarium most certainly ought to be given. No one likes to work for nothing. Many times work like professional services done for nothing is worth just that much. Why not pay the secretary a reasonable salary?

Pick out a man who is interested in the work and who has a bent for writing and one who knows the doctors and can work with them and for them and make him secretary of the County Society, and then be business-like enough to keep him on the job

W L M

## COUNTY MEDICAL SOCIETY MEETINGS

During the month of December, twenty-seven County Medical Societies held their annual meetings. It was our privilege to attend seven of these, namely

December 2nd, Herkimer Co at Herkimer  
December 9th, Otsego Co at Oneonta  
December 9th, Ulster Co at Kingston  
December 10th, Montgomery Co at Amsterdam  
December 16th, Nassau Co at Hempstead  
December 18th, Monroe Co at Rochester  
December 19th, Cortland Co at Cortland

We should have attended more had it not been that so many of them met on the same days, for instance, on the second Tuesday eleven of the twenty-seven held their meetings, and the other sixteen were divided among eight different days. It is our aim to meet at least once with every County Society as early as we can, in order that we may learn how the State Society, through its office, can best serve the component County Societies. We are convinced that there are no more powerful medical units than the County Societies of the State of New York, and as they develop their possibilities and assume their responsibilities, mutually cooperating with one another, they will strengthen the State Society and thereby secure for it the position it deserves in the medical world. Its membership, through its sixty component County Societies, has passed the ten thousand mark, indicating that more than

two-thirds of the physicians of the State are enrolled in the organization. As each County Society realizes that it is the only legalized medical organization in the County, and makes it a part of its business to keep in touch—either directly through its *Comitia Minora* or through its special committees,—with every medical activity undertaken or inaugurated in the County, will its local influence develop. For a Society to function effectively, it is quite essential that it should have frequent meetings in order that proper consideration may be given to the medical needs of the community, as well as to the medical activities that may arise outside of the Society.

At another time we will take occasion to discuss the wisdom of having frequent meetings of the County Societies, but in the meantime it might be worth our while to know that two Societies in the State have but one regular meeting a year, thirty per cent of the Societies have two meetings a year, thirty-three per cent have four meetings a year, and only twenty per cent have six or more meetings annually.

Since it was impossible for us to attend the meetings held by those two Societies which meet but once a year, it will be necessary for us to wait another year before we can meet the physicians of those Counties and discuss the active program which the State Society is undertaking.

J S L

## STATE MEDICAL LIBRARY

The larger County Medical Societies conduct more or less extensive libraries. Kings County is the proud possessor of a library that ranks with the leading medical libraries of the United States. The two main influences upon which the practitioner, as well as the research worker, depend for assistance and stimulation, are the libraries and clinics. The clinics are difficult to move from the larger hospitals, and yet very successful clinics of a specialized type have at times been conducted in remote parts of the State.

An opportunity for extending library facilities to every section of the State is afforded by the medical library which is a part of the general library located in the Education Building in Albany. On its shelves will be found more than five hundred journals, purely medical in character published by societies from all parts of the world. In other divisions of the library will be found more than an equal number of journals on allied subjects. In its alcoves will be found the latest books on every medical subject. Great pains are taken by the authorities to make the library as useful to the physician

as possible. In this connection it should be more generally known that all books and journals are available to any physician in the State, and can be secured by simply making application to the State Medical Library. If a physician is writing a paper or wishes to inform himself more extensively on any particular subject, the librarian will assist him by either preparing for him a list of the latest books that have been written upon the subject and the most recent articles, or, if he has the references, sending him for his own study the books and journals in which they appear. For this service there is no cost to the physician except to pay postage when returning books and journals. They may be retained for four weeks, longer if requested.

This information should be particularly valuable to the Secretaries of County Societies when they are endeavoring to persuade local men to prepare papers for their meeting. With the assistance of the librarian any physician, no matter where he is located in the State, can, in the course of a month or six weeks, familiarize himself with the latest opinions on any subject that he may select.

J S L





# LEGAL



By GEORGE W. WHITESIDE, Esq  
Counsel, Medical Society of the State of New York

## MEDICAL TESTIMONY

Hon Mitchell May, Justice of the Supreme Court, recently delivered a charge to the jury in a malpractice case tried by counsel which is a model for clarity, fairness and learning. The plaintiff in the case was a child of eleven years who had fractured his femur and was suing, through his guardian, the physician who attended him, claiming that an X-ray had not been taken early enough in the treatment to discover an overriding of the fragments, with the result that an open operation was made necessary to break up the callus that had formed and to reduce the fracture.

A child-plaintiff makes a strong appeal to a jury, who are often influenced by their sympathy for his suffering or deformity. In treating this phase of the case Judge May, in the charge, said:

"You have, also, an unusual situation, because there is an appeal to you, an appeal to the human qualities that you possess, that tugs on the one side and pulls on the other, for we have before us, by way of a strange coincidence, a boy who was injured just one year ago today, who today suffers from the consequences of the injury that he then sustained and who will continue to suffer some inconvenience for a considerable period of time, his knee joint having stiffened as a result, no matter by what means, or methods, as a result of this accident. We know that he suffered pain, that he suffers added pain and our hearts go out to every boy, for most of us are fathers and we understand the position that the boy is in. We feel for him keenly and we wish him well. Could this whole thing have been undone, it would have been undone, but that is neither here nor there. We are to deal with that phase of the case just as it is, recognizing that our sympathies may play no part.

"And on the other hand we have the tug, the recognition that there is at stake a doctor's reputation, to a large extent, for care and for skill and we know that he is a young man starting out today full of enthusiasm, who has given of his service to his country, who has done, perhaps, from his standpoint, the best that he thought he could do. He is now under attack. And that should play no part in this case, for we are not concerned with the consequences or the results of this case. We are concerned in seeing that justice is meted out, and if the fault lies at the door of the doctor through some carelessness on his part for which he is now accountable, then he may not complain, because it is his own fault, and if the proof is not of sufficient quality to justify a jury in drawing its conclusions that that responsibility lies at his door, the jury may not place upon him a burden which is not rightfully his."

In this way the Judge balanced the sympathetic features on each side, so as practically to eliminate them from the case.

Speaking of the medical testimony, of which there was considerable, as eight doctors had testified in the case, the Judge continued:

"You and I know, and it has been frequently said, that medicine is not an exact science. Medicine is far from being an exact science, because there are so many instrumentalities at work, so many influences that are brought to bear, that there is no certainty about the result of anything that we may suffer from—whether from the ordinary diseases or whether from these injuries that sometimes result in deformity. And no doctor is called upon as a guarantor, or an insurer, that he will produce the very best results, that he is going to produce a perfect boy, a perfect union, a perfect result. Those things are not within contemplation, nor does anybody expect that. We all know that from our experience, the uncertainties of life, the uncertainties of the treatment of diseases and the ailments from which we suffer, and we simply ask, as we have the right to expect from a physician, that he possess the ordinary qualifications of a physician to treat the kind of sickness that he undertakes to treat, as is recognized by the people in his neighborhood, as is performed and done by physicians of his standing in his neighborhood.

"We do not expect of the physician, the ordinary physician, that he have the qualities of the great expert. One man selects a great expert, a man of unusual standing, he recognizes that that man may command a big figure for his services, that man has been singled out, and if all men were put upon the same plane, subjected to the same criticism for his work, as would be the man of superior talent, or the man of recognized superior ability and be chargeable for failing to do those things which a man of superior ability does, then no physician would undertake to do his work. If he had to guarantee his work, no physician would undertake his work, because it would be too hazardous and the chance of law suits would be ever imminent, ever present."

Judge May said, concerning the issue as to the taking of the X-ray in the case:

"The main complaint in this case, however, is not with the instrumentalities that he used but with the failure on his part to have an X-ray plate taken within a reasonable time after the injury. Around that hinges practically the whole of this case and it is in the light of that that you may make close study for the purpose of determining what the defendant did or whether he failed or what he failed to do, for the facts themselves are not in dispute.

"The accident happened on December 9th. And then on December 30th, eighteen days thereafter, this X-ray picture was taken, and this X-ray picture disclosed that there was an overriding, or overlapping, and it may become an important thing for you, in the determination of this case, to arrive at a conclusion as to the amount of the overlapping or the overriding. The theory of the plaintiff's case is this: That the X-ray is an instrumentality in ordinary common use. Doctors use it to aid their diagnosis. Doctors use it in fractures, for the purpose of determining the manner in which the bones lay, for, after a bone is set in plaster cast—and that is done for the purpose of immobilizing bones, for the

purpose of preventing them from moving—the bones start to set, because as soon as a fracture occurs, there is exuded from the bone, certain material, we will call it cement, we will call it callus, it is a liquid that is sent out by nature for the purpose of re-uniting, by way of cement, by way of bony substance, in time, these fragments that were split apart. And by taking an X-ray within a reasonable time after an injury, it is claimed by the plaintiff that there could have been discovered this condition of overlapping and that means could have been adopted at that time to have overcome the result of that overlapping, that overriding, and that by failure on the part of the defendant within a reasonable time, to have this X-ray taken, this leg started to unite in this condition, so that there was overlapping, overriding, and plaintiff claims that there would have been a resultant deformity which would have lasted through life and that resultant deformity could only be corrected by the method which has been spoken of as the open operation, and that that operation would have become unnecessary and that that deformity would not have existed if the defendant had, by the use of an X-ray, ascertained in time, before these bones started to unite, the condition of overriding and have used such methods as would be found necessary to have overcome the effect of it."

On this branch of the case the court charge gave consideration to the conditions facing the doctor, as follows

"He had no X-ray machine, nor is he chargeable with negligence for not having an X-ray machine, nor did he hold himself out to the world as being the possessor of an X-ray machine. We have proof here as to the X-ray machines that are in the neighborhood. What is the defendant called upon to do? To use, firstly, his best judgment, and if he makes an error of judgment, he is not held accountable. You and I know, as we drive along the highways in our automobiles, it may come to an emergency where we have the right to choose one of two or three directions to go. We use our best judgment and ultimately it may prove fatal or serious. We are not chargeable with that. No man is chargeable, if he uses his best judgment, unless before that time he has committed some negligent act which calls upon him to use judgment. Then his judgment is not excused, if the negligent act is the primary basis for the use of the judgment.

"And here the defendant is not chargeable if he made an error of judgment, so long as he used his best judgment, so long as he possessed the skill that he said he possessed as I have charged it to you, so long as he applied that skill in an ordinary skillful manner. \* \* \* When he has done that he has observed every responsibility. Whereas, if he has failed to do that, he is chargeable with negligence and with all the results that flow from his negligence. \* \* \* You must have in mind the situation that prevailed, you must have in mind the question whether the defendant used his judgment in not transporting the boy to a hospital under the conditions that he said as to the dangers that were present in transporting the boy, about the cost of bringing the machine there, whether he used reasonable judgment, whether he acted fairly, as a conscientious man, an ordinary, skillful man would have done under the circumstances."

Speaking of the proof offered by the expert witnesses, Judge May said

"And then we have the expert proof. And here we are going into a field with which you, gentlemen, are unfamiliar. We are treading on soil that is strange to you, talking about matters with which you have no ordinary concern. Yet, you have listened, and what concerned you most, is the application of the same tests to these expert gentlemen as you give to every other witness, the same application. You are to be influenced by your judgment of their knowledge, of their accuracy, of their honesty, of their fairness, and of their frankness. Those are the tests. You apply those tests to these men. \* \* \*

"You have heard, on the one hand, that this buckling overriding, of whatever the amount was in this case, was a deformity. You have heard, on the other hand, that that deformity would remain during life, that it could be cured, or corrected, or relieved by a sole, an extended sole, upon the shoe. That is what you have heard.

"You have heard, on the other hand, that nature would have taken care of that in due course of time. One physician said between two and five years that deformity could have been overcome and others say that by the time he arrived at twenty-one years of age, it would have been corrected, because nature would have attempted to correct it, to cure it, to compensate for it, and that the bones, the part of the bone where it had its growth was still intact and that though there was a shortening as a result of this overriding, that bone would grow longer, relatively speaking, than the other, so they both would be the same length from end to end by the time the boy became twenty-one years of age.

"And we have heard the testimony that this condition, as it was left by the defendant, was a good condition and we have heard by other physicians that this condition, as left by the defendant, was not a good condition. \* \* \* There is a dispute as to whether that open operation was, under the circumstances, the best thing to be done. An open operation is a dangerous operation. It has been testified to here that very few men will undertake such an operation upon children, that there is danger of infection, and they say that infection did develop here and that infection has disappeared. But there is no telling, when an operation of that kind is undertaken, what the ultimate results will be. \* \* \*

This case ran through four days of trial, some sessions lasting until late into the night. There was a mass of lay and expert testimony on both sides of the case. Yet from this maze Judge May delicately eliminated the sympathy on either side, fixed the jury's attention clearly on the salient issues, brought out in bold relief the conflicting contentions of the parties, guided the jury's judgment in weighing the expert testimony, and reduced the case to a simple issue—all with flawless precision of choice English and without any legal error, and without exception being taken to any statement made in the charge by counsel on either side. It was a masterly charge, delivered without the use of notes and evidenced a high judicial wisdom and scholarly understanding. The jury returned a verdict in favor of the doctor.



# LEGISLATION



By JAMES N. VANDER VEER, M.D.  
Chairman, Committee on Legislation

## RECOMMENDATIONS FOR 1925

The business of the Committee on Legislation, as laid down by your organized body represented in the Society, has commenced. From now on questions of import will be presented to the society and the practitioner of this State through the Journal and through the discussion within the various medical groups.

It is to be hoped that the Legislative Chairmen of the individual County Society Legislative Committees will function to the utmost and even to a greater percentage than has heretofore been seen in the dissemination of such information as may be gathered and sent in to your Legislative Bureau for the purpose of classification and reissuing to the Society as a whole.

During the next few months your Committee on Legislation earnestly asks each individual member of the State Society or others who are not as yet members and into whose hands the Journal may come, for press clippings, articles delivered before lay bodies which in any way touch upon public health or the relation of the medical profession to the body politic, bits of information relative to the various angles that come up within the profession or lay groups politically, civil, or of legislative import.

Your Committee on Legislation cannot urge too strongly that the newer or recently elected Chairmen of the individual County Society Legislative Committees immediately get in personal touch with their individual legislators before whom will come the important questions as the session advances.

It is to be recognized that the Chairmen who have served in years past have already taken up the duties which they owe to their County and to their State, as individual citizens and equally as well premised to be those educated in matters of public health, to once more discuss freely and frankly and without bias questions that are likely to come up with their representatives.

With each recurrent Legislature there are naturally two groups which must be brought into the open—made acquainted with each other and which must show to each other their real interest in the work assigned them. The first group is composed of the Chairmen of the individual County Society Legislative Committees newly elected and who never before have had to do with legislative work and who therefore are in a measure unacquainted with the fairness and frankness which must be shown in legislation in this State.

The second group is composed of those newly elected legislators who never before have sat within the legislative bodies. It is with these men that the County Legislative Chairman—be he old or new—has much to do in behalf of the safety of the public health of this State.

In some Counties perhaps there may be a third grouping in that we find newly elected Chairmen and newly elected legislators, both of whom are unfamiliar with procedures and methods of lawmaking bodies.

Frankness of discussion and the furnishing of information that is incontrovertible in the eyes of a fair minded man, are the duties in the main of the County Legislative Chairmen from now on for some months to come.

It is to be recognized that New York State stands foremost among all the States of the Union in the matter of its scientific work of whatever nature, and that the medical profession of this State stands at the head of the list in comparison with all the other States of the Union.

It is recognized throughout the world that the State of New York stands first on the list in the matter of education and that the State Department of Education is looked up to and patterned after by the various States of the Union.

It is beyond cavil among the lay people who know the public health worker and the medical profession of the world, that our State Department of Health has no equal.

These standards have been brought about by none other than those who, year after year, have sat in our legislative halls and patiently have listened to the arguments which have raised the State to its present high position, and by their efforts have placed the State in its present high standing.

It may also be said that just as patiently have they listened to the arguments of those who would break down the standards which it has taken so long to establish and with equal clear vision have voted against such questions as would undermine the standing of the Empire State in the eyes of the world.

It is to be hoped that whatever this legislative session brings forth, no backward steps will have been taken to jeopardize the health of the people of the State, and that when the session comes to a close the medical profession may feel grateful to the people and to the legislators for

a maintenance of the high standards, and that the legislators can depart for their various homes satisfied in their innermost hearts by the knowledge that they have contributed to keeping New York State at its high pinnacle as demanded by the true sciences of the present day, exhibited through the efforts of the individual citizen

Your Legislative Bureau would recommend to the Presidents and Chairmen of the Legislative Committee that they endeavor to have their County Societies appropriate sufficient funds to pay for subscriptions to the following journals, that these two officers, at least, may be kept posted up to the minute on matters medical in the State and in the Nation

- 1 Journal of the American Medical Association,
- 2 Hygeia,
- 3 American Medical Association Bulletin

All of these are published by the American Medical Association, and can be obtained from their headquarters at 535 North Dearborn Street, Chicago, Ill

These periodicals are invaluable to those members of the medical profession who desire to keep posted on the medical views of the day of the other States and of the nation

Your Legislative Bureau would be pleased to receive the names of local publications put out by the various Societies, large or small, in order that it might subscribe to the same and thus be kept posted from the standpoint of the local or community thought

Your Legislative Bureau is ever ready to advise with individuals or County Societies or their officers, through the Committee on Legislation or the Executive Officer, during the legislative session, concerning questions which lie within their jurisdiction, and it is to be hoped that the individual County Societies and the individual members of the State Society will learn to use the Bureau more and more on matters of this sort as time progresses and the Bureau is developed

If a thing in this world is good, it should be used, and in proportion as its use increases, so in a greater proportion does its worth and value increase

Once more your Committee on Legislation addresses itself to the Chairmen of the individual County Society Legislative Committees, as the law-making branches of the people of the State come together in annual session

Questions of moment from now on will develop slowly or very quickly, as the minds of the legislators are directed toward the problems of the State

Among them quite naturally will be many questions of public health, or those which deal with the medical profession in its relation to the people of the State individually or as a whole, and the profession again must put itself squarely before the people, and especially before their representatives in the State legislature, that they are not the avaricious group upon whom are heaped all of the abuse by the unthinking, who only see a possible immediate benefit for their own personal interest

Many a physician cannot sense for a time the why and wherefore of the action of the Medical Society as a whole because he is not in touch with the situations throughout the State and because in many instances he has not the initiative to study such problems the same as he would attack a question of diagnosis in a patient where the symptoms at first were obscure but gradually cleared themselves as time went on

Just so is it with the legislators, who are in the main anxious and willing to do that which is the best for their own local constituents, but who sometimes take a wrong view of situations as they present when unacquainted with the conditions throughout the rest of the State

For this reason it is seen that many times a bill is left within a Committee or before the House for long periods of time before it is called forth or called up for passage. Thus it is allowed to the legislator to gather his facts and with discussion back home be thoroughly posted as to what his action should be

In some instances, however, as in every walk of life, there are physicians and there are legislators who are so selfish as not to be open to reason or who are unwilling to listen to argument without flying off the handle and abusing everything and everybody not in agreement with their position

The medical profession in this State as a whole has nothing to hide in its relation with the people, and as such can come before the legislators with clean hands as to questions that involve the profession and its relation to the people in the various lines along which legislative thought tends

It is to be hoped that in this session there will be accorded the same frankness and courtesy on the part of the profession toward the individual legislators as has been shown in past years and that as a profession we may meet each individual where he or we have matters of public interest to discuss with the same courtesy and kindness as has been heretofore shown



# State Department of Health



## TYPHOID BACILLI OBTAINED FROM AN INTRAMUSCULAR ABSCESS

According to a history received from the Albany Department of Health and from the physician attending the case, a patient was recently operated upon at the Albany Hospital for an intramuscular abscess occurring near the scar of a cholecystectomy operation performed in another city. Two months after the first operation, a tumor, circular in outline, pulsating in character, and firmly adherent to the abdominal muscle wall, appeared near the scar. A pure culture of typhoid bacilli was obtained from the contents of this abscess. Examination of a fecal specimen from this patient showed the presence of typhoid organism. In 1890, the patient had an illness which was diagnosed as malaria.

## "PERI-SPLENITIS"

An outbreak of about 125 cases of an unusual illness recently occurred in the practice of two physicians in Broadalbin and Mayfield. The distribution was entirely rural. The cases began about September 1st and continued during the month. They were characterized by a sudden onset of pain in the epigastric region, centering very soon about the spleen, with temperature ranging from 101° to 104°. The patients frequently had paroxysmal pain, similar to acute gall stone colic, requiring opiates for relief, and great difficulty in breathing, similar to an acute pleurisy. The attack lasted about 24 to 48 hours and was relieved markedly by a tight bandage across the lower ribs, broad enough to reach down to the level of the umbilicus. No enlargement of the spleen was observed, neither was any digestive disturbance noted. Aspirin for a day, followed by a generous dose of castor oil, seemed to be all the treatment needed.

One of the physicians noted that when the bandage restricting respiratory movements was removed too early the individual seemed to have a recurrence, with another two-day seizure. In the absence of a better term the attending physicians called this disease "Peri-splenitis." Sources of milk, water, and other foods were largely individual. It is not stated whether those affected had attended any social gathering in common. Nearly all the cases were male adults—20 to 60 years of age—but there were a few women patients. No children were sick. So far as known no laboratory specimens were submitted.

## PHYSICIAN'S NEGLIGENCE ALMOST RESULTS IN TRAGEDY

For years the fact that the normal habitat of the tetanus bacillus in the intestinal tract of domestic animals has been well established, and with this knowledge wise practitioners invariably administer tetanus antitoxin to any person with a wound liable to have been contaminated with manure. Recently, however, there came to the attention of the Department an instance of tetanus in which the wound had been contaminated with horse hair, and yet apparently no antitoxin had been given. Moreover, even after definite typical symptoms of tetanus had developed, the attending physician failed to recognize their significance and, according to the patient's statement, told him that his pains were only muscular.

The patient, a farmer, while driving a team of horses, slipped and ran a splinter under the nail of the middle finger of the right hand. His wife attempted to extract the splinter, but succeeded in removing only a small portion of it *together with a few horse hairs*. The next day, because of considerable pain in the finger, the patient consulted a physician, who made no attempt to cleanse the wound, but advised soaking the finger in hot water in the hope that the splinter would become loosened and the patient be able to remove it himself.

Twelve days later the patient complained of swollen neck, sore gums, pressure under the shoulders and slight stiffening of the jaw. Three days after this he once more consulted his physician who again made no attempt to cleanse the wound, and advised him, as stated above, that the pains were muscular.

During the next two days the patient became rapidly worse and another physician was called. He immediately recognized the case as one of well-developed tetanus. As this time the jaws were completely set, the abdominal, back and cervical muscles rigid, the patient had extreme difficulty in breathing and was covered with a profuse perspiration.

The original wound was opened widely and foreign matter removed. An attempt was made to administer tetanus antitoxin intraspinally without success, but through heroic doses of antitoxin intravenously and subcutaneously the patient was well enough two weeks later to leave the hospital.



# MEDICAL SURVEY



## MEDICINE IN TOMPKINS COUNTY, N Y

*Editor's Note* The survey on which this report was founded was made by the Executive Editor on December 4 and 5, 1924. For this information the Editor is indebted principally to Dr. Luzerne Coville, Vice-President of the Medical Society of the State of New York, Dr. L. T. Genung, Health Officer of Ithaca, and Dr. A. T. Kerr, Secretary of the Cornell Medical College at Ithaca.

Tompkins County is situated in the west central part of New York State. It has an area of 476 square miles. Its population is 35,285, according to the 1920 census.

The only city in Tompkins County is Ithaca, which is situated at the southern end of Cayuga Lake. It had a population of 17,004 in 1920, and had grown 13 per cent during the decade. It has few factories or other industrial concerns, but it is the site of Cornell University, which has a student body of over five thousand young men and women. The University is constantly expanding, and is one of the principal factors in the growth of the city.

The population of Tompkins County outside of Ithaca was 18,281 in 1920, and has been slowly decreasing for the last few decades. There are six incorporated villages in the County with a total population of 4,737. The County has a population of 13,544 that may be classed as strictly rural.

*Physicians* Ithaca has 46 physicians, according to the Directory of the Medical Society of the State of New York. This gives a proportion of one physician to every 370 of population. Many of the physicians are specialists whose consultation work extends over a radius of many miles around the city. Dr. M. B. Tinker, formerly president of the Medical Society of the State of New York, has attained national fame for his operations for goiter.

Tompkins County outside of Ithaca has 19 physicians who live in 13 localities. The rural section of the County has one physician in every 945 of population. Ithaca is the medical center of Tompkins and the surrounding counties. The nearest other centers are Geneva, 40 miles north, Elmira, 30 miles southwest, and Binghamton, 40 miles southeast.

The physicians and scientists of Cornell University have a marked influence on the physicians of Tompkins County and the neighboring districts, especially along the lines of scientific medicine. They have always been ready to give

their services as consultants and advisors, especially in public health matters, and they have placed their laboratories at the disposal of the physicians and health officers. Dr. Sutherland Simpson, of the Medical Faculty, is conducting extensive observations on sheep and goats from which the thyroids have been removed, and has frequently shown lantern slides and moving pictures of the animals before Medical Societies. The professors of the Veterinary College work on problems such as rabies and bovine tuberculosis, which are of vital interest to physicians and to human health, and they are always ready to cooperate with the doctors of medicine. The department of pathology and bacteriology is particularly helpful. The workers in zoology and botany also contribute to the scientific information which is of value to physicians. The result is a broadening of the scope of medical thought and a widening of the field of action of the physicians of Tompkins County.

*Medical Society* The Medical Society of the County of Tompkins represents the medical thought of the entire County, including Ithaca. It has 62 members, or 91 per cent of the physicians who are listed in Tompkins County. This percentage is extremely high, and is probably not excelled by that of any other county in New York State. The Society holds meetings monthly, except during July and August. Once a year a joint meeting is held with the Medical Society of the County of Cortland.

*Hospitals* Ithaca has one general hospital—the Ithaca City Hospital. The hospital has 105 beds, and is supported by private contributions, and by a grant of \$10,000 annually from the Community Chest. The city has recently appropriated \$92,000 for an annex with 36 rooms to be used for cases of contagious diseases. The hospital will manage the annex, and will receive pay from the city for the support of the cases. The annex will also be available for ordinary cases when the wards and rooms are not needed for contagious cases.

The hospital maintains an ambulance service, and the city pays for calls sent by the police or firemen.

The hospital has a staff of 44 local physicians, but no internes. Nine staff meetings are held during the year. A historian is employed who takes the original histories and indexes and files them, but the progress sheets are made by the physicians. The physicians of the staff find it difficult to maintain full efficiency in the histories

without an interne to relieve them of the detailed duties of caring for the sick

A dietitian is employed, and special attention is given to diabetic cases, and to metabolism studies

The hospital has an excellent laboratory in which the Department of Health work is done. The Wassermanns are sent to the State Laboratory in Albany, and the milk, water and rabies examination are done in the New York State Veterinary College of Cornell University

The hospital has a nurses' training school with 47 pupil nurses. It is in charge of Mrs Clifford, who is thoroughly competent and maintains the standards of the nurses' division of the State Department of Education

The hospital trustees have planned to extend the hospital work along three lines, first, an outpatient department, since there is no dispensary in the city, second, to assume the prenatal clinic work which is now done on a small scale in the health center, and third, to send the pupil nurses to private homes to assist in obstetrical cases

It is the intention of the trustees and staff to continue to develop the hospital service along original lines that are suited to the peculiar needs of the city of Ithaca, as they have done in the past

Tompkins County has a tuberculosis hospital with a capacity of about 20 cases. It is housed in a building that was formerly a residence. Its Superintendent, Dr Keith Sears, gives only part of his time to tuberculosis work, and does not live in the hospital, but he makes good use of his meager equipment, and holds clinics in Ithaca and other centers in the county

The Ithaca Tuberculosis Association conducts a summer camp or preventorium for undernourished boys and girls of tuberculous parentage. It accommodates about 25 children, and is open during the summer months. The children who return from the camp make regular visits to the clinic room in Ithaca during the rest of the year, for weighing and examination. The work is highly successful, and appeals for support and receives a ready response from the people

The Reconstruction Home for Infantile Paralysis cases is located in Ithaca. It was started to care for the local cases that developed in Ithaca during the great epidemic, but later it was promoted by rotary clubs and other organizations, and is now a reception center for cases within a radius of fifty miles of Ithaca. It has a capacity of 26 cases, and is always filled. About 200 cases have been admitted since the Home was founded. The ages of its patients range from 2 to 42, but most of the inmates are children of school age for whom the Department of Education of Ithaca supplies a teacher. The institution is managed by a local board of directors, and the medi-

cal service is supplied by the physicians of Ithaca under the unofficial supervision of Dr Leroy W Hubbard, Orthopedic Surgeon of the State Department of Health. The Home is efficiently conducted, and the reconstruction results are so satisfactory that the establishment of similar homes throughout the State is urged as the solution of the problem of the care of crippled children

The hospital capacity of Tompkins County is about 150 beds, if those in the Reconstruction Home are counted. This gives a proportion of 43 beds for every one thousand of population. But the Home and the Ithaca City Hospital are both used by patients outside of Tompkins County, and so the County has only about three beds available for one thousand of population

*Department of Health* The official public health work of Ithaca is centralized in one man, Dr L. T. Genung, who is both Health Officer and Medical Examiner of the city schools and gives full time to his official duties. He is assisted in his Health Department work by two part-time physicians, and by a full-time veterinarian for milk inspections, a nurse for general public health work, and a visiting nurse. His school staff consists of two nurses, a dental hygienist, and also a dentist who holds two clinics weekly

Dr Genung's office is also a health center which is supported jointly by the City and the County Tuberculosis Association. The health center receives \$3,900 from the Community Chest in place of conducting a sale of Christmas Seals in the city. Two clinics in tuberculosis and one each in child welfare and prenatal work are held weekly, and one mental clinic and one mentally defective clinic are held monthly. School children who show defects are treated in the Ithaca City Hospital with the cooperation of the physicians and the City Board of Charities

Special attention is paid to goiter prevention, since Ithaca is in the goiter belt, and a large proportion of the girl pupils in the schools show enlarged thyroid glands. The table salt that is sold in grocery stores is iodized

All the milk offered for sale in Ithaca is either pasteurized or is produced by tuberculin tested cows

*Public Health Nursing* There are nine nurses engaged in community health work in Tompkins County as follows

Ithaca Department of Health	2
Ithaca School	2
County Tuberculosis	1
County Red Cross, Visiting	1
Industrial Plants	3
	<hr/> 9

Ithaca has a community organization, called the West Side Social Service League, which has a great effect on public health. The League is located on the low lands of the western part of the city and is housed in a large building which is well adapted for games, meetings and classes. Its activities include a gymnasium, mothers' clubs, classes for cooking and sewing, and recreation for small children. It receives support from the Community Chest. It is well conducted and managed and supplements the work of the Health Center, the churches, and the schools.

*Newspapers* Ithaca has one daily paper, the *Journal-News*, which is published evenings. This paper cooperates with the health authorities and physicians, and is always ready to print medical information. We have had occasion to comment favorably on the *Journal-News* in our Daily Press Department (see page 327 of the March 7th issue).

*Medical Service of Cornell University* Cornell University maintains an excellent medical service for its resident students, who number about 3,800 young men and 1,200 women. The service may be considered under four divisions.

- 1 Dispensary and out-patient service to those who are mildly sick.
- 2 Hospital service to those who should be in bed.
- 3 Publicity and education along hygienic lines.
- 4 Periodic physical examinations of all students.

These four branches of medical service are the same as the activities which are promoted by the Medical Society of the State of New York, and physicians generally will be interested in the way in which Cornell performs the medical service.

Every student in Cornell pays ten dollars annually to the University for its health service. In return the student receives free dispensary advice whenever he wishes it, treatment and support in the University Hospital, a full physical examination every year with hygienic advice regarding the correction of defects and hygienic living, and classroom instruction in hygiene once a week for a year.

The Dispensary is located on the campus, and is open for medical consultation from nine o'clock in the morning until six o'clock in the afternoon. Nine full time physicians are in attendance. Over 25,000 consultations were sought by the students during the past year, or an average of five calls per student. This may seem to be a large proportion of calls, but it is the policy of the University to encourage students to consult

the Dispensary physicians on the first signs of illness or approaching disorders. This policy is further encouraged by the requirement that every student who seeks to be excused from classes on account of sickness or physical depression of any kind must obtain the excuse from the Dispensary. Three kinds of excuses are issued.

- 1 On the physical evidence of disease.
- 2 On certificate of a physician outside of the University.
- 3 On the statement of the student.

The University is liberal in issuing certificates on the first visit of the student, but it follows the case carefully and keeps accurate records with the result that there is very little malingering.

The University Hospital, called the Cornell Infirmary, has a normal capacity of 90 beds, only half of which were occupied on the day of our visit. It has a complete equipment, including laboratory and an X-ray outfit. The student is permitted to have a medical attendant of his own choice, but the University will supply medical services to any one who is unable to employ a private physician. The University sends students to the Hospital for observation on the first signs of fever or colds or other illness which may be dangerous to the patient or others.

The semi-annual examinations of all students is one of the oldest health activities of American colleges. Cornell has expanded this activity along modern lines, and provides the machinery to make corrective measures effective. The chief examiner is a deputy health officer of the city, and is empowered to deal with any health emergency that arises.

The semi-weekly classroom instruction is along practical lines, and is designed to give the students an intelligent idea of how not only to prevent disease, but also to maintain abounding health. The great number of calls at the Dispensary is evidence that the students are interested in the early signs of illness. A further indication of the practical character of the instruction is the extremely small number of cases of venereal diseases among the students.

The Cornell University health service covers all phases of medical attention which will enable intelligent persons to maintain their health and efficiency. It is not paternalistic, and the University does not assume responsibility for the health of any student. It offers health service on the only acceptance which is that they shall attend to their hygiene and have the necessary examinations. The Cornell University health service demonstrates the practical value of the Cornell Health Service.



without an interne to relieve them of the detailed duties of caring for the sick

A dietitian is employed, and special attention is given to diabetic cases, and to metabolism studies

The hospital has an excellent laboratory in which the Department of Health work is done. The Wassermanns are sent to the State Laboratory in Albany, and the milk, water and rabies examination are done in the New York State Veterinary College of Cornell University

The hospital has a nurses' training school with 47 pupil nurses. It is in charge of Mrs Clifford, who is thoroughly competent and maintains the standards of the nurses' division of the State Department of Education

The hospital trustees have planned to extend the hospital work along three lines, first, an outpatient department, since there is no dispensary in the city, second, to assume the prenatal clinic work which is now done on a small scale in the health center, and third, to send the pupil nurses to private homes to assist in obstetrical cases

It is the intention of the trustees and staff to continue to develop the hospital service along original lines that are suited to the peculiar needs of the city of Ithaca, as they have done in the past

Tompkins County has a tuberculosis hospital with a capacity of about 20 cases. It is housed in a building that was formerly a residence. Its Superintendent, Dr Keith Sears, gives only part of his time to tuberculosis work, and does not live in the hospital, but he makes good use of his meager equipment, and holds clinics in Ithaca and other centers in the county

The Ithaca Tuberculosis Association conducts a summer camp or preventorium for undernourished boys and girls of tuberculous parentage. It accommodates about 25 children, and is open during the summer months. The children who return from the camp make regular visits to the clinic room in Ithaca during the rest of the year, for weighing and examination. The work is highly successful, and appeals for support and receives a ready response from the people

The Reconstruction Home for Infantile Paralysis cases is located in Ithaca. It was started to care for the local cases that developed in Ithaca during the great epidemic, but later it was promoted by rotary clubs and other organizations, and is now a reception center for cases within a radius of fifty miles of Ithaca. It has a capacity of 26 cases, and is always filled. About 200 cases have been admitted since the Home was founded. The ages of its patients range from 2 to 42, but most of the inmates are children of school age for whom the Department of Education of Ithaca supplies a teacher. The institution is managed by a local board of directors, and the medi-

cal service is supplied by the physicians of Ithaca under the unofficial supervision of Dr Leroy W Hubbard, Orthopedic Surgeon of the State Department of Health. The Home is efficiently conducted, and the reconstruction results are so satisfactory that the establishment of similar homes throughout the State is urged as the solution of the problem of the care of crippled children

The hospital capacity of Tompkins County is about 150 beds, if those in the Reconstruction Home are counted. This gives a proportion of 43 beds for every one thousand of population. But the Home and the Ithaca City Hospital are both used by patients outside of Tompkins County, and so the County has only about three beds available for one thousand of population

*Department of Health* The official public health work of Ithaca is centralized in one man, Dr L. T. Genung, who is both Health Officer and Medical Examiner of the city schools and gives full time to his official duties. He is assisted in his Health Department work by two part-time physicians, and by a full-time veterinarian for milk inspections, a nurse for general public health work, and a visiting nurse. His school staff consists of two nurses, a dental hygienist, and also a dentist who holds two clinics weekly

Dr Genung's office is also a health center which is supported jointly by the City and the County Tuberculosis Association. The health center receives \$3,900 from the Community Chest in place of conducting a sale of Christmas Seals in the city. Two clinics in tuberculosis and one each in child welfare and prenatal work are held weekly, and one mental clinic and one mentally defective clinic are held monthly. School children who show defects are treated in the Ithaca City Hospital with the cooperation of the physicians and the City Board of Charities

Special attention is paid to goiter prevention, since Ithaca is in the goiter belt, and a large proportion of the girl pupils in the schools show enlarged thyroid glands. The table salt that is sold in grocery stores is iodized

All the milk offered for sale in Ithaca is either pasteurized or is produced by tuberculin tested cows

*Public Health Nursing* There are nine nurses engaged in community health work in Tompkins County as follows

Ithaca Department of Health	2
Ithaca School	2
County Tuberculosis	1
County Red Cross, Visiting	1
Industrial Plants	3
	<hr/> 9

Ithaca has a community organization called the West Side Social Service League which has a great effect on public health. The League is located on the low lands of the western part of the city, and is housed in a large building which is well adapted for games, meetings and classes. Its activities include a gymnasium, mothers' clubs, classes for cooking and sewing, and recreation for small children. It receives support from the Community Chest. It is well conducted and managed and supplements the work of the Health Center, the churches and the schools.

**Newspapers** Ithaca has one daily paper the *Journal-News* which is published evenings. This paper cooperates with the health authorities and physicians, and is always ready to print medical information. We have had occasion to comment favorably on the *Journal-News* in our Daily Press Department (see page 327 of the March 7th issue).

**Medical Service of Cornell University:** Cornell University maintains an excellent medical service for its resident students, who number about 3,800 young men and 1,200 women. The service may be considered under four divisions:

- 1 Dispensary and out-patient service to those who are mildly sick.
- 2 Hospital service to those who should be in bed.
- 3 Publicity and education along hygienic lines.
- 4 Periodic physical examinations of all students.

These four branches of medical service are the same as the activities which are promoted by the Medical Society of the State of New York and physicians generally will be interested in the way in which Cornell performs the medical service.

Every student in Cornell pays ten dollars annually to the University for its health service. In return the student receives free dispensary service whenever he wishes it, treatment and surgery in the University Hospital, a full physical examination every year with hygienic advice regarding the correction of defects and hygienic living, and classroom instruction in hygiene once a week for a year.

The Dispensary is located on the campus and is open for medical consultation from 9 o'clock in the morning until six o'clock in the afternoon. Nine full time physicians are in attendance. Over 25,000 consultations were requested by the students during the past year, or an average of five calls per student. This may seem to be a large proportion of calls, but it is the policy of the University to encourage student to consult

the Dispensary physicians at the first signs of illness or approaching illness. This policy is further encouraged by the requirement that every student who seeks to be excused from classes on account of sickness or physical condition of any kind must obtain the excuse from the Dispensary. Three kinds of excuses are issued:

1. On the physical evidence of illness.
2. On certificate of a physician outside of the University.
3. On the statement of the student.

The University is liberal in issuing certificates on the first visit of the student, but it follows the case carefully and keeps a constant record with the result that there is very little malpractice.

The University Hospital, called the Cornell Infirmary, has a normal capacity of 90 beds, only half of which were occupied on the day of our visit. It has a complete equipment including laboratory and an X-ray outfit. The student is permitted to have a medical adviser of his own choice, but the University Hospital renders services to any one who is unable to consult a private physician. The University sends patients to the Hospital for observation or treatment of fever or cold, or other conditions which are dangerous to the patient or to others.

The semi-annual examination of all students is one of the oldest features of the Cornell colleges. Cornell's examination is a modern, modernized examination. The examination is a general health examination. It is supervised by the University Health Service, which is a part of the Cornell University.

The semi-annual examination is a part of the Cornell University Health Service. It is a part of the Cornell University Health Service, which is a part of the Cornell University. The examination is a part of the Cornell University Health Service, which is a part of the Cornell University.

The Cornell University Health Service covers all phases of medical activity which will enable the student to take care of his health and efficiency for his personal life and the University. It does not assume responsibility for the health of any student. It offers health service, but the only assistance which is required of the student is that they shall attend classroom instruction in hygiene and have their annual physical examination. The experience of several years have demonstrated the practicality and efficiency of the Cornell Health Service.

Ithaca has a community organization, called the West Side Social Service League, which has a great effect on public health. The League is located on the low lands of the western part of the city, and is housed in a large building which is well adapted for games, meetings and classes. Its activities include a gymnasium, mothers' clubs, classes for cooking and sewing, and recreation for small children. It receives support from the Community Chest. It is well conducted and managed, and supplements the work of the Health Center, the churches, and the schools.

*Newspapers* Ithaca has one daily paper, the *Journal-News*, which is published evenings. This paper cooperates with the health authorities and physicians, and is always ready to print medical information. We have had occasion to comment favorably on the *Journal-News* in our Daily Press Department (see page 327 of the March 7th issue).

*Medical Service of Cornell University* Cornell University maintains an excellent medical service for its resident students, who number about 3,800 young men and 1,200 women. The service may be considered under four divisions:

- 1 Dispensary and out-patient service to those who are mildly sick
- 2 Hospital service to those who should be in bed
- 3 Publicity and education along hygienic lines
- 4 Periodic physical examinations of all students

These four branches of medical service are the same as the activities which are promoted by the Medical Society of the State of New York, and physicians generally will be interested in the way in which Cornell performs the medical service.

Every student in Cornell pays ten dollars annually to the University for its health service. In return the student receives free dispensary advice whenever he wishes it, treatment and support in the University Hospital, a full physical examination every year with hygienic advice regarding the correction of defects and hygienic living, and classroom instruction in hygiene once a week for a year.

The Dispensary is located on the campus, and is open for medical consultation from nine o'clock in the morning until six o'clock in the afternoon. Nine full time physicians are in attendance. Over 25,000 consultations were sought by the students during the past year, or an average of five calls per student. This may seem to be a large proportion of calls, but it is the policy of the University to encourage students to consult

the Dispensary physicians on the first signs of illness or approaching disorders. This policy is further encouraged by the requirement that every student who seeks to be excused from classes on account of sickness or physical depression of any kind must obtain the excuse from the Dispensary. Three kinds of excuses are issued:

- 1 On the physical evidence of disease
- 2 On certificate of a physician outside of the University
- 3 On the statement of the student

The University is liberal in issuing certificates on the first visit of the student, but it follows the case carefully and keeps accurate records with the result that there is very little malingerer.

The University Hospital, called the Cornell Infirmary, has a normal capacity of 90 beds, only half of which were occupied on the day of our visit. It has a complete equipment, including laboratory and an X-ray outfit. The student is permitted to have a medical attendant of his own choice, but the University will supply medical services to any one who is unable to employ a private physician. The University sends students to the Hospital for observation on the first signs of fever or colds or other illness which may be dangerous to the patient or others.

The semi-annual examinations of all students is one of the oldest health activities of American colleges. Cornell has expanded this activity along modern lines, and provides the machinery to make corrective measures effective. The chief examiner is a deputy health officer of the city, and is empowered to deal with any health emergency that arises.

The semi-weekly classroom instruction is along practical lines, and is designed to give the students an intelligent idea of how not only to prevent disease, but also to maintain abounding health. The great number of calls at the Dispensary is evidence that the students are interested in the early signs of illness. A further indication of the practical character of the instruction is the extremely small number of cases of venereal diseases among the students.

The Cornell University health service covers all phases of medical attention which will enable intelligent persons to maintain their health and efficiency. It is not paternalistic, and the University does not assume responsibility for the health of any student. It offers health service, but the only acceptance which is required of the students is that they shall attend classroom instruction in hygiene and have their annual physical examinations. The experiences of several years have demonstrated the practicality and efficiency of the Cornell Health Service.



# Periodic Health Examinations



## MEDICAL SOCIETY OF THE COUNTY OF NEW YORK REPORT OF THE COMMITTEE ON HEALTH EXAMINATION GIVEN ON DECEMBER 9, 1924, BY ORRIN SAGE WIGHTMAN, M D, CHAIRMAN

At a stated meeting of The Medical Society of the County of New York, on May 26, 1924, the following resolution was adopted by the Society

RESOLVED, That The Medical Society of the County of New York immediately take steps through an appropriate committee, to formulate a feasible and workable plan to promote Periodic Health Examinations through the agency of the general practitioner

In line with this resolution the President appointed the following Committee

Orrin Sage Wightman, Chairman, Selan Neu-hof, Harry Finkelstein, Samuel A Blauner, Louis I Harris, Wendell C Phillips, Samuel J Kopetzky, Everett W Gould, Arthur Freeborn Chace, Terry M Townsend, Henry M Groehl

At the first meeting of the Committee the Chairman subdivided it under the following headings

### (1) *Education of the Physician*

\*Selan Neu-hof, C Ward Crampton, Chairman, Arthur F Chace, S A Blauner

### (2) *Technique and Methods of Securing and Filing Histories for Physicians*

L I Harris, Chairman, E W Gould, H M Groehl

Dr C Ward Crampton appointed in his stead

### (3) *Publicity for the Physician and the Public*

S J Kopetzky, Chairman, H Finkelstein, T M Townsend

During the past five years, the subject of periodic health examinations has attracted the attention of the medical profession, lay bodies and foundations, and the surveys and studies thus far made have shown the necessity of an economic consideration of it from a medical standpoint. In view of the fact that the physician must be the essential element in any plan for the carrying out of this scheme of examination, it is extremely important that the profession should take the leadership in outlining a sane and sensible solution of the problem

The matter is of so broad a scope and has received, comparatively, so little intensive study that your Committee has been required to give it careful analysis, particularly with the idea of presenting to the Society a plan both comprehensive and feasible

We realize that as public health is so impor-

tant a factor in the life of the community, unless the doctor takes the initiative in matters of this character, lay organizations and foundations may not only usurp the privilege but also demand legislative measures and the leadership which should naturally belong to the medical profession will be relegated to hands not properly equipped to cope with the situation

It was for this reason that your Committee gladly took up the work assigned to them and now attempts to offer you a plan which we hope and trust will be broad enough in scope to warrant your confidence and, at the same time, have possibilities of future growth which will further tend toward the betterment of the health of our citizens

The fundamental thought in formulating this plan has resulted in the sub-division of the subject into three primary requirements

### *First* The education of the physician

*Second* Some technique or method whereby physicians could properly secure the needed data in record form, which would be so simple as to meet the approval of the profession at large and yet contain sufficient subject-matter to be of value in the study of the histories of patients

*Third* That some method or means of publicity should be offered which would not be the burden of the doctor, but be rather the responsibility of foundations and lay organizations which could, as a civic and public duty, bring the need of Periodic Health Examinations before the people in general

It is highly undesirable that a profession which has resented the entrance of lay organizations into the scientific field of medicine—in some instances condemning their methods and their results—should appear to reverse its attitude and state that what was done formerly by the foundation alone was wrong, but now when done by the physician has become ethical and proper and of extreme value. The medical profession should rather be placed upon record as desiring Periodic Health Examinations done by properly qualified men, with carefully kept records, and the public coming to the doctor for his examination

Under the headings outlined above, your Committee has formulated a workable plan. Taking these up in order we would state

*First The Education of the Physician* The average medical graduate is thoroughly competent to make physical examinations, keep records, and carry out the requirements of Periodic

\*Deceased Dr C. Ward Crampton appointed in his stead

**Health Examinations** This idea of educating the physician is not primarily a matter of education, but, rather, of presenting ways and means which will not only refresh his memory but will make his work parallel with that of his brother physician when records are compared. In other words, the results of any examination to be of value must be uniform, and the method of examination must follow along parallel lines.

Another thing which must be borne in mind is that many people who come to a physician for a Periodic Health Examination, have learned through years of association to have a regard and reverence for this particular doctor. The patient may not have realized that through this long period his physician has gradually developed some specialty which has taken him out of the realm of general practice. The patient's feeling is that what his old doctor says must be so. This is very flattering to the physician, but if he is to be just to himself and expects to reassure an inquiring patient as to his health, it is very necessary that he again take up some of the fundamentals, long laid aside, in order to secure a really satisfactory examination of his patient.

Your Committee has felt that the most important phase of this work is to do away with perfunctory examinations, incomplete tests, and hasty conclusions, not justified by a scientific method of procedure. In other words, if a Periodic Health Examination is to be worth anything to the patient, it should be done properly. We therefore, under this head, offer you the following:

We feel that it is necessary to send to the medical profession a circular, explaining the breadth and intent of this work and stating:

- (a) The outline of health examinations,
- (b) The scope of health examinations,
- (c) What the health examination should comprise,

- (d) Information relative to health examinations, including post-graduate courses, the bibliography of literature at present published, etc.

We have also arranged for a complete set of lectures in the form of a symposium. Those are to be given on Tuesdays and Thursdays, beginning January 6, 1925, and will follow a prescribed course, as outlined by the Chairman of the sub-Committee. With this literature, bibliography and the proposed symposium of lectures for the physician, we feel that a good beginning will have been made toward launching Periodic Health Examinations with the medical profession.

We will give the physician a chance of knowing what the Periodic Health Examination should be, its scope, its intent, and where he may take up any course of study that he feels is necessary. We will put him in touch with specialists in our symposium who will give him the angle of the specialist with particular reference to exam-

ining his patients and emphasizing abnormalities that count, and, in addition, we will refer him to the Academy's library, where he can further study all of the literature referred to.

The second phase has been the development of some simple method whereby the profession could adopt a technique for filing histories which would be accurate and uniform. With this in mind your Committee desires to offer the history examination card, which was compiled after exhaustive studies of the blanks offered by Kings County Medical Society, the American Medical Association, the New York Board of Health, and various insurance companies. The result of this study has been a card 5 x 8 in in size (standard for records) which we hope will offer a basis to meet the necessary demands for uniform filing.

Your Committee further feels that the physicians should be assisted in filling out this filing card by a question guide for health examination, and therefore it offers you a Guide Card which will enable the doctor to correlate his findings for record on his filing card.

We feel that this Guide Card for use by physicians is very necessary, as much space is usually provided on examination sheets for data, little of which is of a positive character. The attempt of your Committee was to concentrate on the preservation of findings which would really be valuable, rather than the filling in of a long card which recorded little of permanent value. We feel that this questionnaire will enable the physician to thoroughly question his patient so that abnormalities will not escape him.

Another point seriously considered and adopted by your Committee is the necessity for recording abnormalities discovered by the physician and suggestions for their correction. Both the findings and the corrections are to be handed to the patient on the completion of his examination on separate stationery or on some form devised by the physician, but complying with the blank as offered by your Committee for the purpose. This will enable the physician to make a thorough examination, to keep his files complete, and, at the same time, to give the patient the findings and suggestions which normally belong to him, without giving him a duplicate of the record which is perfectly proper for the doctor's files, but which, if given to the patient, might be a source of annoyance not only to the doctor but to the patient himself.

The third sub-division of our work has been the consideration of the matter of publicity for the physician. As previously stated, we have been reticent about suddenly approving or the physician's doing what we previously condemned when done by lay organizations. Your Committee realizes that it is difficult for us now to go to the public and tell them that they need

**Periodic Health Examinations** We want to be ready and qualified to do this work, but it is eminently more fitting that organizations particularly equipped for publicity work should bring the need of medical examinations to the public. We should be equipped to do it, but should not be the ones to advise them to have it done.

A source of former criticism by the medical profession was that lay organizations were frightening the public into real or imaginary troubles, intensifying minor abnormalities into serious complaints, and then by a process of correlation were giving out extensive reports to the public, some of which were subsequently proven to be either over-emphasized or inaccurate. This led to the suspicion on the part of the medical profession that lay organizations attempting health work frequently frightened patients into the idea that they were seriously affected for the pecuniary return that might accrue.

Therefore, the medical profession must be doubly careful that this whole matter of publicity should be brought to their attention by outside

organizations and that they be prepared to co-operate, rather than that they take the attitude, as previously stated, that what was formerly wrong is now right.

With this larger conception of the subject in mind, the sub-committee on publicity has sought the assistance of certain lay organizations, such as the Milbank Foundation, the New York Tuberculosis Association, and other organizations engaged in publicity work, and these organizations, in turn, have promised us aid in bringing the importance and need of Periodic Health Examinations to the public. They all naturally require an outline as to what our aims are, what program we have in mind, and what it will cost to carry out these ideas. They have offered us freely street-car ads, radio talks, and a speaker service, and, under our guidance, will do what circularizing we wish, thus co-operating in every way with the medical fraternity.

Under the circumstances, the large scope of this work cannot but succeed with so universal an approval of the greater motive we have in view.

## PREPARATION FOR MAKING PERIODIC HEALTH EXAMINATIONS

The Committee on Periodic Health Examinations of the Medical Society of the County of New York, acting with a similar committee of the New York Academy of Medicine, has arranged a symposium on The Preclinical Signs of Disease with special reference to the management of the Health Examinations. The symposium will be held in nine sessions, each of which will consist of two lectures by prominent clinicians. The sessions will be held in the Academy of Medicine at four o'clock on Tuesday and Thursday afternoons. The program is as follows:

January 6—The Gastro-Intestinal Tract, Arthur F Chace, M D Orthopedics, Reginald H Sayre, M D

January 8—The Heart and Circulation, Walter L Niles, M D Infections—Infectious Diseases and Immunization, William H Park, M D

January 13—The Nervous System, Foster

Kennedy, M D Gynecology, Charles G Child, Jr, M D

January 15—Genito-Urinary System, Edward L Keyes, M D Skin and Syphilis, Howard Fox, M D

January 20—The Respiratory System, James Alex Miller, M D Eye, Ear, Nose and Throat, Daniel S Dougherty, M D

January 22—Pre-Surgical Conditions including Cancer, Eugene H Pool, M D Endocrinology, Walter Timme, M D

January 27—Allergy and Pre-Asthmatic Conditions, Robert A Cooke, M D Metabolic Diseases—Diabetes, Rheumatism and Gout, H O Mosenthal, M D

January 29—Occupational Hazards—Fatigue, Work and Rest, Louis I Harris, M D Pediatrics, William St Lawrence, M D

February 3—Prescription and Management of Exercise, Prescription and Management of Diet, Summary, C Ward Crampton, M D

## PRE-CLINICAL SIGNS OF DISEASE OF THE GASTRO-INTESTINAL TRACT

By Arthur F Chace, M D, Professor of Medicine, New York Post-Graduate Medical School

Abstract of the first lecture in the symposium on Periodic Health Examinations given in the New York Academy of Medicine on January 6, 1925, under the auspices of the Medical Society of the County of New York.

The Periodic Examination is the practice of

pre-clinical medicine, or the examination and treatment of apparently healthy persons. The object is not only to detect the signs of approaching debility, but also to advise the one examined how to prevent the development of the debility. Physicians have been accustomed to think of the prevention of sickness only in connection with contagious diseases, but it also has its applica-

tion to chronic troubles of a functional nature. The practice of pre-clinical medicine involves a consideration of the first signs of a functional trouble which, if unrelied, will go on to organic disability, or sickness, or death. For example, a man has a tendency to an ulcer of the stomach. It is the duty of the examining physician not only to detect the signs of conditions which may lead to an ulcer, but also to advise the patient what to do to avoid the ulcer.

We will confine our attention to the pre-clinical signs of gastro-intestinal disease. Suppose an apparently well man comes to you for an examination, and all that he complains of is that he is not so full of activity as his team-mate in business. The physician will first observe the man for any tendency toward disease. His skin may be sallow, scaly, or red, or his nose may betray his drinking habits. His breathing may be panting and labored. A metallic taste in his mouth may suggest indicanuria. His coated tongue may point to liver insufficiency, or a red tongue may betray an over-acidity of the stomach and a tendency toward gastric ulcer. A long waist or distance from the sternum to the pubis may indicate gastropnoia. A splashing sound over the stomach indicates gastric relaxation, and a flabbiness over the cecum betrays a stasis in the beginning of the large intestine,—the cesspool of the body. Localized tenderness or pain suggests appendicitis or cholecystitis.

In a periodic examination, do not neglect an inspection of the rectum. A small, hard nodule that gives no trouble at all may be the beginning of a cancer, which can be completely cured in that stage of its development.

These are the main points to observe in making a hasty physical examination of the gastro-intestinal tract. Now, let us consider symptoms.

There are four principal organic diseases of the gastro-intestinal tract to be considered in an adult. 1. Appendicitis, 2. Cholecystitis, 3. Ulcer of the stomach or duodenum, 4. Cancer.

Heartburn is a symptom which is suggestive of future trouble. An ulcer is usually preceded by a long history of sour stomach for which soda or other alkalis have been taken. For example, a prominent physician apparently in good health passed a tarry stool while on a train going to read a paper before a medical society. On his return he had to spend six weeks in bed while he underwent treatment for a gastric ulcer. He had a chronic heartburn, and had been in the habit of taking soda for its relief for months, and yet had not thought it necessary to consult a brother physician. If he had eaten food which did not produce excessive acidity of the stomach, he would have avoided the ulcer.

Cancer also has its suggestive signs. A slow progressive trouble with food in a person who has been well previously is a suggestion of

cancer. For example, a watchman in a dispensary came for an examination because his wife said he had become fussy over his food. His abdomen showed a cancer the size of a hen's egg.

Difficult and painful swallowing in a person past fifty years of age suggests cancer of the esophagus.

A chronic irritation of the stomach is often the only subjective symptom of appendicitis or cholecystitis. An inflammation of the gall bladder is likely to produce gallstones, which can be relieved only by operation, but in every case there is a time when the inflammation may be relieved by such means as lavage or colonic irrigations.

We will now consider the common signs of functional disorders of the gastro-intestinal tract. These are as important as the organic disorders.

Constipation and the retention of toxic substances often result in mental depression and dullness, migraine, and other nervous disorders. Many persons who suppose they have good bowel movements daily have a retention of much toxic substances. Make a test by giving a capsule of carmine or charcoal, and seeing how long the coloring matter persists in the movements. A normal person excretes all of it within two days, but specks of it appearing for five or six days indicate constipation which requires treatment, and which, if neglected, may produce colitis and other inflammatory conditions.

Observation of the bowel movements may reveal much of what is taking place in the intestine. A dark, foul stool indicates protein putrefaction. A light, foamy, gaseous stool indicates carbohydrate fermentation, which is often difficult to overcome.

Four chronic conditions outside of the gastro-intestinal tract are likely to give gastro-intestinal symptoms. These are 1. Incipient tuberculosis, 2. Nephritis, 3. Cardiac decompensation, 4. Cirrhosis of the liver.

An indigestion is very often the first sign of pulmonary tuberculosis that is noticed, and to it is ascribed the usual loss of weight. A progressive indigestion always calls for an examination of the lungs.

Kidney disease often produces an indigestion which is the only sign that calls attention to the urinary disorders. An examination of the urine is not complete unless an indican test is made. Cirrhosis of the liver often has an insidious onset with indigestion as its prominent symptom. Look for confirmatory signs, such as sallowness and a coated tongue.

Making a periodic examination consists in thinking of the conditions which precede the more evident signs and symptoms of disease, and considering what these conditions may lead to if they are not treated.



# NEWS NOTES



## THE GOVERNOR'S MESSAGE

Governor Alfred E. Smith devoted the unusually high proportion of 10 per cent of his Annual Message, on January 7, 1925, to public health topics. He says "Preservation of public health is an important part of the business of the State of New York. We know how to reckon its value. Our State Department of Health furnishes one of the best illustrations of what a consistent policy, extended over a period of years, will accomplish."

Governor Smith then proceeds to comment at considerable length on some of the accomplishments of the Department of Health, especially in the saving of the lives of infants and of women in childbirth. He comments on the work of the orthopedic surgeons among crippled children, and on the survey now being made to determine the extent of the problem of this care. He describes the State aid in public health nursing and local laboratories, the protection of the people against smallpox and tuberculosis, the eradication of bovine tuberculosis, and the protection of oysters from sewage pollution.

The Governor commends the attempts to pass an efficient Medical Practice Act, and says "This is not a political or partisan matter. It concerns the health and lives of the people of this State. I earnestly hope that the present Legislature will give this matter careful consideration, and enact legislation which will justly and effectively safeguard the public health and enforce the Medical Practice Act."

The Governor concludes the public health part of his address with a consideration of the needs of the State Hospital service. He especially commends the mental clinics, and says "There is an urgent demand that the work of these clinics be extended to problem children, to the end that early criminal tendencies may be checked, faulty mental habits corrected, and proper adjustment of the child to his environment be made."

Governor Smith has dignified public health work, and made its importance co-ordinate with that of the State's finances, canals, militia, and other great activities of the State government.

F O

## SURVEY OF CRIPPLED CHILDREN

The New York State Commission for the Survey of Crippled Children desires the aid and co-operation of the physicians of the State in its attempt to enumerate and classify crippled children.

This commission, created by the last Legislature, consists of eight members, four members of the Legislature, and a representative of each of the State Departments of Health, Education, and Charities, and the New York State Society for Crippled Children. Senator William T. Byrne is chairman of the commission, and the survey is under the direction of Henry C. Wright of New York, director of the Hospital and Institutional Bureau of Consultation.

In general, the program of work of the Commission includes, on the one hand, enumerating and classifying the different types of crippled children of the State, and on the other hand, finding the existing facilities for medical, surgical, and convalescent care, and for general and special education and maintenance.

The general procedure of locating cripples is through the means of the school teachers, aided by physicians, nurses, and various persons inter-

ested in each community. Census cards are beginning to be returned in good numbers, and in most cases, the physical condition has been rechecked by the family physicians or school medical inspectors. The chief shortcoming in the returns so far, is the failure to locate as large a proportion of crippled children under school age as probably exists. These cripples are not, of course, on the school register, and must be located through other school children and their physicians or friends in the community that have knowledge of them.

Greater New York has not been included in this school census because facts in regard to the number of cripples were secured in the census made there in 1919-1920.

The Counties of Cattaraugus and Onondaga are also omitted because of surveys being made by Health Associations in these two counties.

Although the Commission does not yet have sufficient facts on which to formulate a definite program, certain needs are already evident. One of these is the necessity for some automatic means of reporting and registering all crippled children from birth to 18 years of age. The only existing public record of children is that which



is made by school enumerators, and this, of course, includes children of school age only

If all parents, when a child is injured or afflicted with a disease that may cause him to be a cripple, would call in a family physician, the case would undoubtedly get attention, but unfortunately, many parents do not ask medical aid and do not report such cases. The census of cripples in New York City in 1919-1920 revealed the fact that nearly fifty per cent of cripples had not been reported to physicians nor had received other medical attention. These children were chiefly of foreign parents who probably feared that their children would be taken away from them if they reported to public authorities or physicians, or that some operation would be per-

formed that would result in death. It is probable that the same fear is in the minds of ignorant parents throughout the State of New York, and that many children are crippled by accident or disease without that fact becoming known to any physicians, hospitals, or clinics. This situation makes it imperative that some procedure be adopted by the State to discover crippled children who are not revealed by physicians.

The Commission urgently requests the physicians throughout the State to assist the school teachers in locating all crippled children, and particularly to aid the teachers in rechecking the record of physical defects.

HENRY C. WRIGHT,  
Director of Survey

---

## THE MEDICAL SOCIETY OF THE COUNTY OF KINGS

The December *Bulletin* of the Medical Society of the County of Kings contains an appreciation of its leaders which will apply equally well to any other live County Medical Society. We are printing it as an ideal answer to those whose minds run to destructive rather than constructive criticism.

"A certain type of physician says no. I never go to the meetings. They're the same old things. Yes, a clique, an inner ring, run things to suit themselves. They skim the cream. The glory I don't know what's going on. I'm not interested."

"The president is your leader—chosen by you—not by a clique. He is not 'made' by the office. He makes the office, having earned a distinct reputation as a leader in the field of medical endeavor. His year in office is one of hard, untiring effort. The position pays no salary directly or indirectly. The reverse is true. The office of president is one of ceaseless labor, hard work, and minus glory or profit."

"Therefore, every member should get in the game. The small mind should learn the true facts and stop casting slurs. Rather, it is up to him to admit his sin and reform by putting his shoulder to the wheel and doing something worthy for the good of the order."

"But, upon reflection, maybe we are wrong. A clique may run things, after all. The chairman of a committee has invited an out-of-town man to address us. That chairman is allowed to entertain the guest at dinner, perhaps arrange a theatre party for him. In the course of events motion pictures may be exhibited. The projection machine (perhaps, two of them), the booth, the operator—all costs money. You think

the Society foots these bills? Nay, brother, nay, it is one of the honors permitted the chairman."

The Joint Committee, Graduate Education met and organized. Money was needed to do business. No. The Society did not advance it. Instead, each and every member of the committee wrote a check and underwrote the undertaking. Glory!! Quickly, now. Who are the men on that committee? Do you know that certain unnamed gentlemen have pledged themselves the sum of \$250 each year for a certain work? Close as we are to the 'know' we cannot tell offhand who these gentlemen, hungry for glory, are.

"Look beneath the surface and you'll find the clique to be an unorganized number of physicians who love the society, who have stood by it for years through thick and thin, fat and lean, who made enviable reputations without the aid of the society, who have given their time, of their pocketbook, their thought, and their devotion to the society. They are ever on the lookout for the man with ability to be a leader eager to get behind that one and lead him to the high places, asking only that he, too, love the society and will make good. We have learned to our sorrow that such men are hard to find. And so, if you are a critic, a student of theories, if you can measure up to these specifications, a place is waiting for you."

"There always will be leaders. I suppose there always will be scoffers, little men who stand off and bark from a safe distance. But the scoffers never created or built up. So after all, it is the clique, the leaders, who are the safe ones to pilot our craft through the waters."

### THIRTY-EIGHT PHYSICIANS SEEK RURAL PRACTICE

Considerable concern has been manifested by welfare associations and those interested in rural community life, by the apparent growing tendency on the part of physicians to move their residence from the rural districts to the larger centers, where hospital and laboratory facilities will be more accessible. In some instances this withdrawal has occasioned considerable alarm on the part of the community thus apparently forsaken.

A more careful study of the problem recently thrust upon this office has afforded an opportunity for seeing the matter from another angle. In a majority of instances the community lost its old family physician because "Father Time" had a claim upon him, and no young man has offered to take up his practice because, with the advent of the automobile and good roads, it is possible for the residents of such communities to call a physician in attendance in less time than could the old family physician, when he was a young man, attend their fathers. The forlornness of these communities is, in many instances, considerably exaggerated through sentiment. The fact that the country store which at one time prospered at the cross-roads, has disappeared, has been accepted as a normal evidence

of development. The farmers, with their automobiles, prefer to do their shopping in the larger centers, and are justified in doing so. Likewise, when they are in need of medical service, not emergency in character, they also prefer to seek such service in larger cities, and are capable of doing so with the aid of the automobile. Thus the physician living in the rural district is overlooked and the more lucrative practice is carried to the city, or the city physician is induced to come out, which he willingly does when the roads are passable, and the high regard which the community feels for this local physician never comes to the surface until he, responding to the pressure of conditions, decides to take up his residence in a larger center.

That physicians would be willing to live in rural districts, providing they could do so and effectively "keep the wolf from the door," is manifested by the fact that within the last month thirty-eight physicians have written to this office asking for a list of rural communities in need of physicians. Unfortunately we had at our disposal only four places where the County Medical Societies thought physicians might be able to develop a practice warranting their taking up the location.

J S L

---

### TRAINING NURSES FOR TUBERCULOSIS WORK

The following resolution was adopted by the Public Health Committee of the New York Academy of Medicine:

WHEREAS, There is a well recognized and widespread need of trained nurses for the care of tuberculosis patients, and

WHEREAS, The nursing of such patients requires a special technique which, as a rule, is not taught in the course of the training of registered nurses for the reason that most of the hospitals in which such nurses are trained do not take cases of pulmonary tuberculosis, and

WHEREAS, It is found that registered nurses as a rule give themselves up to the care of pulmonary tuberculosis with great reluctance, or not at all, and consequently there is a very great shortage of properly qualified nurses to take care of this large group of cases, and

WHEREAS, The chief source of supply of nurses for the care of pulmonary tuberculosis is from women who have themselves had tuberculosis and been cured of it,

*Therefore Be It Resolved*, That the Public Health Committee of the New York Academy of Medicine favor an amendment to the Nurse Practice Act which shall give official recognition with a suitable title to graduates of training schools operated in conjunction with tuberculosis sanatoria in this State, provided the sanatoria meet the requirements to be established by the Board of Regents and provided the course of instruction be of at least two years' duration and that it meet also any specific requirements for the training of nurses to care for the tuberculosis sick, which shall be formulated jointly by the Board of Regents and representatives of the tuberculosis sanatoria in the State.

Official recognition of this type of nurse with a suitable title would be similar to the recognition accorded to graduates of training schools in the State institutions, or institutions under the visitation of the State Hospital Commission (Chapter 742—Public Health Laws of 1920, Paragraph 252—c)

# PRIZE ESSAYS

## COMMITTEE ON PRIZE ESSAYS

The Committee on Prize Essays takes pleasure in once more drawing the attention of the members of the Medical Society of the State of New York to the Merritt H Cash prize and the Lucien Howe prize, which will be open for competition at the next annual meeting of the State Society, which will be held in Syracuse on May 11, 1925

The Lucien Howe prize, consisting of a medal and \$50 in cash, will be awarded for the best original contribution to the knowledge of surgery, preferably ophthalmology, and is not limited to the members of the State Society, any physician being at liberty to compete for it

The Merritt H Cash prize of \$100 will be awarded for the best original essay on medical or surgical subjects and is only open to members of the Medical Society of the State of New York

The essay shall be typewritten or printed, and the only means of identification of the author shall be a motto or other device. It shall be accompanied by a sealed envelope, having on the outside the same motto or device, and containing the name and address of the writer. Essays must be sent to the chairman of the committee, Dr Lucien Howe, 520 Delaware Avenue, Buffalo, N Y, not later than the first of April, 1925

### CONCERNING THE PRIZE IN OPHTHALMOLOGY

It is probably worth while to call the attention of the Society to the prize in ophthalmology and to changes adopted last year concerning the method of awarding the medal

In America the idea of a medal for distinguished service in science is comparatively new. But it is a plan long since recognized in England and especially on the continent. Thus, the Royal College of Physicians of London awards two. The Royal College of Surgeons of England awards the John Hunter gold medal, also an entire series known as the Blane gold medals and the honorary medal of the college. L'Institut de France, Academie des Science, awards also medals or prizes, some of them being of unusual value. The same is true of the "Nobelstitten" of Stockholm. Numerous other medals are offered to savants in other foreign countries for re-

searches in various branches of medicine and surgery

In America prizes such as the Boylston prize of Harvard and the Cartwright prize of the College of Physicians and Surgeons of New York, are usually in money, although the well-known Knapp prize is in the form of a medal.

Moreover, the decorations given to American soldiers and sailors, by other countries and by our own, have taught democratic America that service for country, as for science, can not always be paid for in dollars and cents, as well as it can by some mark of appreciation, however small in itself, which can be held permanently by the recipient and then handed down to his children and to his children's children

It is not surprising, therefore, that one who has been a member of our State Society for nearly half a century should have followed the example of a still earlier member in giving to the Society several years ago some fifteen hundred dollars, understanding in general terms that the interest on that amount was to be awarded for some essay of special merit relating to ophthalmology. But as experiences proved that evidences of research, as shown by essays restricted entirely to that branch, were offered only occasionally, and also that some earnest students would much prefer a medal in recognition of their achievements to a prize in money which would later vanish, therefore the donor of the prize, who was last year the chairman of the committee, and the two other members associated with him, recommended that as the annual income from the fund originally given to this Society now amounts to over one hundred dollars, that when the prize is awarded it shall be in the form of a gold medal to cost fifty dollars, the other fifty dollars to be expended in printing and distributing copies of the essay for which the prize was awarded

The committee also recommended that the chairman should resign each year and a new member be chosen by the President of the Society that choice being such that the committee shall always consist of two ophthalmologists and one general surgeon

The final and important recommendation was that the competitors for the prize shall present their material to the chairman of this committee at least one month before the annual meeting of the society. This means, evidently, that anyone who has been engaged in real research in ophthalmology or in any of its allied branches of surgery, should lose no time in completing his work if he has any idea of competing for this prize



# COUNTY SOCIETIES



## MEDICAL SOCIETY OF THE COUNTY OF ALBANY

The annual meeting of the Albany County Society was held Tuesday evening, December 9, at the Auditorium of the Municipal Gas Company. Dr Edgar A Vander Veer presided.

The following members were unanimously elected to the Society: Drs James R Lisa, Emily A Pratt, and Wesley A Van Deusen.

The following officers were elected for 1925: President, Henry L K Shaw, vice-president, William P Howard, secretary, Clarence Graham, treasurer, James Lyons. Censors: Drs John E Heslin, Clinton Hawn, Brayton E Kinne, Frederic C Curtis, Arthur Holding. Delegates: Dr Nelson K Fromm, Arthur Dickinson, L H Gorham. Alternate Delegates: Drs Wm E Lawson, Thomas O Jenkins, Harold Peck.

A rising vote of thanks was given to the retiring officers.

The death of the late Dr William J Nellis was brought before the Society by the President, who appointed the following committee to draw resolution on his death: The doctors are Frederic C Curtis, James W Wiltse, Louis LeBrun.

Dr Arthur J Bedell gave notice of an amendment to the constitution to be presented at the June meeting.

Dr H D Cochrane, of Albany, gave an interesting talk on "Evacuation of Wounded in Campaign."

A special committee called the "Committee on Economics," composed of the following members: Arthur J Bedell, James F Rooney, Frederic C Conway, presented the following written report:

"We have considered the economic aspect of the profession and feel that many conditions which have caused friction have to some degree been removed.

"It cannot be said that one of the most pressing conditions has been entirely rectified. That is the relationship of members of the profession to the Workman's Compensation Law. It is believed, however, that the fee question is more satisfactory than in the past. There are certain matters relating to this bureau, however, that are in the opinion of your committee manifest evils, especially the practice which is tolerated and we think it may be said, encouraged by the Labor Department and the insurance carriers of engaging physicians to act for all three parties, Labor Insurance carrier and employer, and the patient or claimant.

"It must be evident to any normal mind that this situation can be and is not only a temptation to evil, but that it does enure to injustice either to claimant, carrier or the State or to all three. If one were to suggest that in an action in equity tried in court one attorney should be the Judge, the jury and the party at bar, it needs but the statement to show its ridiculousness.

"There are many instances where injured workmen are being deprived of the best medical services because they must be treated by certain physicians who are designated by the carrier who has contracted with them for either a stipulated price for treatment which is less than the usual to the best in the profession or a salary contract, lump sum per annum. This condition of affairs we believe leads to prolongation of the period of disability or downright quackery.

"Some physicians are charging carriers extravagant fees for services which are unnecessary, ineffective or superfluous. This may in part be due to carelessness or ignorance, but is frequently because they believe a corporation pays the bills. Certainly we must rectify the evils, few though they may be, existing among ourselves, before we can properly ask action to remove those which afflict us.

"Your committee reviews with regret that the high ethical standard the ideal which has animated the profession, is slowly but with increasing rapidity, deteriorating and sinking into the morass of industrialism and commercialism. The increasingly common tendency to consult with those who are now by statute covered by the professional toga and others who are not licensed to practice medicine in this State, is a saddening fact which must be deprecated.

"It is desired to draw attention of the Society to the economic features concerned in certain proposed legislation in the House of Delegates of the American Medical Association which is to be introduced in Congress, relating to amendments of the National Prohibition and the Harrison Narcotic Acts, reducing the formalities required by the former and extending the physician's rights to prescribe and in the latter reducing or abolishing the unjust tax.

"A serious economic question which is becoming more prominent and more threatening is the gradual consolidation of all medical powers, appointments and employment in the community, municipality, the State and the Nation, in small consolidated and through chance, not necessarily

able, powerful groups This is really the industrialization of the medical profession It can well be seen by viewing the results of this process in other aspects of this so-called civilization, that its tendency is to aggrandize power in an oligarchy and to enslave the mass No great creative things have ever risen from an oligarchy or slavery, but there has grown out of both frightful evils that have only been washed out in the birth pangs of revolution The medical profession in its very nature if it is to perform its function of healing, is and must remain individualistic, freedom of opportunity and advancement must be based on ability and efficiency only, it cannot be governed by the same standard as romantic love where kissing goes by favor The domination of the profession by highly financed lay-interests is overwhelming, this dictation counseled though it may be by certain self-constituted authorities who are, however, in the end not at all responsible for or to their medical colleagues, is becoming a menace This tendency

should be mightily resisted else the profession will become merely an arm moved by another's brain

"Your Committee, therefore, presents the following recommendations

"1 That a committee of five be appointed to act as the official intermediary of this Society in the matter of differences of any sort that may arise among the parties at interest under the Workmen's Compensation Law, this Committee to be titled the Compensation Arbitration Committee No physician of the Society shall be eligible to this Committee who has a contract or agreement for constant employment with any of the parties at interest

"2 That the Secretary be directed to inform the United States Senators from this State and the Representative in Congress from this district of the action of the Society in relation to the proposed amendments to the National Prohibition and the Harrison-Narcotic Acts "

### TOMPKINS COUNTY MEDICAL SOCIETY

The Annual Meeting of the Tompkins County Medical Society was held Tuesday evening, December 16, 1924, in the parlors of the Board of Commerce, Ithaca, N Y, President Parker in the chair

The minutes of the November meeting were read and approved

The Comitia Minora reported that membership dues will be the same as last year, \$3 00

Election of officers for the ensuing year resulted as follows President, Dr John W Judd, Ithaca, Vice-President, Dr Keith Sears, Trumansburg, N Y, Secretary-Treasurer, Dr Wilber G Fish, Ithaca, Censors, Drs Luzerne Coville, L T Genung, W F Lee, H G Bull, W B Holton

Applications for Associate Membership were received from Prof Henry N Ogden of Cornell, Sanitary Engineer and member of the State Public Health Council, and Dr W A Hagan, Pathologist and Bacteriologist in the State Veterinary College at Cornell Being properly recommended and endorsed by the Censors they were duly elected to Associate Membership

A summary of the report of the Treasurer showed a balance on hand December 18, 1923, of \$101 84 Cash received during the year \$568 Cash paid out \$655 97 Balance on hand this date, \$13 87

The Secretary's report was as follows

The Society began the year with 65 Active members, 30 Associate, and one Honorary member A total of 96

One Active member died during the year and two Associate members moved away

One Active member has been gained by election

We therefore close the year with 65 Active members, 28 Associate and 1 Honorary member, a total of 94

A short analysis of our membership may be interesting

Of 55 practicing physicians in the county 53 are members

Of 39 practicing physicians in the City of Ithaca 38 are members

Of the 65 holding active membership, 7 are not in practice

Of these 7 one is President of Cornell University One is Dean of the Medical College of Cornell at Ithaca One is Professor of Histology and Embryology in the same college One is Dean of the State Veterinary College at Cornell One is in the Laboratory of Parke Davis & Co at Detroit One prefers the selling of life insurance to practicing medicine One retired from practice upon annexing an M D husband

Among others not in general practice, one is Medical Advisor of Women at Cornell University Two are in Government service without the State One is in the Health Service of the Ohio State University at Columbus, Ohio Eleven are Health Officers and one is Coroner

The Society has held 10 regular meetings during the year at which 16 scientific papers were delivered Eight of these were by members and

eight by men of high standing in the profession from New York City, Cleveland, Rochester, Syracuse and Utica

Both the Annual Banquet, held in March, and the joint meeting with the Cortland County Society held in June were very successful and fully enjoyed

During the year our meeting place has been changed from rented quarters to the very convenient and comfortable parlors of the Board of Commerce for which we are charged no rental I venture to suggest, that in order to show our appreciation of this courtesy, the Society, as such, should take out a membership in the Board of Commerce

Madam President If I may be allowed to include in this report some matters which, under strict interpretation, may be considered extraneous thereto, I would like to suggest the Society may profitably consider the coming year, some matters heretofore but lightly touched upon

1 Why not a meeting devoted to the business needs of the profession with talks by one or more bankers or business men on such subjects as investments, business methods for the professional man, wills and estates, etc

2 Why not the Committee on Public Health arrange a meeting devoted to public health matters, both state and local, with the City Board of Health and the eleven Health Officers of the county who are members of the Society and the District State Health Officer taking part?

3 Why not work with the City Officials and the staff and Board of Trustees of the City Hospital to the end that when the contagious wing is built there may be a room so arranged and fitted that clinical cases may be safely, easily, comfortably and properly be presented to Staff and Medical Society meetings to be held therein?

4 Why not get in closer touch with the Dental and Nurses' societies of the city, possibly by joint meetings occasionally or by some other means?

5 Why not one meeting during the year devoted to a discussion of the community and civic problems of the city in which most of us live and some of us pay taxes, with members of the civic bodies present to discuss these problems with us?

6 Why not a committee to study out and if possible formulate a feasible plan for the education of the public regarding the difference between the regular practice of medicine and the practice by the cults?

7 If State Legislative matters effecting the profession are looming large, why not bring them before the Society for discussion?

It would seem that these subjects, or some of them, would afford profitable and beneficial study

Respectfully submitted,  
WILBER G FISH, *Secretary*

The following Scientific Program was then presented

"Peculiar Effects of Thyroxin on the Cutaneous System," Dr Sutherland Simpson of Cornell, This was illustrated by lantern slides showing the effect of these experiments upon sheep

"The Effect of Thyroxin upon the Central Nervous System of Thyrorectomized Sheep," H L Liddell, Assistant to Dr Simpson, illustrated with lantern slides

These were practically additions to former papers given earlier in the year, thus bringing results of the experiments up to date

"A Demonstration of the Qualitative and Quantitative Determination of Sugar in Urine," James B Sumner, Professor of Biochemistry in Cornell The demonstration was made upon the urine of a diabetic

"Duplication of Ureter on One or Both Sides in Man," Dr Abram Kerr, Professor of Anatomy in Cornell

Lantern drawings were shown illustrating several cases as discovered upon the dissecting table

Each paper was brief, terse and to the point, interesting and instructive, and each was followed by a short discussion A vote of thanks was given the speakers

It was moved by Dr Coville, seconded by Dr Kerr, that the Society take out a membership in the Ithaca Board of Commerce Motion carried

Dr B F Lockwood of Brookton spoke very feelingly of the aged widow of the late Dr W C Gallagher of Slaterville Springs (a long time member of this Society whose death occurred December 24, 1921, in his 81st year), stating, among other things, that while physically feeble and over 80 years of age, she is still mentally alert and takes a vital interest in things of today, and suggested it would be a fine and courteous thing for this society to call upon her in a body and he felt sure she would be delighted and very appreciative of such attention

It was moved, seconded and carried that a committee be appointed to arrange for such a call upon Mrs Gallagher

The President appointed as such committee Drs B F Lockwood, Edward L Bull and Helen D Bull

Upon motion the meeting adjourned

WILBER G FISH, *Secretary*

## MEDICAL SOCIETY OF ULSTER COUNTY

The Medical Society of Ulster County held its Annual Meeting at the Stuyvesant Hotel, Kingston, December 9, 1924

There was a banquet at 7 30 p m at which the ladies were present

The meeting was called to order at 9 30 p m by the President, Dr Cranston

The minutes of the last meeting were read and approved as read

The following officers were elected for 1925 President, Orlando DuBois Ingalls, Vice-President, Mary-Gage Day, Secretary, Fred H Voss, Treasurer, E E Norwood, Censors Frank L Eastman, Frederick Snyder, Elbert DuBois Loughran, Alfred S Vrooman, Harold L Van Nostrand, Delegate, Luther Emerick, Alternate, John F Larkin

Dr Joseph Lawrence, Executive Officer of the New York State Medical Society, addressed the Society with a few remarks along the following lines

County Society as the medical unit

County Society should have committees to cover every phase of medical work

All physicians fall in one of two classes (1) cooperative, (2) non-cooperative

Physicians are too busy to cooperate, and so

the cultists have an easy time of it and are not usually refuted by County Societies

County Society should be responsible for medical work done in the County

Every meeting or gathering in the County dealing with medical topics should have a representative of the medical organizations present

Secretary should write the Legislators of the County kindly asking them to look after physicians' interests during the coming season, and at the end of the year thank them

Opinions are desired by the State Department as to the working of the Workmen's Compensation Law Suggestions for amendments to it are welcome

County Society should see that men who start practice in the County have the proper qualifications

County Society to furnish medical education for its men by open clinics

Free for physicians of Society

Fee for outsiders

Dr John F Larkin, the Chairman, introduced Dr Philip MacGuire, Post Graduate Hospital, New York City, who spoke on the subject "Acute Abdomen" A general discussion followed

The meeting was closed with an address by the retiring President

## MEDICAL SOCIETY OF THE COUNTY OF FRANKLIN

The regular annual meeting of the Medical Society of the County of Franklin was held at the Elks Club in Malone on Tuesday, November 18, 1924

The business session was called to order at 12 o'clock

Members present Drs F B Trudeau, president, Abbott, Dalphin, MacArtney, Sprague, Stoughton, Van Dyke, Finney, Wardner, Rust, Stamatiades, Kissane, Baldwin, White and Heise

The minutes of the last meeting and the report of the Comitia Minora were read and approved as read

Drs Henry W Leetch and George Eliot Wilson were elected to membership Dr Harold D Sehl, of Burke, was transferred from the Clinton County Society to the Franklin County Society

The following officers were elected for 1925 President, Dr F F Finney, vice-president, Dr John A Farrell, secretary and treasurer, Dr G M Abbott, delegate to the State Medical Society, Dr S F Blanchet, alternate, Dr P F Laphin of Malone, censor for three years, Dr L P Sprague, of Chateaugay

The secretary and treasurer read his reports which, by vote, were accepted as read

Under the head of new business the subject

of changing the date of the annual meeting was taken up, and after considerable discussion an amendment to Section 2, Chapter 9, of our by-laws was offered, to change the date from the second Tuesday of November in each year to the fourth Tuesday of October

The president-elect appointed the following committees Legislation—Dr John E White, Malone, chairman, Dr L P Sprague, Chateaugay, and Dr F B Trudeau, Saranac Lake. Public Health—Dr C C Trembley, Saranac Lake, chairman, Dr W A Wardner, St Regis Falls, and Dr J S Emans, Rainbow Lake

Meeting adjourned for lunch

The scientific session was called to order at 2 o'clock, and the following papers were read and discussed

"Bronchitis, Acute and Chronic," Dr Edward R Baldwin, Saranac Lake

"The Therapeutics of Bone Meal," Dr William N MacArtney, Fort Covington

"The Negative Diagnosis of Pulmonary Tuberculosis," Dr Fred H Heise, Trudeau Sanatorium

"Pulmonary Tuberculosis With Non-acid Fast Tubercle Bacilli in the Sputum," Dr R E Heimbach, Ray Brook Sanatorium



# THE DAILY PRESS



The Christmas Seal sale is the principal health subject which is found among our Daily Press clippings for December. Over half of our clippings are on that subject. They have come from thirty cities in New York State, and doubtless more than that number have been overlooked.

Some of the newspapers stress the local needs of the community. The *Binghamton Press*, December 3rd, states that there are 89 annual deaths in Broome County from tuberculosis, and that the number of living cases is nine times that number. Other newspapers lay stress on the work accomplished with the Christmas Seal money during the last year. The *Hudson Star*, November 26, states that the Committee plans to sell \$3,452.77 worth of Christmas Seals this year, and we presume that approximately that value of seals was sold last year. The activities conducted by the expenditure of this money included occupational therapy, clinics, relief of poor cases of tuberculosis, and the employment of a paid secretary. It would seem that the amount to be raised would be spread rather thin if it covers all these activities.

The *Catskill Mail*, December 1st, has an article complaining of the lack of public interest in the sale of Christmas Seals. Apparently the Chairman of the Greene County Tuberculosis Committee ascribes the public indifference to a belief that the money is used for work outside of the local county. He argues "Surely Catskill and Greene County, whose prosperity so largely depend on health resort reputation, cannot afford to shirk this manifest duty (to buy Christmas seals)."

In all the accounts of the Christmas Seal sale, we saw no reference to a county sanatorium, or to the tuberculosis work that is done as an official activity of a county. Some of the results ascribed to the activity of the unofficial committee were in fact accomplished by the sanatorium superintendents and the official county nurses. While the lay committees of many cities and counties have done excellent work, yet the unsung accomplishments of the official sanatoriums have probably exceeded the amount of work done by the tuberculosis committees. (See this Journal, December, 1924, page 1024.)

The clippings on Christmas Seal sales have failed to disclose a single reference to the periodic health examination campaign which is being promoted by the State Tuberculosis Committee as one of the important activities of the county tuberculosis committees. The advertising and publicity matter in promoting the sales mention only direct tuberculosis work, yet 12 per cent of the money received goes to the State Tuberculosis

Committee, and a large proportion of that percentage goes to promote work which has no direct bearing on the suppression of tuberculosis.

The clippings from the newspapers of Middletown have exceeded those of any other city in the State. Credit for this is probably due to the Health Officer, Dr. H. J. Shelley, who seems to have a proper sense of the value of newspaper publicity. Among the health topics which are mentioned in the items are sewage disposal, Health Department activities, low water in the city reservoir, Mothers' Helpers activities, infant mortality, the medical examination of food handlers, and the winning fight for compliance with health regulations by a large baking company, children's clinics, and infantile paralysis reconstruction work. The Health Department of Middletown is evidently doing excellent work, and is taking pains to inform the people about the health activities in which they are interested.

An epidemic form of plague among live poultry is described in several newspapers of New York City, and has led to an embargo on the shipment of live fowl into the city, although dressed poultry may still be sent into the city. According to the *New York Journal*, December 17th, a committee of Four Borough Poultry Dealers' Association has made public the serious charge that "bootleg" poultry is being brought into the city. The counsel for the Association is quoted as saying:

"By the term 'bootleg' poultry he meant dressed poultry which had died from the prevalent chicken disease, but which was being dressed after death, rushed into the New York market by motor trucks from neighboring states and here offered for sale as 'dressed poultry'."

"'Bootleg' poultry is being brought in by motor trucks from neighboring states, most of which is affected by the plague. Plagued and diseased poultry are being dressed after death from the disease and sold as dressed poultry."

"What is the effect upon the eating public from eating such diseased and plagued poultry? Surely it must be harmful."

The *New York Times*, December 19th, has the headlines "Two More States Put a Ban on Chickens. New Jersey and Connecticut Embargo Shipments from All Parts of the Country—53,343 Pounds Destroyed. Two Carloads of Infected Fowl Reach Jersey Terminal. Scouts Danger to Health."

The newspapers say that the nature and cause



of the disease has not been divulged, and probably is not known. The condition is serious from an economic point of view, and may be grave from a health standpoint.

The New York City Department of Health has an epidemic of typhoid fever to deal with. An excess of cases are also reported in the commuting area around the city. The *New York Times*, December 16th, says

"At the request of Dr. Frank J. Monaghan, Commissioner of the Department of Health of New York, the Board of Estimate appropriated yesterday a special fund of \$50,000 which is to be used for the joint purpose of preventing an increase in the number of typhoid cases here and for the enforcement of the embargo against the shipment to New York of chickens suffering from the European pest.

"Dr. Monaghan said that there were about 350 cases of typhoid under treatment and that they were scattered through all five of the city's boroughs. Sixteen new cases were reported on Sunday and twelve yesterday, as compared with three on the corresponding date of last year.

"A very large number of these cases now in New York have been brought into the city after inoculation from some source of infection outside. I am inclined to believe that automobile touring and the assembling together of great masses of pleasure seekers in the athletic fields and stadia incidental to the autumn football season are accountable for a large proportion of the typhoid cases both here and in Chicago.

"These many thousands of pleasure-seeking spectators came together from many cities, hosts of them going and coming in automobile pleasure parties, eating more or less indiscreetly along the way, drinking probably from creeks and springs and wells along the road without paying much attention to the purity of the water."

The newspaper reports suggest oysters as the cause of the outbreak. The *New York Herald*, December 18th, says

"The embargo action took the form of a warning for New Yorkers to abstain from eating uncooked shellfish, and the exclusion of oysters, clams and mussels from lower New York Bay, Raritan Bay, Sandy Hook Bay, Princess Bay and their tributary waters.

"Steps will be taken today, the Commissioner said, to make this exclusion order a strict embargo, and a guard will be set over docks at which shellfish are discharged.

"I know that this order will cause some disturbance," he added, "but it must be in force until we can definitely ascertain the source of the typhoid infection. Up to the present we have only the histories of a number of patients indicating that shellfish was consumed by them during the period of incubation, but as a precautionary

measure, I am advising the public to abstain, for the time being, from eating uncooked oysters, clams or mussels."

We have failed to find any newspaper reference to preventive inoculations against typhoid, although the present typhoid outbreak gives an excellent opportunity for publicity of the vaccines.

Epidemics of hiccoughs have been reported in several sections of the State, and the outbreak of epidemic encephalitis is discussed in several newspapers. The *Utica Observer Dispatch*, December 11, says

"In order that epidemics of hiccough in several parts of the state may be subjected to a thorough study, Dr. Matthias Nicoll, Jr., state commissioner of health, has directed physicians to report full details of fatal cases.

"Dr. Nicoll says that although there is nothing alarming in the situation the matter was fully considered at a recent meeting of the Public Health Council.

"Dr. Simon Flexner, chairman of the Public Health Council and director of the laboratories of the Rockefeller Institute for Medical Research, gave out the following statement following the meeting of the council:

"Epidemics of hiccough have at times coincided with or followed in the wake of outbreaks of epidemic encephalitis. They are in some way connected."

The Chlorine Gas treatment of colds is discussed by several newspapers, especially by the press of New York City. An editorial in the *New York Herald*, December 2nd, says

#### "DEFIANT SNEEZES"

"Possibly the chlorine gas treatment for colds in the head as administered by the Chemical Warfare Service has a militant quality lacking in civilian clinics. It is hard to account for the failure of the New York Health Department 'inhalatoriums' to cure colds, in view of the almost uniform success reported by the army physicians in Washington.

"The chlorine offensive came to New York with splendid indorsements. Its fumes banished a cough for Secretary Weeks. President Coolidge then put a cold to rout by a gentle inhalation. It helped a score of Senators and Representatives to quiet breathing. Perhaps colds along the Hudson are more stubborn than the Potomac variety. At any rate, this city's Health Department, after a painstaking trial of two months, has found little or no beneficial effects from the gas remedy. The diverse results in Washington and New York add a new puzzle to an old mystery."



# THE DAILY PRESS



The Christmas Seal sale is the principal health subject which is found among our Daily Press clippings for December. Over half of our clippings are on that subject. They have come from thirty cities in New York State, and doubtless more than that number have been overlooked.

Some of the newspapers stress the local needs of the community. The *Binghamton Press*, December 3rd, states that there are 89 annual deaths in Broome County from tuberculosis, and that the number of living cases is nine times that number. Other newspapers lay stress on the work accomplished with the Christmas Seal money during the last year. The *Hudson Star*, November 26, states that the Committee plans to sell \$3,452.77 worth of Christmas Seals this year, and we presume that approximately that value of seals was sold last year. The activities conducted by the expenditure of this money included occupational therapy, clinics, relief of poor cases of tuberculosis, and the employment of a paid secretary. It would seem that the amount to be raised would be spread rather thin if it covers all these activities.

The *Catskill Mail*, December 1st, has an article complaining of the lack of public interest in the sale of Christmas Seals. Apparently the Chairman of the Greene County Tuberculosis Committee ascribes the public indifference to a belief that the money is used for work outside of the local county. He argues "Surely Catskill and Greene County, whose prosperity so largely depend on health resort reputation, cannot afford to shirk this manifest duty (to buy Christmas seals)."

In all the accounts of the Christmas Seal sale, we saw no reference to a county sanatorium, or to the tuberculosis work that is done as an official activity of a county. Some of the results ascribed to the activity of the unofficial committee were in fact accomplished by the sanatorium superintendents and the official county nurses. While the lay committees of many cities and counties have done excellent work, yet the unsung accomplishments of the official sanatoriums have probably exceeded the amount of work done by the tuberculosis committees. (See this Journal, December, 1924, page 1024.)

The clippings on Christmas Seal sales have failed to disclose a single reference to the periodic health examination campaign which is being promoted by the State Tuberculosis Committee as one of the important activities of the county tuberculosis committees. The advertising and publicity matter in promoting the sales mention only direct tuberculosis work, yet 12 per cent of the money received goes to the State Tuberculosis

Committee, and a large proportion of that percentage goes to promote work which has no direct bearing on the suppression of tuberculosis.

The clippings from the newspapers of Middletown have exceeded those of any other city in the State. Credit for this is probably due to the Health Officer, Dr. H. J. Shelley, who seems to have a proper sense of the value of newspaper publicity. Among the health topics which are mentioned in the items are sewage disposal, Health Department activities, low water in the city reservoir, Mothers' Helpers activities, infant mortality, the medical examination of food handlers, and the winning fight for compliance with health regulations by a large baking company, children's clinics, and infantile paralysis reconstruction work. The Health Department of Middletown is evidently doing excellent work, and is taking pains to inform the people about the health activities in which they are interested.

An epidemic form of plague among live poultry is described in several newspapers of New York City, and has led to an embargo on the shipment of live fowl into the city, although dressed poultry may still be sent into the city. According to the *New York Journal*, December 17th, a committee of Four Borough Poultry Dealers' Association has made public the serious charge that "bootleg" poultry is being brought into the city. The counsel for the Association is quoted as saying:

"By the term 'bootleg' poultry he meant dressed poultry which had died from the prevalent chicken disease, but which was being dressed after death, rushed into the New York market by motor trucks from neighboring states and here offered for sale as 'dressed poultry'."

"'Bootleg' poultry is being brought in by motor trucks from neighboring states, most of which is affected by the plague. Plagued and diseased poultry are being dressed after death from the disease and sold as dressed poultry."

"What is the effect upon the eating public from eating such diseased and plagued poultry? Surely it must be harmful."

The *New York Times*, December 19th, has the headlines "Two More States Put a Ban on Chickens. New Jersey and Connecticut Embargo Shipments from All Parts of the Country—53,343 Pounds Destroyed. Two Carloads of Infected Fowl Reach Jersey Terminal. Scouts Danger to Health."

The newspapers say that the nature and cause

# BOOK REVIEWS

**HIGH BLOOD PRESSURE, ITS VARIATIONS AND CONTROL.** A Manual for Practitioners By J F HALLS DALLY, M A, M D, B C, Cantab, M R C P, Lond. Physician to the Mount Vernon Hospital for Tuberculosis and Diseases of the Heart and Lungs, Senior Physician to the St. Marylebone General Dispensary William Wood and Company, New York, 1924 Price, \$3.25

This is a readable book covering the various phases of the subject. The technique of estimation of blood pressure is described in detail. The importance of the diastolic pressure is stressed and the author believes that it should be read at the point where the dull tone first appears and not at the point of disappearance of all sound. He states that the period from the first appearance of the dull tone to the absence of all sound varies from 3 to 55 M M. The hyperpiesia of Clifford Allbutt and the different types of arterio-sclerosis are discussed.

In considering the dietetic treatment of hypertension, the writer states that "although there is no absolute agreement as to the influence of protein foodstuffs on arterial pressure, all the most recent work goes to prove that arterial pressure is not raised by the ingestion of proteins." This is true, as the proponents of a very low protein diet have very little real evidence to bear out their views. Excess of the total food seems to be more harmful than a moderate amount of protein in a well balanced diet. The value of mental and physical rest in conjunction with a low diet, when pressure is very high, is emphasized.

Among the drugs, the author has faith in the efficacy of benzyl benzoate, and thinks that headache, giddiness, numbness and vascular pains are relieved by it.

One of the best parts of the book is the carefully arranged bibliography which comprises one hundred and ninety references, many of them to standard American journals.

W E. McCOLLOM

**OBSTETRICS FOR NURSES** By JOSEPH D DeLEE, A M, M D. Seventh Edition, entirely reset 12mo of 621 pages, illustrated Phila. & London, W B Saunders Co, 1924 Cloth, \$3.00

DeLee's work is so well known in America that a review of this book need be but brief and explicit. It is one of the best, as it follows the usual high standard that DeLee maintains.

G W P

**MEDICAL AND SANITARY INSPECTION OF SCHOOLS** For the Health Officer, the Physician, the Nurse and the Teacher By S W NEWMAYER, A B, M D (Second Edition) 12mo of 462 pages with 79 illustrations and 6 plates Phila. & New York, Lea and Febiger, 1924 Cloth, \$4.00

This is a complete handbook on Medical School Inspection for the use of ordinary physicians and nurses who are called upon to do medical inspections of school children. It covers the broad topics of Administration, Records, Sanitation of the Building, Communicable Diseases, Physical Defects, Teachers' Health, and Mental Tests and Standards, and it gives an outline of each subdivision. It is well illustrated with photographs, and is written in a clear, concise style. It emphasizes the details of how to do things, and considers the practical points which an ordinary physician must decide. For example, it gives detailed plans of a simple boys' toilet for a small rural school.

A physician or nurse desiring to prepare to do medical inspection work in schools will find that the book will be a satisfactory guide to all phases of the work.

F O

**THE HOSPITAL SITUATION IN GREATER NEW YORK** Report of a Survey of Hospitals in New York City by the Public Health Committee of the New York Academy of Medicine. Prepared by E H LEWINSKI-CORWIN, Ph.D., Executive Secretary Illustrations G P Putnam's Sons, New York, 1924

Books that are of value to the doctor interested in the problems of hospital organization are very few indeed. Dr Corwin's book is a distinct contribution. The survey of hospital facilities in New York City is very complete, and the chapters on hospital administration and finance are very valuable and easily read. Of particular interest to the doctor is the analysis of hospital records of several New York hospitals. Over twelve hundred records were selected at random from twenty one general and eleven special hospitals and critically dissected. The results are astonishing, and of tremendous interest. This chapter might well be read by every doctor who takes care of his patients in a hospital. More of this kind of work is needed. Scant space is devoted to a study of organized teaching, and the extra mural undergraduate instruction of the Long Island College Hospital Medical College is ignored. The Brooklyn Extension Plan and the Practical Lecture Series which are being closely watched everywhere are hardly mentioned. It may be that Brooklyn overrates the importance of her educational plans, but the success of the movement has been instantaneous. The book on the whole is one that no hospital man can afford to be without, and it might well be read with profit all over the country.

C A G

**SYNOPSIS OF MIDWIFERY** By A. C. MAGIAN, M D 12mo of 245 pages London, William Heinemann, Ltd., 1923 Cloth, 8 shillings 6 pence.

This small book is an excellent synopsis of the leading facts and principles of treatment in Obstetrics.

There is little of the new, or bizarre, that is presented, but on the other hand, the author clings to those well established methods which time has proven the worth of, and which we deem to call, conservative.

In a book of this size, little opportunity is afforded for the discussion of various theories and methods, but the author has selected those theories and methods, which time and experience has established, as being most practical.

In conclusion, the reviewer feels that this small book can be recommended as a safe and sane synopsis of midwifery.

G W P

**INTERNATIONAL CLINICS** By leading members of the Medical Profession throughout the world Vol II Thirty-fourth Series, 1924 J B Lippincott Co, 1924, Phila., Pa.

This volume includes a number of excellent articles. The first article on a new technic for intranasal diseases opens a new field for diathermy and the report seems to show results. The article on mechanical vibration in cardiovascular conditions seems to report the results of an enthusiast, but are worthy of consideration and examination into the permanent results of this treatment. Dorland's article on the influence of X-rays and allied substances on living tissues is a carefully prepared study and shows most extensive research into the literature of the subject. It is difficult to comment on individual articles as the standard of all the papers is excellent. Ashhurst's lecture on osteomyelitis is timely and thorough. Pepper's article on Metastasis is most interesting and gives a good discussion on the action of tumors in the body. The general excellence of this volume continues the high standard of this publication.

H M M



# BOOKS RECEIVED



Acknowledgment of all books received will be made in this column and this will be deemed by us a full equivalent to those sending them. A selection from these columns will be made for review, as dictated by their merits, or in the interest of our readers.

- MEDICAL CLINICS OF NORTH AMERICA** Volume 8, Number 1, July 1924 (New York Number) Published every other month by the W B Saunders Company, Phila and London Per Clinic Year (6 issues) Cloth, \$16 00 net, paper, \$12 00 net
- BASAL METABOLISM** Determination of the Metabolic Rate in the Practice of Medicine By JOHN T KING, JR., M D Octavo of 118 pages Baltimore, Williams & Wilkins Company, 1924 Cloth, \$2 50
- SURGICAL CLINICS OF NORTH AMERICA** Volume 4, No 3, June 1924 (Chicago Number) Published every other month by the W B Saunders Company, Phila and London Per Clinic Year (6 issues) Cloth, \$16 00 net, paper, \$12 00 net
- THE PRINCIPLES AND PRACTICE OF OBSTETRICS** By JOSEPH B DeLEE, A M, M D Fourth Edition, thoroughly revised. Large octavo of 1123 pages with 1128 illustrations Phila and London, W B Saunders Company, 1924 Cloth, \$12 00
- MEDICAL GYNECOLOGY** By SAMUEL WYLLIS BANDLER, M D Fourth Edition, thoroughly revised Octavo of 930 pages with 157 original illustrations Phila and London, W B Saunders Company Cloth, \$8 00
- ANGINA PECTORIS** By SIR JAMES MACKENZIE, M D, LL D Large Octavo of 253 pages, illustrated London, Henry Frowde & Holder & Stoughton, New York, Oxford University Press, 1923 Cloth, \$9 00 (Oxford Medical Publications)
- GONORRHOEA** By DAVID THOMSON, O B E, M B Large Octavo of 519 pages with illustrations and plates Oxford University Press, 1923 Cloth, \$12 75 (Oxford Medical Publications)
- CHRONIC INTESTINAL STASIS (ARBUTHNOT LANE'S DISEASE) A Radiological Study** By ALFRED C JORDAN, M D Large octavo of 230 pages with 314 illustrations New York, Oxford University Press, 1923 Cloth, \$7 50 (Oxford Medical Publications)
- DISEASES OF THE MALE ORGANS OF GENERATION** By KENNETH M WALKER, M A, M B BC Octavo of 234 pages illustrated. New York Oxford University Press, 1923 Cloth, \$4 00 (Oxford Medical Publications)
- NEW VIEWS ON DIABETES MELITUS** By P J CAMMIDGE, M D, and H A H HOWARD, B Sc. Octavo of 611 pages, illustrated Oxford University Press, 1923 Cloth, \$6 50 (Oxford Medical Publications)
- THE PATHOLOGY AND TREATMENT OF DIABETES MELLITUS** By GEORGE GRAHAM, M A, M D 12mo of 188 pages New York, Oxford University Press, 1923 Cloth, \$2 00 (Oxford Medical Publications)
- SURGICAL CLINICS OF NORTH AMERICA** Volume 4, No 4, August, 1924 (Cleveland Clinic Number) Published every other month by the W B Saunders Company, Phila and London Per Clinic Year (6 issues), Cloth, \$16 00 net, paper, \$12 00 net
- DEVELOPMENTAL ANATOMY** A Text-Book and Laboratory Manual of Embryology By LESLIE BRAINERD AREY, Prof of Anatomy, Northwestern University Medical School, Chicago Octavo 433 pages, 419 illustrations Phila and London, W B Saunders Company, 1924 Cloth, \$5 50
- ESSENTIALS OF PRESCRIPTION WRITING** By CARY EGGLESTON, M D Third Edition, revised 146 pages. Phila and London, W B Saunders Co, 1924 Cloth, \$1 50
- MANUAL OF DISEASES OF THE NOSE, THROAT AND EAR.** By E B GLEASON M D, LL D Fifth Edition, thoroughly revised 12mo of 660 pages, with 212 illustrations Phila and London, W B Saunders Company, 1924 Cloth, \$4 00
- HUMAN CONSTITUTION A CONSIDERATION OF ITS RELATIONSHIP TO DISEASE** By GEORGE DRAPER, M D Octavo of 345 pages with 208 illustrations and 105 tables Phila and London, W B Saunders Company, 1924 Cloth, \$7 50
- OPERATIVE SURGERY** Covering the Operative Technic Involved in the Operations of General and Special Surgerv By WARREN STONE BICKHAM, M D, F A C S Vol 5 Octavo of 880 pages with 1118 illustrations Phila and London, W B Saunders Company, 1924 Cloth, \$10 00 per volume. Sold by subscription only (To be complete in six volumes with desk index)
- PATHOGENIC MICROORGANISMS A Practical Manual for Students, Physicians and Health Officers** By WILLIAM HALLOCH PARK, M D, ANNA WESSELS WILLIAMS, M D, and CHARLES KRUMWIEDE, M D Eighth Edition, enlarged and thoroughly revised Octavo 811, 211 engravings and 9 full-page plates Phila and New York, Lea & Febiger, 1924 Cloth, \$6.50
- BASAL METABOLISM IN HEALTH AND DISEASE.** By EUGENE F DuBois, M D Octavo of 372 pages, illustrated with 79 engravings Phila and New York, Lea & Febiger, 1924 Cloth, \$4 75
- OUTLINES OF INTERNAL MEDICINE FOR THE USE OF NURSES AND JUNIOR MEDICAL STUDENTS** By CLIFFORD BAILEY FARR, A M, M D Fourth and revised edition. 12mo of 377 pages, with 69 illustrations and 6 plates Phila and New York, Lea & Febiger, 1924 Cloth, \$2 75
- MODERN METHODS IN THE DIAGNOSIS AND TREATMENT OF RENAL DISEASE.** By HUGH MACLEAN M D, D Sc. Second Edition, revised and enlarged Octavo of 110 pages, with four colored plates Phila and New York, Lea & Febiger, 1924 Cloth, \$2 50
- ANATOMY OF THE HUMAN BODY** By HENRY GRAY FRS Twenty-first Edition, thoroughly revised and re-edited by WARREN H LEWIS B S, M D Octavo of 1417 pages with 1283 illustrations Phila and New York, Lea & Febiger, 1924 Cloth, \$10 00
- ABT'S PEDIATRICS** by 150 Specialists Edited by ISAAC A ABT, M D Volume 4, containing 1271 pages with 271 illustrations (Set to be complete in eight octavo volumes) Phila and London, W B Saunders Company, 1924 Cloth, \$10 00 per volume Sold by subscription
- LECTURES ON PATHOLOGY** (Delivered in the United States, 1924) By Ludwig Aschoff M D, Professor Pathologic Anatomy, University Freiburg Thirty-five illustrations Paul B Hoeber, Inc, New York, 1924 Price, \$5 00
- ANESTHESIA FOR NURSES** By Colonel William Webster, D S O, M D, C M Professor Anesthesiology, University of Manitoba Medical School Illustrated The C V Mosby Co, St Louis 1924 Price, \$2 00
- A TREATISE ON INFLUENZA**, with special reference to the Pandemic of 1918 By Rajendra Kumar Sen, Medical Officer, Hurmatty Tea Co, Ltd, Assam John Bale, Sons & Danielsson, Ltd, Oxford House, London, W I

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL. 25, No 2

NEW YORK, N. Y.

JANUARY 23, 1925

## THE LOW CERVICAL CESAREAN SECTION—ITS ADVANTAGES\*

By J. K. QUIGLEY, M.D., F.A.C.S.,

ROCHESTER, N. Y.

THE performance of the classical Cesarean section upon patients in labor who have been subjected to vaginal examinations through an unclean field (unshaven pubes, sometimes unscrubbed) by an attendant of questionable or unquestionable aseptic technic, sometimes hours after rupture of the membranes has been attended by a high morbidity and relatively high mortality. These cases are potentially infected and while many patients so handled do after a spontaneous delivery exhibit little or no evidence of puerperal sepsis nevertheless they are not good risks for abdominal delivery.

This left the choice of operation in cases of disproportion, between a Cesarean section followed by hysterectomy, the Porro operation, pubiotomy or symphysiotomy and craniotomy on the living child. The first of these is often safe but sacrifices the uterus, the second is not free from mortality in infected cases to say nothing of the objections to division of the pelvic girdle such as operative hemorrhage, injury to the bladder and difficult locomotion afterward. The third or last mentioned is too horrible to contemplate unless all other avenues are closed.

To overcome this shortcoming of abdominal delivery Frank of Cologne in 1907 proposed the extra peritoneal operation of which the Kuestner is a type. By this operation the uterus is reached in its lower segment laterally over Poupart's ligament and opened without invasion of the general peritoneal cavity. In the type of case under discussion good results have been obtained by this method in several series of cases. Kuestner reported 200 cases with only two deaths, 56 of these were so-called doubtful or infected cases. Markoe and McPherson of the New York Lying-In Hospital described their operation a Kuestner technic plus Carrel-Dakin after-treatment, their results were good.

However this procedure has several objections

First, its technical difficulty. Troublesome hemorrhage has been encountered in opening the uterus low and laterally, difficulty has been experienced in extraction of the child resulting in foetal death. Döderlein and Kuestner reported ten foetal deaths in 279 extra peritoneal operations, while in 274 transperitoneal sections performed by Franz, Bausch, Hofmeier and Fehling only two children were lost—a foetal mortality one-fifth as high. Because of adhesions its repetition is difficult or impossible, in addition there is danger of injury to the bladder or ureter. In 200 cases of extra-peritoneal operations in Kuestner's clinic there were two ureteral and one vesicocervical fistula. There is the possibility of opening into the peritoneal cavity thus defeating the object sought and according to Rohrbach six to eight per cent of these patients develop hernia.

At the last meeting of the American Association of Obstetricians and Gynecologists Dr. Asa B. Davis of New York presented a paper on extraperitoneal Cesarean section on supposedly infected cases all of which ran a high temperature post operative, his results were two deaths in twenty-eight cases operated, general peritonitis being responsible for one and pneumonia for the second. There were three still births, though the foetal heart was heard in all immediately before operation, and four neonatal deaths. I wish to quote from Dr. Davis' paper—"All of these cases had high temperatures after operation—In no case was it possible to secure primary-union of the abdominal wound—In twenty-one cases part or the whole length of the wound separated down to the aponeurosis, in four cases the whole depth of the wound broke down with considerable sloughing—The operation is physically and technically a very difficult one to perform. In early cases I spent something over two hours." There was one urinary fistula and in several of Dr. Davis' early operations the uterine artery was torn across by an extension of the wound. My object in quoting so extensively from Dr. Davis

\*Read at the Annual Meeting of the Medical Society of the State of New York, at Rochester April 22 1924

**A DIABETIC MANUAL FOR THE MUTUAL USE OF DOCTOR AND PATIENT** By ELLIOTT P. JOSLIN, M.D. Third Edition, thoroughly revised. Illustrated. Phila. and New York, Lea & Febiger, 1924. Cloth, \$2.00

The most time consuming and tedious part of caring for diabetics is undoubtedly the education of these patients, and it is at the same time, the most important service a doctor has to do. Doctor Joslin's Manual is admirably conceived for this purpose, and the endless number of necessary details are presented in a simple and masterly manner.

He discusses for the laity, the mechanism and cause of the disease, and gives the facts about insulin, its discovery, its use, the signs of an over-dose, and the procedures to be followed in such a case. In a series of questions and answers, he tells in simple language, what the diabetic should know, and it is noteworthy that for the milder cases he expects them to be able to arrange their daily food-intake, without the use of scales. His presentation of the arithmetic, the food values, and the balancing of fat, carbohydrate and protein, is made very plain and simplified, by telling illustrations and charts. Particularly he emphasizes the information the patient himself may obtain by urine examination, and indicates how he may better distribute his food during the day, or balance his food and insulin.

The weight charts, the emphasis on the hygiene of the diabetic, the care of the teeth, skin and feet, and the dietetic suggestions, recipes, and menus, are largely the same as in his larger volume, and it is these very details which have prompted us to recommend the larger volume to patients.

In these 203 pages there is sufficient information in a compact and convenient form for the physician, and for the patient it is undoubtedly one of the best manuals which have been offered.

LOUIS C. JOHNSON

**BACTERIOLOGY** A study of Microorganisms and Their Relation to Human Welfare. By H. W. CONN, Ph.D., and HAROLD J. CONN, Ph.D. Second Edition. Octavo of 449 pages, illustrated. Baltimore, Williams & Wilkins Co., 1924. Cloth, \$4.00

This is a text-book on general bacteriology, only a portion of which is devoted to the group of organisms pathogenic to man. Although designed as an introduction to the subject for college students, which purpose it admirably fulfills, the medical reader will find it both interesting and instructive. So much attention is focussed upon the pathogenic bacteria, that there is need for such a book as this to call attention to the vitally important rôle played by bacteria in agriculture and industry.

Part 1 deals with the history of bacteriology, which is well told, and general facts about bacteria. Part 2 deals with the bacteria in agriculture and industry. Part 3 with pathogenic bacteria. The authors have stressed general principles and left technical details to other writers, which makes this a particularly readable book for layman and physician alike.

E. B. SMITH

**ANESTHESIA** By JAMES TAYLOR GWATHMEY, M.D., with collaborators on special subjects. Second Revised Edition. The Macmillan Co., New York, 1924. Mirabile dictu! Here is a revision of a ten year old book containing nearly 150 pages less than the original. Truly, the author had a sensible appreciation of comparative values when he substituted up-to-date material for that which had become of only historical interest. To be sure we now have to look for the omitted agents

in a real chemistry—they belonged there anyway in the first place.

The first half of the book remains "as was." The very interesting new matter comprises mainly the author's own researches into colonic anesthesia, and a restatement of the principles of the synergism of agents, and a valuable contribution to our knowledge of their combinations. Colonic anesthesia is advocated for obstetric needs. The more recent reports of its successful use at the N. Y. Lying-in Hospital and the noteworthy demonstrations at a recent session of the Eastern Society of Anesthetists are clear indications of its probably wide acceptance as a substitute for older methods.

Whether the revision of the section on topical anesthesia had added much to its value for the general anesthetist is a matter of opinion. As a matter of fact this field is so uniformly left to the operating surgeon, and the matter is so well treated in its own literature, that there seems hardly place for it in this book except as an item of related interest.

The medico-legal status of the anesthetist is receiving, in these days, well-merited consideration. Much has been added to the subject during the past ten years, hence it may be regretted that the chapter was not brought up to date—anesthetists think hard about the illegal practice of employing nurses, for instance. It would have made interesting reading if Mr. Crim had made a careful study of that vexed question.

There is an index of 36 pages and a list of authors cited, containing about 800 names. No wonder a surgeon said, after looking through these 800 pages, "I had no idea there was so much to anesthesia." We are all glad to see this new edition.

A. F. E.

**THE RELATIVE POSITION OF REST OF THE EYES AND THE PROLONGED OCCLUSION TEST** By F. W. MARLOW, M.D., M.R.C.S., Eng. F.A.C.S., Professor Ophthalmology, College of Medicine, Syracuse University. Illustrated with original diagrams and charts. F. A. Davis Co., Philadelphia, 1924. Price \$2.50 net.

In this monograph the author describes at greater length and with more insistent attention a method which he has used for years and which he has written about before. The basis of the article is an analysis of 700 cases examined by his method, with plates of results obtained, classified under the various phorias. There are also charts of several especially interesting or illustrative cases.

It is interesting to see the often marked changes which take place in the muscle imbalances under the influence of the prolonged occlusion of one eye,—apparent esophoria becoming an exophoria, right hyperphoria becoming a left hyperphoria, etc.

The author conclusively demonstrates that he has found a means of relieving some of those stubborn cases of asthenopia heretofore untouched by correcting merely the refractive error.

E. CLIFFORD PLACE.

**HYGIENE AND PUBLIC HEALTH** By GEORGE M. PRICE, M.D. Third Edition, thoroughly revised. 12mo of 306 pages. Phila. and New York, Lea & Febiger, 1924. Cloth, \$2.25.

This is an epitome of the most important essentials of public health work. The author presents his material in a concise and assertive style and at the end of each chapter he gives a list of questions pertaining to the preceding text.

Students in elementary courses in public health work will find this book of immense value.

E. H. M.

The danger of peritonitis in infected cases in the classical section comes not from the amniotic spill at the time of operation but from the escape of infective lochia through the incision. The site of operation is through the thick contractile portion of the uterus and the sutures are necessarily tight to secure hemostasis thus raising the possibility of necrosis, in addition the incision is subjected to the alternate contraction and relaxation of the uterus during the first few days of its healing process. In the low cervical site the sutures need not be as tight and are in a relatively immobile field. The chief advantage in the Kroenig Beck operation comes from the sealing off from the general peritoneal cavity the cervico uterine incision, for, a few hours after the operation the two overlapping layers of peritoneum are united and should intra-uterine infection spread it would localize itself under this flap posterior to the bladder and drain either through the cervix, point towards the skin or be easily opened by an anterior colpotomy—while seepage of bacteria-laden lochia between the sutures of a fundal incision infects the general peritoneal cavity.

Again the post operative discomfort is reduced to a minimum probably due largely to the absence of exposure or handling of bowel and other viscera, the condition of these patients for the first few days after operation compared to the classical section is often surprising. There is less vomiting, many times none, distention is slight and relieved by the first high enema, shock is notable by its absence and the general picture is usually better than that following a difficult forceps delivery. In addition the fundus can be palpated above the line of incision, watched and stimulated if necessary for bleeding. DeLee has called attention to the advantage in the site of the incision in the cervix which stands infection better than the body of the uterus because it is used to it, also the lower abdomen is more resistant to infection.

There are few or no adhesions which may follow so-called clean classical sections. Abdominal hernia is less liable to occur. There is less operative hemorrhage.

What of the liability to uterine rupture—does a scar in this location possess a greater or less liability to rupture during a subsequent pregnancy or labor than one through the fundus where it is pretty well established that the chance is one in twenty-five or 4 per cent? Little has been written upon this important phase of the subject and it is this lack of knowledge as to future pregnancies that deters me from choosing this type of operation for the elective section. What data there is available is favorable to the low operation. There are only two cases on record of the rupture of a scar in this location during a later pregnancy. Phaneuf gives his results in six sec-

ondary operations and in "none of these cases were there any weak points in the scar and it was almost impossible to distinguish a scar as such." Gaifami, a French operator, repeated the section in eleven cases and the cicatrix was firm in all. Four of DeLee's first 145 cases were delivered by a second low cervical section and the "scar could hardly be found." DeLee is doing most of his Cesarean section through this route today, and Vogt of Berlin believes it makes the classical operation obsolete.

A comparison of mortality rates for the classical section and the newer procedure shows a distinct advantage for the low operation.

De Lee's 233 cases with one death, or less than one-half of 1 per cent as against 100 cases of the classical section done by the same operator with a mortality of 6 per cent and Holmes' series of ninety-two classical sections with six deaths. King of New Orleans with admirable frankness reported 117 classical Cesarean sections. Seventy-six women recovered, twenty-five died from the disease for which the operation was performed, such as eclampsia, bad heart lesions, etc., and twelve died from peritonitis, two from sepsis and two from other operative causes, a total of sixteen operative deaths (13.6%). It is from the improper selection of cases unsuitable for Cesarean section that the operation is injured and will fall into disrepute. It seems almost certain that several of the fourteen in this series dying from peritonitis or sepsis would have recovered had the low two flap cervical section been done. To be sure there have been several series of 100 cases or thereabouts of classical section on well selected cases with no maternal mortality but no operator will always report a zero mortality for this or any other abdominal operation and the mortality for classical section even under the best of circumstances will run between 3 and 5 per cent—while the rate in general on all classes of cases is given between 2.9 and 14 per cent, depending upon the length of labor, number of vaginal examinations and whether the membranes have ruptured and if so how long since, these figures are the result of a compilation by Polak and Beck of 2,200 cases operated in various American clinics.

Holland and Murro Kerr in the British Medical Journal reported 4,000 collected cases operated between 1911 and 1920 and the analysis of this large number of operations confirmed that which has long been believed.

The mortality of those cases

First—Not in labor was	16%
Second—Early in labor	18%
Third—Late in labor	10.7%
Fourth—After induction of labor	14 %
Fifth—After attempts at forceps delivery	27 %

is not to disparage his mortality rate which for this class of case is low, but to emphasize the objections to the extraperitoneal operation, technically difficult, unnecessarily long and beset with many dangers such as severe hemorrhage, vesical fistula, sloughing of the wound and high infant mortality

McGlinn in a paper published in 1920 said

"Theoretically in clean cases the extra peritoneal operation is the ideal operation, but its disadvantages overshadow its advantages. The transperitoneal operation is superior to the classical Cesarean section for the reason that the resulting adhesions are in a situation less likely to give trouble. The Beck operation is superior to the transperitoneal operation, as it has all the advantages of the former and none of its difficulties

"My own feeling is that the Beck operation with thorough protection of the peritoneal cavity and perfect peritonealization of the uterine incision is superior to the transperitoneal operation as a routine procedure. While theoretically it is not as efficient as the extraperitoneal method, practically, on account of the many disadvantages of the latter, it is the better operation"

In the *American Journal of Obstetrics* for February, 1919, Dr Alfred C Beck of Brooklyn published a paper entitled, "Observations on a series of cases of Cesarean section done at the Long Island College Hospital during the past six years" in which Dr Beck described his modification of the Kroenig operation

In 1919 DeLee published a paper, "The newer methods of Cesarean section, Report of Forty Cases." This is a transperitoneal or low cervical operation, a modification of the operation done by Kroenig since 1912. He was closely followed by Barton Cooke Hirst in 1920 who reported thirty infected cases operated by his modification of the Veit-Fromme technic, there were no deaths in this series. In 1921 and 1922 Beck and Polak of Brooklyn, Phaneuf and Hegarty of Boston, DeLee and Cornell of Chicago and Vogt of Berlin reported 397 low cervical operations with a slight variation in technic all on patients in labor and not considered good risks for the classical operation, with a surprisingly low mortality. Last year DeLee published his results in a total of 233 laparotrachelotomies with only one maternal and three foetal deaths. Still later John C Hirst and W W Van Dolsen this year report 107 cases in advanced labor operated by the Kroenig Beck method with two deaths, one from gangrene of the colon from mesenteric embolism and the other from acute dilatation of the heart on the eighteenth day in a patient with chronic myocarditis. At present this operation is known by several more or less descriptive names

Transperitoneal Cesarean Section  
Laparotrachelotomy, DeLee's title

Suprasymphyseal Cesarean Section, used by the Germans

Low Cervical Cesarean section, favored by Polak

There are also four variations in technic

*First*—The Kroenig

The abdomen is opened by a longitudinal incision below the umbilicus, the visceral peritoneum above the bladder reflection, incised and stripped down the bladder is now held back by a suprapubic retractor and the cervix opened longitudinally by a knife and enlarged with blunt scissors for three and a half to four inches, the child is delivered by forceps, the placenta removed and the cervico-uterine incision closed by interrupted chromic catgut. After this the flap of peritoneum attached to the bladder is brought up overlapping the incision in the visceral peritoneum and sutured here with a continuous chromic suture. The abdomen is closed as usual

*Second*—The Beck or two flap operation is a modification of the Kroenig and differs in this respect. After transversely incising the visceral peritoneum one-half to one inch from the bladder the peritoneum is stripped up and down thus forming two flaps and exposing the lower uterine segment and cervix for three and a half to four inches. After the uterus is emptied and sutured the upper flap is tacked down to the uterus by three or four interrupted fine chromic sutures and the lower flap carrying the bladder brought up to overlap the upper by an inch and similarly tacked down, care being taken that none of these interrupted transverse sutures coincides with those closing the vertical sutures in the cervix and lower segment to obviate a possibility of infection from within traveling outward through a suture line

*Third*—DeLee's modification of the Kroenig operation. Here the fascia over the lower uterine segment is sutured burying the cervical incision

*Fourth*—Hirst modification of the Veit-Fromme operation. Sometimes called the transperitoneal method

The abdomen is opened below the umbilicus by a vertical incision, the peritoneum over the uterus is incised vertically and stripped back laterally forming two lateral flaps, the edge of each is united to the edges of the parietal peritoneum by interrupted catgut sutures (some use clamps), this exposes an area of the lower uterine segment and cervix through which a vertical incision is made and the child delivered—after closure of the uterine wound the united parieto-visceral layers of peritoneum are brought together by fine continuous chromic catgut—this leaves the uterine incision at the end of twenty-four hours practically sealed off from the general peritoneal cavity



The operation presented no particular difficulty, hemorrhage was severe in none and below the usual amount encountered in the classical section in all. Some difficulty in the first few cases was experienced in extraction of the head with the forceps and in two or three the children were delivered by the feet, in the later operations the head was delivered manually passing one hand over the pubes beneath the head, elevating it and at the same time employing pressure upon the fundus. The post operative course in two patients (cases one and seven) was somewhat stormy, there was no vomiting, little pain and only moderate distention but the lochia was foul and the temperature as high as 103 for two days. Neither of these patients developed any infection outside the uterus. Two patients vomited once each, four had moderate distention, four little and seven none at all. Three had moderate pain postoperative and in twelve it was absent or slight. One patient had a slight infection of the skin incision. All the patients were discharged in good condition and all the babies, except one, a monstrosity, which died.

#### The routine post operative care

Tap water per rectum, eight ounces every four hours till she is retaining water by mouth.

Morphine if needed for pain.

Fowler position at the end of twenty-four hours.

For bleeding post operative ice bag to fundus, pituitrin and ergot. These two drugs are given only on indication and not as a routine.

High gas enema on the second day, if this is followed by a result, liquid food is allowed.

No douches either as a routine or for foul lochia.

No cathartics as a routine.

No dressing of wound routinely until ninth or tenth day when sutures are removed and patient is allowed to sit out of bed on the twelfth day, they are discharged fourteen to eighteen days post operative.

#### Conclusions

The low cervical Cesarean section has two fields of usefulness.

First, for the case where because of length of labor, frequent examinations, ruptured membranes or induction of labor, one would hesitate to do a classical section.

Second, it permits of a test of labor in the border line pelvis and because of this many cases can be safely delivered per vaginam which other-

wise might be subjected to a classical Cesarean section early in labor.

It is not claimed that by the employment of this technic all infection is obviated, it will not prevent intrauterine infection—bacteremia, extension through lymphatic channels or embolic processes but it does in the vast majority of cases prevent the development of general peritonitis which is by far the most frequent cause of death following Cesarean section done by the classical method.

#### BIBLIOGRAPHY

- Frank. *Monatschr fur Geburtsh u Gynaek*, 1910, p 680.
- Kuestner, O. *Der abdominale Kaiserschnitt*, Weisbaden, 1915.
- Markoe, J W, and McPherson, Ross. *Surg, Gyn and Obs*, 1918, pp 209-219.
- Doderlein and Kuestner.
- McGinn, John A. *Amer Jour Obstetrics*, vol I, no 1.
- Beck, A C. *Amer Jour Obstetrics*, Feb 1919.
- Walton, Thurston S. *Amer Jour Obstetrics*, Jan 1921, p 351.
- DeLee, J B. *Jour Amer Med Assn*, 1919, pp 91-95.
- Hirst, Barton Cooke. *Atlas of Operative Gynecology*, 1919, pp 234-246.
- Phaneuf, L E and Hegarty, J G. *Boston Med and Surg Jour*, 1922, pp 733-738.
- DeLee, J B and Cornell, E L. *Jour Amer Med Assn*, 1922, pp 109-115.
- Vogt, E. Monograph, pub by S Karger, Berlin, 1921.
- DeLee, J B. Editorial note, *Prac Med Series, Obstetrics*, 1923, p 334.
- Kroenig.
- Phaneuf, Louis E. *Surg Gyn and Obstet*, Dec. 1923, p 765.
- Garfani, P. *Rev franc de gynec et d'obst*, 1923, VII, p 33.
- Holmes R. W and Burdick, A L. *Amer Jour Obstet*, Dec, 1922.
- King, E. L. *Jour Amer Med Assn*, July 8, 1922.
- Polak, J O and Beck, A C. *Surg Gyn and Obstet* May, 1922.
- Holland, E and Kerr, Munro. *Brit Med Jour*, Oct 21, 1921.
- Harris J W. *Bull Johns Hopkins* Sept, 1922.
- Hirst, J C and Van Dolsen, W W. *Jour Amer Med Assn*, Dec 16 1922.
- Hirst, J C and Van Dolsen, W W. *Ibid*, Jan 12, 1924.
- Davis Asa B. *Amer Jour Obstetrics*, April, 1924, p 373.

An interesting study was made by J W Harris of Johns Hopkins upon sixty-four uteri removed in doing 223 Cesarean sections, these were Porro operations done either to effect sterilization or because of frank or suspected infection at the time of operation. Sixty of these were subjected to histo-pathological study. Of these sixty cases the uterus was removed from twenty-eight late in the first stage or during the second stage of labor and eighteen showed definite evidence of ascending infection in the form of leucocytic infiltration in the mucosa and in some bacteria were demonstrated. In the twenty-seven uteri removed from patients at an elected time or within six hours after the onset of labor signs of infection were found in only one.

Contra indications to the low cervical Cesarean section. If local anesthesia is desirable or necessary the upper incision is preferable. Placenta praevia has been given as a contra indication though some operators do not make it an exception.

In the very obese the technical difficulties in the clean case will probably outweigh the advantages.

If great haste were necessary as in cardiac decompensation in the mother, premature separation of the placenta or threatened foetal asphyxia the classical operation offers the best chance.

During the past three years I have done fifteen low cervical Cesarean sections all by the Beck modification of the Kroenig technic. There were ten primiparae, five multipara. Seven of these cases were seen in consultation, four ward cases treated in the course of a service at the Rochester General Hospital and the remaining four were private cases. Only one patient was not in labor and could be considered an elective clean case. Fourteen were in labor from five hours to four days, in six, labor had been in progress over twenty-four hours, seven had had from one to five vaginal examinations, some of them by the ungloved hand through an unprepared vulva, in five the membranes had ruptured. In short fourteen cases because either of duration of labor, rupture of the membranes, vaginal examinations or a combination of these factors were far from good risks for the classical operation.

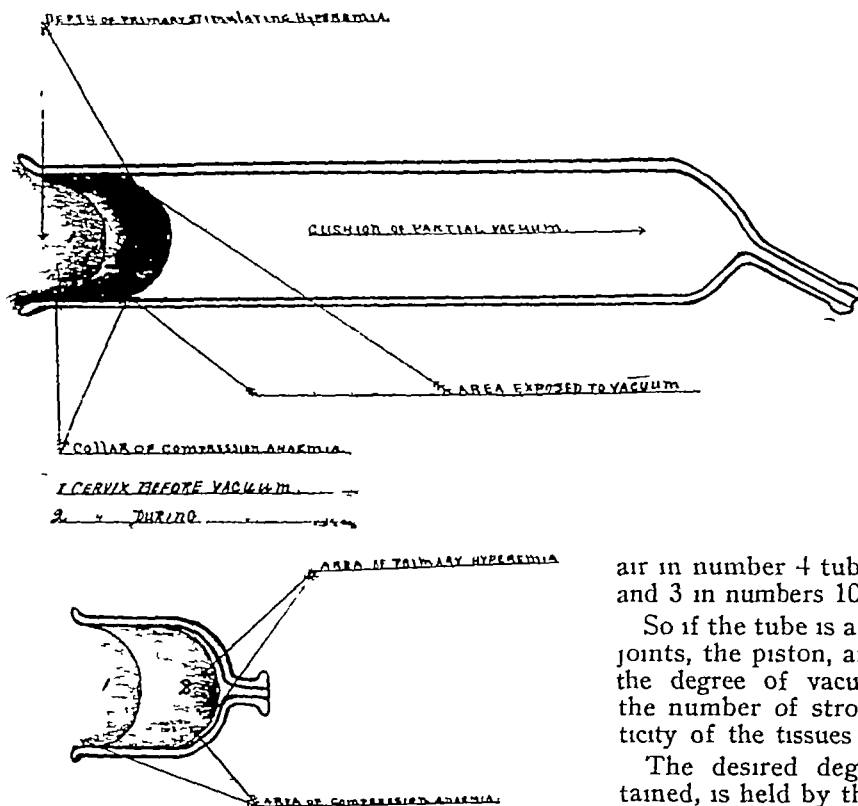
The indications were as follows

Flat pelvis	9
Justo minor pelvis	3
Face posterior presentation, post mature child allowed test of labor	1
Elderly primipara, large baby, test of labor	1
Disproportion, ten pound fourteen ounce baby, test of labor (lost first baby from difficult delivery)	1

Two had had a previous classical section for flat and justo minor pelvis respectively (cases four and ten)

#### THE LOW CERVICAL CESAREAN, ITS ADVANTAGES

No	Age	Para	Status	Indication	Hours in labor	Membr rupt	Hours in labor	Vomiting	Distention	Pain	Fever	Day of Discharge	Baby
1	26	I	consultation	Flat pelvis, Bandl's ring	51	29	5	nonc	moderate	little	102-3	20	O K
2	25	I	private case	Face, L M P test labor	5	7	0	nonc	slight	little	101-2	27	O K
3	25	I	consultation	Flat pelvis, C V 7.5 cm	30	0	0	nonc	moderate	moderate	103	21	O K
4	34	II	consultation, previous classical section	Flat pelvis C V 8.5	5	9	0	oncc	little	after-p 8th day	pneumitis 99½	20	O K
5	32	II	private	Disproportion baby 10' 14"	9	0	0	oncc	little	consid	99-100	19	O K
6	20	I	ward	Justo-minor C V 6.5, cm	14	0	2	nonc	nonc	nonc	100½	22	Dead monstrous O K
7	37	I	consultation	Elderly primipara test	36	0	3	nonc	moderate	slight	103	26	O K
8	26	I	consultation	Flat pelvis C V 7.5 cm	24	0.5	0	nonc	nonc	nonc	101	15	O K
9	37	VII	ward	Flat pelvis C V 6.5 cm	17	0	3	nonc	nonc	slight	infcc incis none	16	O K
10	26	III	ward	Justo-minor	elective	0	0	nonc	nonc	slight	99½	16	O K
11	26	I	ward	Justo-minor	4 days	0	3	nonc	moderate	moderate	100	13	O K
12	25	I	private	Flat pelvis C V 7.5 cm test	24	0	1	nonc	nonc	nonc	100½	13	O K
13	29	I	consultation	Flat pelvis C V 8.5 cm	8	0	4	nonc	nonc	nonc	100½	14	O K
14	31	II	private	Spinal deform tilted pelvis	13	7	0	nonc	little	nonc	100-100	19	O K
15	27	I	consultation	Flat pelvis C V 8.0 cm	10	0	0	nonc	nonc	nonc	99½ 5 days	14	O K



These two drawings show the difference in action of the two types of tubes

2 That the pump should be under complete control and give the desired degree of vacuum in the tube but within limits of safety to the tissues Unless the pump is strong enough to give a considerable degree of vacuum it will be found that conditions will be met where this lack of power on the part of the pump will be a handicap to its usefulness At the same time each stroke of the pump must not be of too great force or a distinct trauma may be inflicted Even with the pump that I use daily I have been surprised by its effect in some cases and have learned to watch it in new cases before giving what is considered an ordinary treatment With a good strong pump repeated tractions on the piston will give any degree of stimulation that is wise to apply to the structure involved

3 The third requirement was an easy breaking of the vacuum To procure this I inserted an air valve midway between the pump and the cup This has proved a most satisfactory method of breaking the partial vacuum

In order to make clear the use and application of aspiratory hyperemia as a method of treatment I will describe the instrument more in detail than in either of my former papers, and give as clearly as I may the indications for

its use, practical points in its application and method of recording findings The instrument consists of an air pump, two pieces of rubber tubing, an air vent, and a set of glass tubes of various sizes and shapes

The air pump is of the ordinary type with a barrel  $10\frac{1}{2}$  c.m long, 13 c.m in circumference, the stroke is 8 c.m, the capacity of the air chamber is  $93\frac{2}{3}$  c.c, this gives one stroke of the piston an exhaust capacity of one volume of

air in number 4 tube,  $1\frac{1}{3}$  in numbers 1 and 2, and 3 in numbers 10, 11, and 12

So if the tube is accurately placed and all the joints, the piston, and the valves are air-tight, the degree of vacuum may be graduated by the number of strokes, allowing for the elasticity of the tissues and the size of the tube

The desired degree of vacuum when obtained, is held by the valves in the pump until freed by opening the air vent

The rubber tubing should be thick-walled ( $\frac{1}{4}$  c.m) with a calibre of  $\frac{1}{2}$  c.m, that is 1 c.m in diameter, a convenient length for the first tubing, that which connects the pump to the air vent is 18 c.m, that of the second, which connects the air vent to the glass tube 27 c.m

The glass tubes, taking number 4 as an example, are 20 c.m long in the shaft, which is 8 c.m in circumference, the application end is slightly belled to 9 c.m in circumference for closer fitting to the cervix, the outer end drawn for attachment to the rubber tubing

Number 4 tube is the one most aptly designed for general use in the type of cases that most frequently require this method of treatment

This instrument, in common with all others, must be kept in order or it cannot be counted upon when needed, its care is simple but must be done at regular intervals The plunger being of leather, must be kept well-oiled, so that it will not dry, a few drops of oil put in through the holes at the top of the barrel, once a week, will suffice Once a month the pump should be taken apart and cleaned, the valves in the plunger and nozzle washed in alcohol, oiled and replaced The air valve vent needs a drop of oil once a month

## A FURTHER STUDY OF ASPIRATION IN GYNAECOLOGY\*

By JOHN VAN DOREN YOUNG, F.A.C.S

**W**ITH the advent of aspiration in the treatment of gynaecological conditions, a most important step forward has been taken, as prior to its use there was no method by which the indicated procedures could be directly and accurately carried out

The indicated procedures, based on the lesions to be treated are as follows

- 1 The mechanical removal of infection and infectious material from the cervix, cervical canal, and uterine cavity
- 2 The emptying of the crypts of the cervical glands
- 3 The drainage of Nabothian cysts
- 4 Hyperemia of the infected area
- 5 Cervical stimulation
- 6 Secondary stimulation of the uterine musculature, with resultant contraction and relaxation, and a betterment of circulation and lymphatic drainage
- 7 Restoration of muscular tone

That the ordinary methods of treatment do not fulfill the above outlined indications I feel sure will be admitted. One of the most common and intractable conditions met in gynaecology is infection of the cervix, in all its stages it constitutes a focal infection which is a menace to the local and general health of the patient, and in its course threatens not only damage to the cervix but remote structures, it is seen in all ages, and civic conditions

In my experience local treatment has failed to relieve this condition, operation carries with it the uncertainty of surgery done through an infected area. Deep cauterization, while of great value, is destructive of tissue that may be restored, and therefore must be used with care. It was a recognition of the foregoing facts that led me to devise an instrument for the production of intermittent aspiratory hyperemia, and since its completion I have found its usefulness covered a much broader field than I anticipated, and coupled with chemical sterilization and other methods of local and general treatment, my results are far better than I had ever obtained before its use. Whether aspiratory stimulation is effective beyond the uterus, I am not prepared to say, but it would seem logical that the relief of inflammatory and circulatory conditions, especially those associated with subinvolution and retroversion,

would have a beneficial effect on all the pelvic structures

Aspiratory stimulation is in my opinion the key to the treatment of a multitude of conditions, both in gynaecology and in surgical conditions generally, wherever there is infection, circulatory stasis, or where stimulation of a superficial area will cause reaction in the deeper structures aspiratory hyperemia has its usefulness

In all probability the theory of hyperemia by aspiratory stimulation originated with cupping which was done in the early history of medicine, and certainly antedated the theory of Bier

The application of the principle as suggested by the author is different in method than either cupping or the ordinary Bier hyperemia. It has always appeared to me that a short or shallow cup gave suction only, for that reason I devised a cup of considerable length, and of various sizes and shapes

The requirements that I found necessary to meet in the instrument, for the application of this theory, were three, namely

- 1 That the cup should be long enough to give a vacuum cushion between the object to be stimulated and the end of the cup

If the tissues to be aspirated are soft, and the cup shallow, any strong suction will fill the cup with the tissue, and the suction will therefore be limited to the size of the cup, and the contact of the tissues to the walls of the cup will produce a pressure anaemia, with hyperemia only at the apex of the tissue in the cup

When the cervix is subjected to this type of cup, it is drawn down until the cup is filled, with the effect as described in the last paragraph, when the suction is released there will be a secondary hyperemia, due to muscular relaxation, but it possesses none of the stimulating effect of the primary hyperemia produced by the long cup

It was an effort to obtain this primary stimulating hyperemia that led me to devise the long shaft tube with its cushion of partial vacuum to act as a direct stimulant to the structures of the cervix exposed to it, and eliminate as far as possible the pressure anaemia, which in this tube is only a collar area where the tissue comes in contact with the glass, while the area exposed to the vacuum develops an acute active aspiratory hyperemia, or if the uterus is over active an acute muscular mechanical anaemia

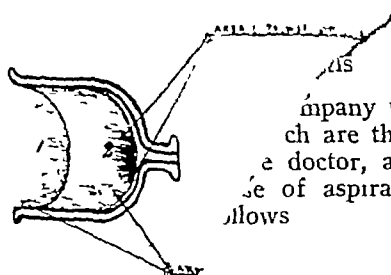
\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester April 23 1924

tion (all types)  
on  
tion  
ion  
degeneration  
cervicitis

tritis  
; Lymphangitis  
tion  
im  
tive  
olution  
Stasis

rus  
Endometritis

company the just men-  
ch are the guides that  
e doctor, and constitute  
e of aspiration, may be  
allows



These two drawings (not due to pregnancy)

action of the two { Not associated with malignancy

2 That the a  
plete control a  
vacuum in the  
to the tissue  
enough to  
vacuum it  
be met wh  
of the pun  
ness At th

Pain { Pelvic  
Back  
Distant  
Reflex

must not al inflammatory conditions, secondary  
trauma mal infection, or circulatory due to uterine  
that I usment, are benefited by this form of  
effect in sit

it in newputing the benefits to be derived from  
sidered an, only in those conditions where the  
strong pyg originates from infection or where  
will giveory stasis, or misplacement exists, can  
to apply be expected In true pathological lesions,

3 The for the elimination of co-existing infec-  
ing of the inflammation it has no use but the very  
an air valtor that infection is in gynecology ten-  
cup Th addition to our methods of treatment

method of isly there are two contra-indications to  
In orde, of aspiration pregnancy and malignancy  
tion of a fore stated, aspiration intensity may be  
treatme, d to a nicety in accordance with the  
in detai indicated  
and giv

A word as to the meaning of the term reaction  
It indicates, first, the degree of contraction of  
the uterine musculature, in response to aspiratory  
stimulation, which when normal causes a cramp-  
like pain, when mildly stimulated, described by  
the patient as equivalent to that of an ordinary  
menstrual pain, secondly the effect on the cervix,  
shown in congestion, anaemia, ecchymosis and  
bleeding, from or through, the cervix. It is  
obvious that in acute and subacute inflamma-  
tions, the degree of vacuum and the number of  
strokes must be limited by the intensity of the  
reaction, which will be much more severe than  
it is in sub-involution, circulatory stasis or retro-  
version, where the reaction is sluggish, and re-  
quires stimulation to a greater degree, and for a  
longer time, to obtain a normal response

In general fibrosis, hyper-involution and infan-  
tile uterus, both uterine and cervical reactions  
will be absent at the beginning of treatment, and  
require several applications before anything ap-  
proaching normal is obtained In this class of  
cases the strokes should be rhythmical, the degree  
of vacuum intense, the treatment continued for  
from 5 to 10 minutes or longer, bearing in mind  
the normal rhythmical contractions of the uterine  
muscle

In the treatment of cervical conditions the  
reaction of this organ is the guide, that of the  
uterus being secondary in importance, although  
it may at times take the first place by the degree  
of incidental pain, as for instance, in the treat-  
ment of an infected eroded cervix with an  
ascending lymphangitis the uterine reaction may  
be very severe, and overshadow that of the cervix.  
The degree of congestion, and amount of bleed-  
ing, together with the severity of ecchymosis  
must be carefully watched in order not to inflict  
unintentional trauma, as these reactions are very  
often severe and do not cause pain

Perhaps the most striking results I have ob-  
tained have been in cases of pathological mecha-  
nical retroversion *cum descensus*, especially post  
partum or post abortive, where the clinical find-  
ings are a large boggy uterus, with little or no  
muscular tone, circulatory stasis, both tubes and  
ovaries in the culdesac, a lacerated infected cer-  
vix, and an ascending lymphangitis On bimanual  
examination the fundus is indefinitely made out,  
and impossible of replacement After treatment  
the muscular structure of the uterus regains its  
tone and contracts to aspiratory stimulation  
The fundus becomes firm, and the uterus is  
easily replaced, with consequent restoration of  
drainage, relief of infection and improvement in  
circulation, local and general symptoms dis-  
appear, and in a percentage of the cases where  
birth trauma is not too extensive a permanent  
result may be obtained

I have devoted much time and study to the  
devisement of a method for the mensuration and

## A FURTHER STUDY OF ASPIRATION IN GYNAECOLOGY\*

By JOHN VAN DOREN YOUNG, F.A.C.S

WITH the advent of aspiration in the treatment of gynaecological conditions, a most important step forward has been taken, as prior to its use there was no method by which the indicated procedures could be directly and accurately carried out

The indicated procedures, based on the lesions to be treated are as follows

10, 11, 1 The mechanical removal of infection with the infectious material from the cervix, same size as the uterine cavity  
number 11 the duplicate of number 10, the application end is beveled, number 12 the cervical the application end belled to  $2\frac{1}{4}$  cm. diameter

In the application of the tubes to the cervix, the selection of the proper size and shape is an important step and requires some experience, as a general rule the tube should be as large as can be easily passed, and preferably belled as they fit the convex contour of the cervix better. If the tube is passed through a bivalve speculum the size cannot exceed number 4, and this only when the blades can be widely opened, where the blades are restricted by unyielding soft parts numbers 1, 2, 3 must be used. Numbers 10, 11, and 12, can be applied through a vaginal speculum, numbers 6, 7, 8 and 9 with the use of a Sims speculum, or where there is relaxation of the structures or birth trauma they may be applied without a speculum. In routine practice I prefer a thin-bladed bivalve speculum, as it offers the least obstruction to the passage of the tubes at the same time giving the best exposure of the cervix, and allowing the tube to be applied by sight and the observed aspiratory reaction recorded.

In some cases it is of advantage to introduce the tube without the speculum, in doing this we have two types of cases, one where the vagina is too small to allow of the use of a guiding finger, and the other where relaxation or birth trauma or both, have made the vagina roomy enough to use the large tube plus the guiding finger without any inconvenience to the patient. Greater ease of introduction will be had if the introitus vaginal wall and tube are thoroughly lubricated.

When the tube is passed without the guiding finger, care must be taken to locate the cervix by the examining finger, after its withdrawal, introduce the tube in the ascertained direction

would have a beneficial effect on all the pelvic structures

Aspiratory stimulation is in my opinion the key to the treatment of a multitude of conditions, both in gynaecology and in surgical conditions generally, wherever there is infection, circulatory stasis, or where stimulation of a superficial area will cause reaction in the deeper structures aspiratory hyperemia has its usefulness

In all probability the theory of hyperemia by aspiratory stimulation originated with cupping which was done in the early history of medicine, and certainly antedated the theory of Bier

The application of the principle as suggested by the author is different in method than near the cupping or the ordinary Bier hyperemia. that used in days appeared to me that a short or hold of the tube gave suction only, for that reason placed in the introitus of considerable length, and of posterior vaginal wall shapes finger of the left hand, that I found necessary to beside the tube and a finger, for the application of application end, until the tube is then manipulated until it is long enough to (under the guidance of the finger) between the object to completely cover the cervix of the cup

In cases of extensive cervical ectopy, the cervix is soft, and trophy, with or without descension, suction will fill the tubes number 8 and 9 are used. If the cervix is firm, suction will there exists they are applied by sight of the cup, and the

Aspiration intensity is varied in proportion to the degree and length of time of application, traction on the tube, and the number of aspiration units per treatment. This type of cup is filled,

To illustrate, if it is desired to give a last para stimulation from  $\frac{1}{2}$  to 1 stroke of the tube, there will liberated at once, or if a very strong muscular reaction is indicated, from 1 to 4 strokes, held in the stimulus with traction on the tube before the hyperemia is freed, and by increasing the number of aspiration units per treatment. In the case of a very stimulus the degree of aspiration intensity, the degree of partial and cervical reaction must be carefully observed in order to avoid unintentional trauma to the

I wish to emphasize two important points to it, and that the tube must be placed over the cervix, the pressure in the centre of the aspirated area, a collar the degree of aspiration intensity be maintained with the by the conditions under treatment vacuum

The pathological conditions in which hyperemia is indicated may be summarized as follows: an acute

whereby records of some value might be made, that would indicate the progress in the treatment of gynaecological cases, hence I have devised the following plan

In the second column on the card marked L is noted the amount, character and reaction of the discharges found in the vaginal vault when the speculum is introduced, as—when there is none, and from 1+ to 4+ when present, modified as follows ac, acid, al, alkaline, cl, clear, cd, cloudy, tk, thick, op, opalescent, m, mucilaginous, o, odor, etc.

In the last column is recorded the condition of the cervix, as lac, lacerated, erd, eroded, cyst, cystic, inf, infected, etc. The vaginal vault is then wiped free from discharge, and the selected tube put in place over the cervix, then indicated aspiration given, and recorded in the column marked asp, as previously described

The amount, character and reaction of the mucus drawn from the cervix is then noted in column marked m, using the same general plan as for vaginal vault mucus, with the difference that the signs 1+ to 4+ indicate a relatively smaller amount. It is often necessary to clear the cervix of thick mucus before it can be completely emptied by aspiration. This is done by twirling a cotton tipped wooden applicator in the canal. If difficulty is had in removing the mucus plug, the cotton is dipped in 10 per cent agno., which coagulates the mucus and renders its removal easy. The aspiration is then continued until the canal is clear

The presence or absence of blood, as the aspiration proceeds is next noted in column B, as—or up to 4+, also if there are clots, and whether the blood comes from the cervix or through the os, as fr c or th o

The amount of bleeding is an indication of the degree to which aspiration may be used with safety. Where the bleeding is profuse, that is 4+, where the tube becomes half filled with blood, aspiration should be used very cautiously. During menstruation the uterus is hyper-reactive to aspiration and the resultant muscular contraction lessens rather than increases the flow

In a percentage of cases an ecchymosis will be noted in the aspirated area, varying from a few spots to the covering of the entire surface. It also shows from very fine spots to blebs of considerable size. The degree of this reaction is marked, from — to 4+ and is in index to the aspiration intensity, that the tissues of the cervix will stand, when 4+, the aspiration should be stopped. Record is made in column ecc and modified, as vf, very fine, f, fine, c, coarse, b, blebs

The circulatory cervical reaction is divided into primary and secondary, and in either may be an anaemia or congestion, and vary in intensity both

indicative of the circulatory and muscular condition of the uterus

My earlier observations seemed to indicate only a hyperemia as the response of the uterus to aspiratory stimulation. I recognized that this was intermittent, but failed to recognize that there were cases of hyper-irritability of the uterine muscle that when stimulated caused a true spasm, with a consequent and direct anaemia of the cervix, which undoubtedly extends through the entire uterus, either as a primary or secondary reaction

The primary reaction is that observed through the glass tube and is recorded in column rect (1), the secondary, that which is seen after the removal of the tube and is recorded in column rect (2). The degree of blanching is indicated as 2— where it is extreme, 1—, or —, in accordance with the reaction. The congestion is noted from 1+ to 6+, 1+ being very mild, 6+ extreme purpling

It is my observation that a degree of congestion follows stimulation of a normal uterus as a primary reaction, and I have designated this as 4+. This may continue as a 4+ in the secondary reaction, or be changed to 1—, but restoration to normal is short.

Where there is a primary blanching to 2—, there is an over irritability of the muscle

Where there is a primary congestion to 6+, a sluggish muscular reaction, with circulatory stasis is indicated. Where the secondary reaction is continued as 6+, and the return to normal is slow, muscular tone is completely lost. In some conditions a 6+ primary is followed by a 2— secondary, which indicates a delayed response to stimulation in an infected cervix

I feel sure that the basis of the congestion or anaemia lies in the response to stimulation of the muscle mechanical mechanism of the uterus section. I wish to stress, at this point, the fact that I do not claim aspiration as a substitute for any other method of treatment of proven value, but as an additional procedure of the greatest value

In point of fact I know nothing that will take its place, or cover as completely all the indications for treatment in gynaecological work

Among other methods of treatment that I desire particularly to call to your attention is the electro-cautery, as recommended by Gibson. This should be used conservatively and with aspiration

The chemical sterilization of the clean cervix is a much more exact procedure than where a layer of viscid mucus separates the application from the tissues to be treated. The applications I have found most effectual are tincture of iodine, mercurochrome 220 sol, 2 per cent solution nitrate of silver and argyrol. The tampon still has an important place as a vehicle of indicated medication





it was considered that she had bronchial asthma, and as such she was referred to us for treatment. Her attacks were no worse at night than during the day. The morning on rising was most difficult, for she raised at that time large quantities of flocculent thick sputum. Her history was not particularly characteristic of asthma, there was no family history of the same, and our impression was rather that of a severe bronchiectasis or pulmonary abscess.

*Examination* Examination of the chest revealed noisy crackling rales especially marked in the inferior lobes posteriorly. There were also fine crackling rales in both apices during inspiration. The respiratory movement was good and equal on both sides, there was no impaired resonance.

An X-ray of the chest showed remarkable parenchymal thickening throughout both lungs. This was so evident as to greatly increase the time of exposure in order to produce a picture of the ordinary density. The mediastinal glands were enlarged, the apices were relatively clear, the left lung being more intensely involved than the right. Her temperature occasionally was as high as 100° by mouth. Repeated sputum examination showed great masses of pus, many staphylococci and pneumococci. There never were any tubercle bacilli. When a culture was made of any specimen, a profuse growth of white glistening characteristics occurred in three days. It grew just as rapidly at room temperature as in the incubator. Microscopical examination showed a yeast. Previous to obtaining the sputum culture, she was tested by the intradermal method to the ordinary inhalants and to bacterial proteins, as she had been considered an asthmatic for some time. The inhalant reactions were insignificant. The bacterial proteins gave moderate reactions to streptococci, pneumococci and staphylococci.

Her nares showed considerable atrophy with no obstruction or impaction on the right side, and a non-obstructive cystic middle turbinate on the left. The tonsils were small and not infected. The post nares and larynx were negative. The trachea by means of the laryngeal mirror could be seen to have a reddened and thickened mucous membrane. On bronchoscopy the mucous membrane seemed to be of a dusky red color along the lower end of the trachea and on inserting the bronchoscope, it bled so profusely as to interfere with further bronchoscopic examination.

*Treatment* As she was at first considered to be an asthmatic, we treated her with a prolonged and intensive course of vaccines, but she showed no decided improvement until exposed to the x-ray. Improvement was so decided following each exposure to the x-ray that she called attention to it, and this fact associated with the profuse culture of yeast seemed to us significant. Con-

sequently, we treated her by weekly exposures to relatively small amounts of X-ray. We soon found that small exposures were indicated.

Our usual technique for X-raying a chest requires 3½ inch gap and 40 m a at 28 inch distance and a three second exposure. We were forced on account of the increased opacity of her lungs to expose for nine seconds with this technique in order to procure a picture of the usual density. Following this exposure, on numerous occasions, she complained of chills and fever with increased cough and sputum during the afternoon and evening of the day of exposure, followed during the next few days by a remarkable diminution in cough and expectoration and by considerable exhalation and feeling of well being. On one of our early exposures, nine seconds, the chills were so severe that she was prostrated within three-quarters of an hour. This was followed, however, by an almost complete cessation of symptoms, except that she was weak and tired during the remainder of that week. She did not return for treatment for three months, during which time she was practically free from cough. Her return then was on account of a slight recurrence of the cough and considerable sputum. Re-application of X-ray exposures, however, practically relieved her symptoms. She still raised some sputum. These specimens on culture did not show any yeast, so that, we considered her remaining symptoms to be those of a simple bronchitis. One year from the beginning of her treatment she said that she had been entirely free from cough and sputum since she was last treated.

At various times during her illness she was saturated with iodides. These eased her cough but gave her so little relief that she repeatedly discontinued the drops against our advice.

*Case 2*—A married woman, aged 52 years, complained of a chronic cough for two years. She had had recurrent attacks of quincy, many head colds and a chronic post nasal discharge. Her appetite was poor, she had occasional night sweats, had lost some weight during the preceding two years, complained that she tired very easily and had considerable exertion dyspnoea.

*Examination* The nares were moderately atrophic, the tonsils were large and infected. The chest revealed no pathology other than a few rales over the larger bronchi. Other examination was negative.

*Treatment* On account of the infected tonsils and repeated attacks of quincy, a tonsillectomy was performed. This, however, had caused no alleviation of her cough, when we saw her nine months later. At this time her cough still troubled her every day and night so that it interfered seriously with her sleep. Her weight had remained about the same as it was on her first visit. A sputum examination of several

The puncture of Nabothian cysts with the cautery or Buttles spear precedes aspiration. In large cysts the sac should be burned by an electro-cautery and reaspirated.

In the art of gynaecological diagnosis the value of the history, and all data obtainable will be enhanced by the study of the aspiratory reaction.

For comparison may I suggest the following as the normal reaction for the healthy uterus

L	Asp	M	B	Ecc	Rect (1)	Rect (2)
—	2+(6sm)	—	—	—	4+	4+s to n or 1-1 to n

Cervix normal

Variations from the above are many, and often instructive, as follows

L	Asp	M	B	Ecc	Rect (1)	Rect (2)
2+	4+(3sm)	3+cd	2+fc	3+	6+	6+2-s to n

Cervix, lac infected, eroded

Reaction found in an infected cervix with ascending lymphangitis

L	Asp	M	B	Ecc	Rect (1)	Rect (2)
—	—(15 sm)	2+	—	—	2+	2-1 to n

Cervix, large, hard and pale

Reaction found in general fibrosis

L	Asp	M	B	Ecc	Rect (1)	Rect (2)
2+	2+(10 sm 5 sv)	2+	tr	—	6+	6+1 to n

Cervix lacerated, eroded, infected

Reaction found in retroversion with circulatory stasis

L	Asp	M	B	Ecc	Rect (1)	Rect (2)
—	—(15 sm)	—	—	—	2+ or 2-	2+ or 4+ 2- 1 to n

Cervix small, may be nicked

Reaction found in hyper-involution or infantile uterus

By recording in sequence the aspiratory findings the progress of the case may be accurately studied and the value of the procedure in a given case determined.

My observations and study of intermittent aspiratory hyperemia in gynaecology justify me in presenting the following conclusions

1 Intermittent aspiratory hyperemia is a definite and distinct method of treatment in gynaecology of great value

2 It is more than simple suction with a shallow cup, or pumping mucus from the cervical canal

3 There is a true cervical aspiration and stimulation with resultant effect on the whole uterus

4 The degree of aspiratory intensity may be regulated to a nicety

5 Drainage of the cervical glands, canal and uterine cavity may be accomplished

6 The tone of the uterine musculature is improved

7 The uterine circulation is improved secondarily to the betterment of the musculature

8 Local infection of the cervix is relieved

9 The method is practical, logical and effective in gynaecology

10 It is easy of application

11 Intermittent aspiratory hyperemia is an addition to, not a substitute for, other methods of treatment of proven value

## THE TREATMENT OF BRONCHO-MYCOSIS WITH X-RAY

By ALEXANDER C HOWE, F A C S, M D, JAMES M SCHMIDT, M D,

BROOKLYN N Y

**I**N a routine examination of patients complaining of cough, it has been our experience on culturing the sputum to frequently find yeast or moulds. As this condition is mentioned in literature and no significance attached to their presence, such have always been passed over without attention. It was not until one patient who had a particularly severe cough, gave us repeated specimens of sputum, whose culture was rank with rapidly growing yeast, that we paid any attention to this fact. This yeast organism rapidly outgrew any staphylococcus or other bacterium present, so that on ordinary dextrose agar at 37½ C the surface of the agar was almost completely covered in three days time. Fearing some contamination, repeated cultures were made with a complete repetition of conditions of growth.

This is presented as Case No 1 in the following, including our method of treatment.

**Case 1**—A married woman, 56 years of age, with a family history of no significance, had had an amputation of the left breast many years ago for carcinoma, with perfect healing and no recurrence. She had always been well, able to work and travel and had spent many years in Germany, her return having been during the past year.

While in Germany she had had some irritating cough which had been treated there entirely without relief, and her return to this country was partly on account of the worry produced by this. It had, however, never been severe until the past two months, it was so violent and racking that she was prostrated after each paroxysm. After consulting a few physicians,

organisms have been yeast, though penicillia and aspergillus have frequently been present. It is true that yeasts and moulds can be obtained from sputa of patients who have no cough or other evident lesion of the respiratory tract, and when we consider that they are the ever present inhabitants of the air, it would be strange if this were not so. We have, however, never been able to demonstrate more than a single cell on an agar slant in any normal case and a finding of two or three colonies has been considered by us as pathological.

The fact that Case 3 had worked as a baker for twenty-five years appeals to us as of possible significance. We have one other baker possessing considerable yeast in his sputum and who has been treated in the manner described with relief of his symptoms.

The characteristics of growth are well described in any bacteriology, and we were unable to determine that these organisms differed in any way from the hundreds of others that have been described.

The texts on medicine report yeast infections of the lungs to be fatal. Any of the above cases seen a few years later may well have presented this outcome. The first and third cases reported above, refer to patients, both of whom have confessed to us many times that they considered themselves as good as dead.

Sodium or potassium iodide had been taken in large doses by some of our cases without improvement. It is an adjunct of great value undoubtedly and should be used in any case requiring relief. Usually, however, the X-ray has presented so prompt a beneficial response that the iodide has been merely something for the patient to do for himself, and he has had the tendency to stop it perhaps before we have told him to.

Examination of the chest has revealed signs ordinarily considered those of pulmonary tuberculosis. That no tubercle bacilli were ever found and that the symptoms were entirely alleviated may be an observation of importance. It would seem that any case of suspected tuberculosis in which no tubercle bacilli can be found should be examined for a possible bronchomycosis.

X-ray treatment of these cases gives relief. Sufficient time has not elapsed for us to judge of the permanence of the treatment.

*Summary* Herein are presented three cases of chronic bronchitis, in whose sputa fungi were demonstrated.

The fungi have disappeared following treatment with X-ray.

The disappearance has been followed with a remarkable improvement in the bronchitis.

## THE EARLY NEUROLOGICAL MANIFESTATIONS OF SYPHILIS \*

By JOHN L. ECKEL, M.D.

BUFFALO, N. Y.

ONE of the great human problems before us today is syphilis and a highly important portion of that total problem is syphilis of the nervous system. Neurosyphilis is so protean in its clinical forms that the significance of it as an etiological factor in nervous diseases is often overlooked. So frequently a physician keeps his eyes on the clinical form and course of a disease that he often forgets that syphilis is a cause of the syndrome.

The distinct dividing lines that were once held between hereditary, acquired and parenchymatous lues are slowly being obliterated and in time we shall probably cease to divide this disease into definite clinical types, but speak only of syphilis of the nervous system.

At the present time there are a few acute and sub-acute psychoses which are recognized to be due to syphilis, and with this fact established, the psychiatric borders of the disease are also much further extended and the classical pictures of forms or types of the disease are becoming

largely literary effort. The actual process going on in the nervous system is what should interest us, as this represents a conflict of man against the invader, the spirochete, and as a result there is not always present the classical type of any one of the various forms in which it may affect the nervous system, but there may be prominence given to one or another form of reaction.

Our knowledge of neurosyphilis is relatively recent, as one soon observes when he checks off the great milestones made in the advancement in this department of medicine. True, as early as the latter part of the fifteenth century it was thought that certain types of paralysis were due to syphilis. Also this was reiterated in the sixteenth and again in the seventeenth century. More accurate knowledge regarding this disease began to take form when that master pathologist, Virchow, in 1858, arranged and described the general pathology underlying syphilis. Our knowledge was further extended by Heubner as a result of his classical description of the vessel changes which was published in 1874. The first lumbar puncture was made in 1891 by Quincke.

\* Read before the Buffalo Academy of Medicine, February 13, 1924.

specimens revealed no tubercle bacilli, but many moulds of the type of *penicillium glaucum*. An X-ray of her chest showed a cervical rib on the right side and enlarged mediastinal glands but was otherwise negative. Her chest examination showed a few rales over the bronchi, no impaired resonance or accentuated voice sounds.

Five days after taking the X-ray she said she was better. Her cough was less violent and she slept through the night for the first time in months. She was exposed to the X-ray approximately once in five days. At each occasion, we used a  $3\frac{1}{2}$  inch gap and 40 m a at a 20 inch distance and exposed for six seconds. Examination of her sputum on several occasions following the first three exposures to the X-ray failed to demonstrate the presence of any fungi. Her improvement was continuous until twenty-three days after the first exposure when she stated that her cough had entirely disappeared and that she could raise no sputum. Following this visit, she did not return for five weeks and then she complained of a moderate recurrence of both cough and sputum. We exposed her chest as before for five seconds. Four days later, she was better and received a six second exposure. Ten days from her return, her cough was very slight and we exposed her chest for six seconds. In fourteen days, she said she had no cough and felt almost as though she could not cough. Following this we gave her two more treatments at five day intervals and when we saw her nine months later, she had had no cough or sputum.

**Case 3**—A man, 53 years of age, had left Germany thirty-three years ago and had always been healthy until the past five years, during which time he had a severe cough. His mother had an exertion dyspnoea, otherwise, the family history was negative. For twenty-five years, he had worked as a baker and it was while occupied thus that his cough began as a slight hack with no sputum, and no evidence of an associated cold or fever. The cough had gradually increased until it had become very severe the past five years. During this time he had been worse at night and when he awakened in the morning, also upon any moderate physical exertion. He could do light work without coughing or excessive fatigue. He perspired freely during both night and day and had a good appetite. Two years before we saw him he weighed 190 pounds and during that time had lost 25 pounds. He considered that he had asthma.

**Examination** The mucous membrane of his nares was pale and dry, showing a tendency to atrophy and poor ethmoidal drainage. His chest showed the respiratory movement limited on the left, resonance fair throughout, accentuated voice sounds in both apices, D'Espines sign negative, inspiratory rales in the left apex and below both clavicles. We felt certain that this examination with his history meant pulmonary tuberculosis.

An X-ray of his chest showed thickening of the parenchyma in the upper left lobe and slight peribronchial thickening throughout. The mediastinal glands were not abnormally large. His temperature ranged from 96.4 to 98 during five days. Blood pressure was 120—65. Repeated sputum cultures demonstrated the presence of many yeast cells.

**Treatment** Four days after the chest was X-rayed, without other treatment, he was much improved. At this time another X-ray was taken, exposing his chest twelve seconds. These pictures showed no other pathology. Seventeen days after his first exposure to the X-ray, his improvement was marked. There was less opacity in the X-ray plates. The chest examination showed the rales much less evident and respiratory movement seemed equal and good. Sputum brought at this time grew many yeast cells. He had twelve seconds of X-ray exposure at this visit.

Twenty-four days from his first exposure, he said he was better but that his cough had not improved as much as previously. We gave him a saturated solution of sodium iodide of which he was to take five drops three times a day. X-ray exposure was six seconds. In thirty days his improvement was marked. He could work without fatigue or even much cough or heavy exercise. Sputum brought at this time showed no yeast cells. X-ray exposure was eight seconds. In four months he had received twelve exposures and his cough was almost entirely absent. He raised a small amount of sputum from which no yeast cells could be obtained.

**Discussion** The above are typical of ten cases in our experience. We have had one case of asthma show yeast cells, out of many for whom sputum cultures were done. She had practically cleared up from a most severe allergic inhalatory type of asthma, before we were able to find any yeast cells. A few small doses of X-ray cleared the remaining symptoms. This case seemed to combine an allergic asthma with a bronchomycosis and the symptoms of the latter did not disappear until treated with X-ray. Also, the history of these patients seems to differ noticeably from that of asthmatics. Their cough is more that of a chronic bronchitis, that is continuous, and less spasmodic and intermittent. There is less complaint of orthopnoea and they do not present the typical whistling rales.

As is well known in any laboratory, all types of moulds and yeasts may be found if enough sputa are cultured. Some are typical and many present the variations of intermediate types. Little attempt has been made to entirely classify them. We have found enough for our clinical purposes, to know that yeasts or moulds are present in the sputum of a case which is complaining of a chronic cough, and which can not be otherwise accounted for. The predominating

quent involvement of the nervous system. In this statement Stokes also agrees.

When the meninges first become involved, we may or may not have clinical symptoms. Thus, cases of severe syphilitic meningitis have been encountered, with slight headache as the only symptom present, while severe headache and nausea have been found when only a meningismus was the cause of the complaint, as shown by negative spinal fluid findings.

When other than pure meningeal symptoms develop in the nervous system, then we are no longer dealing with incipient lues of the central nervous system, but with definite systemic involvement.

While every case of syphilis should have his fluid examined before he is discharged as cured, even in the presence of a negative blood, this becomes imperative in all cases in which the blood does not become negative after the second course of treatment. A so-called Wassermann fast blood in early syphilis nearly always means some systemic involvement of the disease, and calls for careful analysis of the nervous, cardiovascular, osseous, gastro-intestinal and other systems, to search out the one involved. Frequently the spinal fluid is found the offender, and it is in such cases that energetic treatment should be instituted to prevent, if possible, the later development of one of the serious parenchymatous types of the disease.

Syphilis of the central nervous system may exist for many years without the production of any clinical symptoms, but on the contrary, such manifestations may be early, even a few weeks after the appearance of the secondary symptoms of the disease. In such cases, when symptoms present themselves, they are usually manifested by meningeal disturbance, such as headache, nervousness, poor sleep, poor concentration, and added to this, poor vision, or there may be hearing involvement or some irregularity in the outline of the pupils, sluggish light reaction, or there may be various types of pain present or ocular palsies.

Such a case recently came under my observation in which the individual, a male, developed one or two small pimples, which had all the appearance of a chancroid. However, his family physician, to play safe, on the third day of observation sent his blood to the State Laboratory and a negative Wassermann reaction was returned. Under proper treatment these pimples soon cleared and the individual thought himself well. About six or seven weeks later he began having sharp pains in the legs, particularly below the knees and in the feet. These were cramp-like in character and were so severe that he was obliged to give up work. At first the condition was thought one of neuritis, but when it became worse we were asked to give our opinion as to

the cause of the trouble. Careful examination of the nervous system failed to reveal any organic disturbance. Several times during the examination he had sharp cramps in his feet, which were severe enough to draw the feet and legs up, and he showed considerable facial distortion. He had no definite signs of neuritis.

With the history, we felt that there must be lues in this case, so took his blood and tapped the spine. The blood serum was strongly positive. Spinal fluid showed an increase of cells, about 12 per cmm, a definitely positive globulin and a mild change in the luetic zone with the gold-sol test, but gave a negative Wassermann in the spinal fluid. This is a very good example of early involvement of the central nervous system during the so-called secondary period of the disease. Of course, these symptoms cleared rapidly under energetic treatment.

The fact of a negative Wassermann occurring during the first week following the presence of primaries is not an uncommon thing, and I wish to emphasize here this fact, so that we may not be satisfied in such cases with one negative test, but should have it repeated at weekly intervals until we are satisfied that there is no lues in the case.

In sharp contrast to this case, another patient, male, 38, infected seventeen years before he came under our observation, stated that following the infection he had a short period of mouth treatment and thought himself recovered. He felt no symptoms whatever until a few months before we saw him. He states that he then began to feel restless, that his sleep was disturbed, and that there were pains from time to time in various portions of the body and that he had a feeling of apprehension, as of some imminent danger. He lost weight.

Examination of the nervous system showed no physical signs whatever. However, the history of the case, plus the very meager amount of treatment he had received, led us to test up his blood, which was found to be strongly positive. I then suggested spinal puncture and found a very strongly positive spinal fluid. He was subjected to combined method of treatment and all symptoms cleared as shown by reactions. Apparently we were here dealing with the meningo-vascular type of disease, which was somewhat more pronounced in the meninges than in the vessels. It is this type of syphilis of the nervous system which yields best and gives us our most satisfactory results.

Physical signs of the nervous system may develop a few months after infection and manifest themselves with slight irregularity in the pupils or by double vision, or by mild retinitis, or involvement of the eighth nerve, occasional pains along the course of the fifth nerve. Associated with these there may be brisk tendon

Whilst this was done more for medical reasons than for definite research, still it soon opened a large field of possibilities, and a few years later we find Ravaut, Sicard and Widal publishing articles on the cellular changes in the spinal fluid from various types of disease of the nervous system. Some years later, 1903, they added the proteid changes occurring in abnormal fluids. That same year, 1903, Metchnikoff published his article, wherein he stated that he had successfully transmitted the disease to apes. The following year Alzheimer and Nissl published their monumental piece of work on the histopathology of syphilis of the brain. In 1905 Schaudinn and Hoffmann described the spirochete. The next year Wassermann added the serum diagnosis to our knowledge of the disease. Plaut in 1908 applied the principles of this test to the spinal fluid. In 1909 Ehrlich gave us salvarsan, and in 1912 Swift and Ellis salvarsanized serum in the treatment of syphilis of the central nervous system.

Noguchi and Moore, 1913, succeeded in isolating the spirochetæ from the brains of general paralytics and also from cords of tabes, thus forever casting from medical literature the term "parasyphilitic disease" and placing these two conditions in the rank of true syphilitic disease. In 1914 Lange applied the principle of colloids to spinal fluid and gave us his famous gold-sol test, which has further assisted us in differentiating types of the disease of the nervous system. From then on, with the major points established, numerous workers have advanced every phase of our information until at the present time the literature on this disease is most voluminous.

#### DISSEMINATION OF THE SPIROCHETES

From the primary focus of infection the dissemination of the spirochete is early. Brown and Pearce<sup>1</sup> have shown that within forty-eight hours they could obtain living spirochetes from the inguinal glands after inoculation of the testes of rabbits. They were able further to obtain spirochetes from blood culture on the seventh day following inoculation. They believe that there is a rapid multiplication of the spirochetes after infection and that they spread through the body rapidly and invade other tissues and lymph glands and the blood, and thus become widely distributed before the presence of the initial lesion. They believe that the primary lesion is the result of a concentration of spirochetes at a certain point. If no marked concentration occurs, then we have an explanation for the absence of primaries which is so common in histories obtained in neurosyphilis cases.

When the blood stream becomes involved the nervous system may show evidence at any time, as has been demonstrated by cases showing abnormal spinal fluids before the appearance of

primaries or secondaries. Still the vast majority of central nervous system involvement occurs during the secondary or florid state of the disease. It is possible for it to occur later, but this is not common.

#### EARLY TYPES OF INFECTION OF THE NERVOUS SYSTEM

Just why the nervous system or any other system should be selected by the spirochete after blood stream involvement, is hard to explain, except on the basis of the resistance of the individual to the spirochete. In some the nervous system is vulnerable, while in others the vascular, and in others the osseous, and still others the gastro-intestinal tract. Apparently there is little evidence to support the so-called "neurotrophic strain" theory, which has been so ardently supported by the French school. One of the chief arguments against this theory is that in late syphilis we have multiple systems involved. The first expression of the disease in the nervous system is always in the meninges, no matter what form it may assume later. This is demonstrated by an increase of cells in the fluid in over 50 per cent of cases during early secondary syphilis. Globulin increase is not present in quite so high a percentage, and the positive Wassermann reactions on fluid lag much further behind. This does not mean that over 50 per cent of all cases of lues have involvement of the central nervous system, but it does show that the presence of the disease in the blood stream affects the meninges in a high percentage of cases, which, if not treated may later develop into a definite infection of the nervous system. The evidence of irritation of the meninges without a positive Wassermann reaction, usually clears rapidly under treatment. It is agreed that the best time to test the spinal fluid to determine if the central nervous system is involved, is after a few injections of arsphenamine, or better still, at the end of the first course of treatment. At this time, most of the minor changes in the fluid have cleared and one is not so easily misled, and further, there is then no danger of a needle carrying spirochetæ from the blood stream to the spinal fluid as it passes into the canal, which has been reported by competent workers in a few cases. Indifference to the necessity for examination of spinal fluid at the end of the first or second course of treatment is quite probably responsible for the increasing instances of alarming accidents, especially those involving the cranial nerves, which are bringing modern therapeutic methods used in the treatment of syphilis into more or less disrepute.

Wile and Marshall<sup>2</sup> state that if the spinal fluid shows no involvement after secondary eruption, then there is little likelihood of any subse-

reactions and about 40 to 60 per cent showing negative Wassermann reactions of the blood. However, when the physical signs are those of tabes, no matter whether the blood and spinal fluid are positive or negative, our diagnosis should remain tabes. Also, even after the reactions are found negative, it is not proof that the condition is latent or inactive. It merely means that in so far as the blood and spinal fluid are concerned the antigen binding substance in them is so weak that it no longer holds the antigen, thus giving negative blood and spinal fluid reactions. The process is no longer active in the meninges but is doing its deadly work within the cord itself—that is, the parenchymatous portion of the cord.

When one recalls that tabes may begin to manifest itself in any portion of the cord, that is, either sacral, lumbar, dorsal or cervical, he will immediately understand that if we have the lower end of cord involved, we may have the knee and ankle jerks intact, but have absence of sexual power, and with this, some interference with bladder control, also diminished sensation of the testes. This is the so-called "low type" of tabes and is the kind that frequently consults the urologist first, and if he is not alert may lead him into error.

Should the process be a little higher, that is, in the lower portion of the lumbar cord or the lumbar enlargement, which is the most common site of the disease, then we have the classical picture with absence of knee and ankle jerks, some ataxia of gait, be it slight or great. Along with those symptoms, we may have the classical A. R. pupil and there may also be some pains here and there, shooting in character. The intensity of these symptoms will, of course, depend upon the age of the disease and the rapidity of the progress. When tabes is located in this portion of the cord, and presents the typical signs of the disease, I doubt if it is very often overlooked by any physician who will take the trouble to test the reflexes, gait and pupils.

The most baffling types of this disease are those cases which begin with abdominal symptoms, so-called complaints of indigestion or abdominal pains. It is in this type that the condition is very frequently overlooked, with the result that a lot of needless abdominal surgery has followed.

Many of these abdominal types show few or no neurological signs at all. In the history, however, of these cases, if taken carefully, one may often be able to elicit a lead by establishing a probable infection many years previous. Most of them may admit slight primaries, but may deny any secondaries. Of course, this is a frequent complaint in late central nervous involvement, that is, that the primaries and secondaries

may be absent, or be so slight that they are overlooked by the patient.

Stokes-Brown<sup>2</sup> report their results in the careful examination of two hundred cases complaining of abdominal symptoms. After careful history taking they found that nearly 80 per cent of them gave history of probable lues, and by careful analysis of the nervous system from every standpoint, plus serological reactions of both blood and spinal fluid, they were able to establish that the vast majority of them did have central nervous system syphilis, and that only a small percentage of them had definite stomach lesions.

One of the commonest types showing abdominal symptoms is the so-called "crises" cases. These, when they occur according to the classical description of a girdle pain, usually suggest tabes. However, the vast majority of them do not present that type of complaint, but more likely have intermittent pains following eating, with nausea, or even vomiting, inability to handle certain types of food, and also constipation. The peculiar thing about most of these cases is that very few of them show a hyperacidity of stomach contents after test meals, most of them showing a slight hypoacidity. Another strange feature about many of the abdominal cases with severe pain, is that the spinal fluid is often negative. In these cases the disease process has probably involved the vagus, the abdominal ganglia and sympathetic system, and these combined produce the pain complained of.

It is a very safe rule to follow in dealing with vague abdominal conditions associated with pain, to bear in mind the possibility of lues in each and every case, and when a clear-cut diagnosis of some other condition cannot be made, it is far safer to do serological test on both blood and spinal fluid before proceeding with another line of treatment. This, in a great many cases, will save needless surgery and other types of treatment.

One could recite many cases to illustrate these points, because many of them do not present any neurological signs whatever and the only way one learns of the presence of lues is by careful analysis of blood and spinal fluid.

The so-called cervical tabes occurs from time to time and usually manifests itself by pains and paresthesia confined to the upper extremities and along the neck. There is usually present some ataxia of the finger-finger and finger-nose test, and usually also some pupillary changes present, sufficient to arouse a suspicion of diagnosis, which would thus suggest serological analysis to complete.

Quite frequently the first and only symptom of beginning tabes is dimness of vision, which upon careful analysis of eyegrounds proves to be early optic atrophy. The patient will usually

jerks, headaches, poor concentration, restlessness. A combination of these symptoms leads one to suspect a diagnosis of syphilis of the nervous system.

In these early cases involving the nervous system wherein there are physical as well as clinical symptoms, it is quite important that we should make an effort to fix the type of involvement if possible, that is, as to whether we have a meningeal type or meningo-vascular or neuritis, or early tabes, or paresis, or the gummatous variety. This is not a very easy problem, so early. It has been our experience that meningeal or meningo-vascular types clear rather rapidly under treatment. Many of these cases may show the paretic or zone one curve with gold-sol test on the start and lead one to suspect that we have an incipient case of paresis to deal with, but after a few combined treatments this curve breaks and we have then a zone two curve. Later this may diminish in intensity and as improvement continues the other reactions clear up. While it cannot be positively stated that when a curve does not change from a paretic type after energetic treatment, we are dealing with an incipient case of paresis, still we can recall a fair number of cases which have been under our care that eventually did develop paresis. At the present time we have under our observation at least four such cases, which, after prolonged treatment, still show the paretic type curve, and we are awaiting with deep interest the final outcome in these cases. Will they clear up, or will they be paretic? We fear the latter.

It might be of interest to recite briefly the history in one of these cases. A young man, 24, who at the time of his primaries presented himself to a very competent man for treatment, and was given in all five courses of arsphenamine, followed by mercury and iodides. At no time did his blood Wassermann become reduced to negative, but fluctuated between a one and a two plus. At the end of his fifth course of treatment he was referred to us for examination of the nervous system, and whilst we were unable to find a single sign or complaint referable to the nervous system, still with this tendency to Wassermann fast reaction in mind, we advised a puncture and found the fluid contained over 100 cells per cmm, a strong globulin, a four-plus Wassermann reaction and a gold-sol with a paretic curve. He was given a series of combined treatments, followed by a series of mercury in the spine, then by another series of Swift-Ellis combined with mercury, and whilst we reduced the intensity of the reaction of the spinal fluid to nearly negative, still his gold curve always remained paretic. At the end of the third course of treatment he left the city and we did not again see him for three and one-half years. When he returned he was a well-marked paretic, both physically and mentally.

In those cases which do not show enough symptoms to enable us to make definite diagnosis as to the exact type of involvement of the nervous system, and whose curves early are paretic and then break to a zone two curve, we feel that with the usual strenuous treatment we may be able to avoid a serious parenchymatous brain or cord involvement.

The meningo-vascular type may manifest itself in one of a great variety of ways, at any period, even up to thirty or more years after infection. It is not uncommon for one of these cases to begin his complaint with a gradual increasing nervousness associated with disturbance of sleep, dizzy attacks, hesitancy and stumbling over a word, or complaint that the flow of thought is not as easy as formerly. With this complaint there may be slight headache or occasional pain. These individuals usually consult one for their general nervousness and in the course of examination, assisted by a good history of the case, one is led to suspect that lues of the nervous system is the offender. Occasionally they may present only suspicious physical signs. Again there may be definite inequality of pupils, with one or both fixed to light. There may be brisk or diminished reflexes. There may be parenthesis. Beyond this we may find nothing.

In all such cases one should examine the spinal fluid to be sure of his diagnosis. Many of the so-called "strokes" in individuals under forty, are due to syphilis of the vascular system. Monoplegias and paraplegias are very frequently due to the meningo-vascular type of the disease.

#### TABES

When the symptoms of this condition are well established the diagnosis is easy, and we know that we are dealing with a very late manifestation of involvement of the nervous system, and in this paper we shall not spend time on this advanced type, because the syndrome is very familiar to all. Our time here will be given to the non-classical types, that is, to those cases which either reveal only a few or no physical symptoms, and which are forever giving us great difficulty in diagnosis.

It must be constantly borne in mind that tabes is a rather late manifestation of syphilitic involvement of the nervous system and that it rarely appears before the fifth year and may not show any symptoms to attract the patient's attention until as late as thirty-five or even forty years after infection. It is not strange, therefore, that we frequently encounter cases that show negative blood and spinal fluid Wassermann reactions.

The percentage of negative findings in these cases varies somewhat with the observer and the number of cases reported upon. However, I feel that a fair average would be from 30 to 40 per cent showing negative spinal fluid Wassermann



Rarely do we find any superficial sensory disturbance in paresis. However, I might state that the general sensibility to pain is lowered, in that these individuals do not react to stimuli in the same way, no matter where applied, as does the normal individual. This is best shown when one does a lumbar puncture, for very few of them make much fuss over this operation.

If we can establish one or more of the above symptoms, with history of slight but general increase of the mental symptoms mentioned above, and to this possibility add a history of lues or possible lues, I think that the serological tests are in order.

Paresis usually shows a fairly high cell count, nearly all lymphocytes, also definite increase of globulin and albumen, and the paretic curve on gold-sol test. This is quite a constant factor and in my experience rarely or never breaks under treatment, no matter in what form applied. Also 99 per cent plus of positive blood and spinal fluid Wasserman reactions.

If one wishes to give the picture of paresis as it presents itself later in the disease, then he would have to take the separate types mentioned above and give the clinical symptoms of each of these when they are well established. Briefly, the depressed type will show delusions of self-accusations and inadequacy, plus fine tremors and pupillary changes, speech, reflex and serological disturbances.

The agitated type shows restlessness, anxieties, fears, worries, poor sleep, plus the physical signs of the disease.

While the grandiose or expansive type deals in millions and has no hesitancy in writing checks for any sum asked. They are happy, agreeable, never complain, euphoric.

Then we may have the type showing focal symptoms, such as ptosis, partial hemiplegia, partial monoplegia, etc., with mental symptoms of the disease, also seizures and convulsions.

It is characteristic of paresis that some time during the course of the disease a remission of symptoms takes place. This does not occur in all cases but does in the majority of them. This remission may last for a few months or for a year or so, during which time the individual may be able to return to his work. This may occur with or without treatment. However, it is the consensus of opinion among those who have had extensive experience in the treatment of this disease by the combined method that the remissions come more frequently and last longer with treatment than without.

So far as is known today, there is no case of true paresis that has ever recovered. Brain syphilis may and frequently does simulate, both clinically and serologically, true paresis. The differential diagnosis is practically impossible except by therapeutic means. Should the individual

eventually clear and remain clear, we cannot apply the diagnosis of paresis, but must concede that the case was the cerebral type of syphilis.

A feature that is often met with in early paresis is the fact that so many of these individuals are holding important positions. Frequently have I run across early paretics who are railroad engineers and have charge of some of our fastest trains. Think of a paretic running the Twentieth Century Limited! It is for this reason that I think one should be careful in examining mild mental cases or severe neurosis cases, especially males, who present themselves in our offices, for the purpose of eliminating this disease. Because it may advance suddenly, and should the individual, perchance, have some important position, disastrous results to many persons may occur.

### HEREDITARY SYPHILIS

Hereditary syphilis very frequently involves the nervous system and the classification of these symptoms is similar to those in the acquired type. Jeans<sup>4</sup> of St. Louis has collected and studied a large series of these cases and reports that under two years of age all cases showed a positive Wassermann reaction of the blood, that 27 per cent of these gave a positive spinal fluid reaction, of which 32 per cent, in addition to the positive Wassermann reaction of the blood, that physical signs of the disease. In his series of children over two years of age showing positive blood reactions, 20 per cent only showed spinal fluid reactions positive, but 76 per cent of these older children with positive spinal fluid showed physical signs of the disease, and in this series all types of syphilis of the nervous system were manifest, that is, paresis, meningeal type, vascular type, muscular atrophies, etc.

In addition to all these types mentioned above, syphilis does produce a certain number of muscular atrophy cases. There is one type of spastic spinal paraplegia, known as Erb's disease, which is always due to syphilis. Syphilitic myelitis is not uncommon. Pure optic atrophy, without any other neurological sign, is also not an uncommon manifestation of the disease. Gumma may appear anywhere in the nervous system and give symptoms of tumor wherever present. Since the advent of arsphenamine, gumma is rather rare in the nervous system.

We may have neuritis due to syphilis and today we recognize a syphilitic type of neurosthenia and a pseudoparetic mental disturbance, and there are some confused states not clear-cut that are definitely due to syphilis. They may often simulate cases of mania.

So, in reviewing this monster, which is so protean in its manifestations, particularly in the nervous system, one cannot be too careful in examining these cases to look for signs or symptoms that might indicate the presence of this

be found to be healthy otherwise. Careful examination may help in establishing a history in such cases, and then serological reactions complete the diagnosis. Sudden ptosis or strabismus or double vision are frequently first symptoms complained of by patient, as indicating to him the beginning of some trouble in his nervous system. This is another and very frequent mode of onset of tabes.

We have confined our remarks here merely to the early signs and symptoms, believing that the more advanced classical pictures are so familiar to all that repetition of them here is unnecessary.

#### GENERAL PARESIS

It is variously estimated that about two per cent of all syphilitic cases eventually develop general paresis. This is also a rather late manifestation of the disease—that is, in its clinical symptomatology. However, bear in mind that the spinal fluid shows positive reactions from the secondary stage of the disease on, but the process has worked so slowly that the symptoms and physical signs do not present themselves until from five to thirty years after the infection. It differs in mode of onset, symptoms, in pathology and in the serological reactions somewhat from other forms of syphilis of the central nervous system. Just why these differences it is difficult to answer. The pathology is confined to the central nervous system as a whole, but is manifested most in the brain, particularly the cortex, in which, as the disease progresses the entire architecture of the cortex is upset. There is a tremendous increase in the vessels, plasma cell infiltration, glia cell increase, thickening of the meninges and tremendous increase of spinal fluid. The serological reactions are almost 100 per cent positive in both blood and spinal fluid. In fact, it is exceedingly rare to find either a negative blood or negative spinal fluid in a true case of paresis.

The clinical symptoms of this disease develop in most instances very slowly, however, in a few, rapidly. Usually they come so gradually that the family do not suspect anything wrong until the symptoms of the disease have quite well advanced.

Again, the disease manifests itself in quite a number of forms and here again we have difficulty in recognizing a sufficiently clear-cut set of symptoms to enable the average man to suspect syphilis of the nervous system. When one recalls that we may have the simple demented type, a depressed type, an expansive type, the agitated type, those with convulsions, and again types with localized brain symptoms, he will immediately see the difficulties in diagnosing this disease early on a basis of clinical signs alone. The earliest signs, no matter what the type may

be later, are usually slight changes in character and disposition. They are more or less absent minded, they are not as attentive to their family or their business, or to detail as they were wont to be, they are not as neat about their appearance and about their work as they were, slight lapses of memory show themselves, slight discourtesies and slight tendencies toward irritability creep in, all of these gradually increasing in intensity until finally the family or near friends of the individual begin to suspect that all is not well, and it is then that a physician is asked to see the case. If the patient co-operates, we may have the privilege of treating a relatively early case of the disease, if not, the symptoms may advance until we reach a point where the individual shows rather marked mental symptoms, in that there is considerable loss of memory, he begins to show less attention to his business, to his personal appearance, less attention to the family, misplaces things, does foolish things—especially shows reversal of form, that is, if he was parsimonious before, he is liable to become more or less liberal, taking active interest in charities, in the formation of business concerns and the advancement of this or that educational affair. Again, they may become depressed, accuse themselves of wrong, possibly remember that they have had syphilis and fear that this is working upon them and that it has upset their minds. Another type will become agitated, restless, show poor sleep, lack of concentration, inability to carry on work. Whilst others, again, may have inattention, marked dullness, slowing up of their general activities, occasional lapses of memory or lapses of speech control, or they may have twitching of the facial muscles, or even slight convulsive seizures.

When one examines these cases physically, he may or may not find definite physical signs. As a rule, however, there is some irregularity of the pupils and there may be some inequality in size. The vast majority of them react to light and accommodation, however, many of them show the A R pupil. In most of these cases there is fine tremor of the facial muscles, most marked about the eyes and mouth and tongue, also fine tremor of the fingers. The speech, if tested carefully, in nearly all cases shows some disturbance and slight eliding of syllables, or slight stumbling over certain consonants. Again, if one tests the writing, he will find that it is not up to his usual form, that is, there may be fine tremor displayed, a tendency to misspell words, and the entire product is not nearly so neat as formerly.

One observes that the tendon reflexes are usually quite active or exaggerated, except in those cases in which we have a combined form of tabes and paresis, known as taboparesis, and here, if we have a lumbar type of tabes, there will be absence of tendon reflexes plus mental signs.

Finsterer immediately took up the method and found it to be of great value, particularly for operations upon the kidney.

Kappis published his first researches in this field in 1912 in which he reports successful renal and thoracic operations. His interest continued and in 1922, ten years after his first contribution, reported eighty operations upon the kidney by this method.

Ziegel used  $\frac{1}{2}$  per cent novocaine, blocking the posterior roots of the 8th dorsal to the 3rd lumbar. He performed over 2,000 operations under paravertebral anaesthesia between 1914 and 1919, eighty-eight of which were upon the kidney.

Braun, writing in 1914 from the Kiel clinic, considered paravertebral anaesthesia most important, all kidney operations being done under it at that time. Hartel in 1916 wrote an extensive article on the technique of paravertebral anaesthesia. He calls attention to several precautions of importance.

In France, Pouchet, in 1921, and Duvergey have utilized paravertebral anaesthesia. The latter reported seventeen kidney operations, only one of which was unsuccessful.

The most extensive work in urological surgery has been done by Snitzer, working in the splendid clinic of Prof. Illyes in Buda Pest.

American literature on this subject is not very extensive. The principal articles dealing with major surgery under paravertebral anaesthesia have been written by Farr<sup>13</sup>, Lowry<sup>14</sup>, Labat<sup>15</sup>, and Meeker<sup>16</sup>.

This subject is also briefly discussed in the text books of Allen<sup>17</sup>, Braun<sup>9</sup>, Dunn<sup>10</sup>, Farr<sup>13</sup>, Finsterer<sup>19</sup>, and Labat<sup>20</sup>.

#### METHOD OF ADMINISTRATION OF SACRAL AND PARASACRAL ANAESTHESIA

The following is the routine procedure which we have developed, and attempts to deviate from it have caused unsatisfactory results in some way or other.

The patient is prepared for operation in the usual manner, as regards purgation enemata, etc. Before going to the operating room morphine gr  $\frac{1}{8}$  in 50 per cent magnesium sulphate is injected. This is repeated in one half hour and a third dose given just as he starts for the operating room. Upon arrival he is placed upon his elbows and knees or upon his abdomen on the table. The skin is then infiltrated at the point where the needle is to be inserted, the skin first having been sterilized in the usual manner.

The operator then palpates the coccyx, and sliding his finger above this bone reaches the lower part of the sacrum and is usually able to palpate the sacral hiatus without difficulty. The sacral horns adorn the lateral borders of a triangle of which the hiatus is the apex. A 6-inch needle is inserted through the anaesthetized skin and into the sacral canal by puncturing the liga-

ment which covers its lower end. After penetrating this ligament the needle is easily pushed in  $1\frac{1}{2}$  to 2 inches. It has to be guided carefully, otherwise it will impinge on bone and must, of course, be deflected. One learns to tell by the ease with which the needle passes and the direction it takes whether it is in the canal. One of the directions the needle may take is just over and to one side of the roof of the canal. This error is detected by the direction of the needle and the fact that it passes with difficulty. One can also check upon this position, if improperly inserted, by the fact that as soon as the injection is started, the tissue at the end of the needle will infiltrate with the solution.

The sacrum has a great many variations in different individuals and a careful study of the osteology as well as the course of the nerves is a necessary preliminary investigation.

The needle having been inserted into the canal, one observes its end carefully to see whether either blood or spinal fluid runs out. In the event of this complication the needle is withdrawn and the injection made later. If the solution runs in easily one is sure that the needle is in the canal. If, however, the injection is made with difficulty one is quite sure that the needle is not in the canal, and the tissues over the sacrum are observed for infiltration.

We have been using 35 cubic centimeters of freshly prepared 2 per cent novocaine solution injected into the canal without the addition of bicarbonate solution. We have not used adrenalin in the injected solution because we believe that it adds materially to the toxicity of the drug.

The injection into the canal is extradural and presumably elevates the dura from the bone under the pressure used. In this procedure one may safely use a quantity up to 60 cubic centimeters provided the solution is not toxic. We then inject 1 per cent solution of novocaine into the first, second and third sacral foramina on each side in accordance with the method of Labat. The foraminae are located rather easily by passing the needle into the depression just below the transverse processes and by pointing it mesially and slightly upward one's needle usually enters without great difficulty. From 5 to 10 cubic centimeters of 1 per cent novocaine solution is injected into each foramen, the needle being withdrawn in order to distribute it in the entire length of the foramen.

The patient is then placed on his back and 20 minutes by the clock is allowed to elapse before the operation is begun. By that time the part of the patient which sits on a saddle including the scrotum, urethra, and bladder, should be thoroughly anaesthetized, if the injection is successful.

We have found that by starting to operate too soon the patient will often feel pain, and such an apprehensive state of mind will be produced that every movement will cause complaint. On

condition. Care in examining, both physically and serologically, will save many an individual from an early breakdown, because it gives opportunity for early and intensive therapy, and if this is then properly applied, the number of late neurosyphilitic cases will be tremendously reduced, with even a chance for complete prevention.

## REFERENCES

- 1 Brown and Pearce *Arch Dermat and Syph*, Vol 11, 1920
- 2 Wile and Marshall *Arch Dermat and Syph*, Vol III, 1921
- 3 Stokes and Brown *Amer Jour Med Sci*
- 4 Jeans *Amer Jour Dis Children*, Vol XVIII, 1919

## KIDNEY AND PROSTATE OPERATIONS UNDER REGIONAL ANÆSTHESIA MOVING PICTURE DEMONSTRATION \*

By OSWALD SWINNEY LOWSLEY, A.B., M.D., F.A.C.S.,

From the Department of Urology (James Buchanan Brady Foundation), New York Hospital

SEVERAL milestones in the advancement of urological surgery stand out above all others. The discovery of general anæsthesia afforded the means to stimulate progressive surgeons in all types of operations. This, of course, included surgery of the urinary organs.

The next great advance in the march of progress was the invention of the cystoscope by Nitze in 1897. Since that date a very great many ingenious instruments have been devised which renders it possible for the urologist to make his investigations so complete that it is almost never necessary for him to do an exploratory operation upon any organ of the urinary tract.

In recent years the most important advance made has been the realization that the case which is about to be subjected to an urological operation must undergo a period of preliminary preparation. This practice refers particularly to cases which have suffered from retention of urine with its attendant damage to the renal tissue. The development of several excellent methods of testing renal function has been of great value in determining the length of time for the drainage of the individual case. The most important thing about the period of preliminary treatment, in the case of the prostatic, for instance, is to have no set time for it. The operation should only be done when the patient has reached his maximum of renal efficiency. It is our custom to examine repeatedly the 24 hour specimen of urine to determine the excretory ability of the kidneys, a phenol-sulphone phthalein test to determine the renal activity during the time that test is actually being made, and finally a blood chemical examination is made to determine the amount of retention of substances which are ordinarily excreted in health. These tests are repeated as many times as necessary to determine when the patient has ceased to improve and therefore may be considered to have reached his best possible condition and is fit to be operated upon.

The most recent great advance in urologic surgery is the development of methods of adminis-

tering various types of local anæsthetics so that major operations upon the urinary and genital organs may be done.

A brief history of the development of these methods follows.

F. Cathelin and Durant (1902) used sacral anæsthesia for the purpose of treating grave neuralgias, sexual neuroses, and incontinence of urine. The former first used plain water, salt solution and later added cocaine, novocaine, codeine, or morphine. By this method Cathelin reported 49 per cent of the cases of incontinence of urine cured, 35 per cent materially benefited, and 4 per cent failures. He failed in his attempts completely to anæsthetize the sacral nerves in humans but was successful in dogs. A. Læwen used 20 to 25 cubic centimeters of 1½ to 2 per cent novocaine and placed the patient in the sitting posture for some minutes after injection, with the idea of retaining the solution in the lower end of the vertebral canal. O. Gros recommended the addition of sodium bicarbonate, which he states permits the solution readily to penetrate the nerve sheaths. Strauss prepared his solution by the addition of sodium sulphate which he maintains prevents the decomposition or adrenalin, which he also used. Hertzler recommends the uses of quinine and urea, using 60 to 90 cubic centimeters of 6/10 per cent solution. B. Lewis and L. Bartels reported 48 successful cystoscopies out of 68 attempted, and D. R. Pickens reported 81 out of 100 attempted. Splendid work on this subject has been done by Thompson of Galveston, who follows the method described by M. L. Harris. Albert J. Scholl, Jr., used sacral anæsthesia successfully in 140 cystoscopies out of 150 in which it was used.

Hugo Sellheim originated paravertebral anæsthesia in his experimental work on surgery of the abdomen. His work was published in 1905.

Six years later, 1911, Læwen reported a successful nephrotomy on an old man suffering from arterio-sclerosis, emphysema and chronic bronchitis. He produced anæsthesia by injecting the posterior roots of the 9th dorsal to the third lumbar nerves.

\* Read at the Annual Meeting of the Medical Society of the State of New York, at Rochester, N. Y., April 23, 1924.

ranify a little more it is wise to use seven cubic centimeters here.

Attention has several times been called to the danger of puncturing the pleura, but one is more apt to strike the next rib than the pleura. However, it is well to remember that at the point where we travel with our needle, while the nerve is often covered by plenty of muscular structures, it is only separated from the pleura by the internal intercostal fascia. The pleura is also a little closer to us on the left side.

The Quadratus block is now started by injecting widely in all directions (but principally toward the center of this space) both superficially and into the deep planes from the four points previously noted as the corners of this area. This effectually blocks all nerves which may in any way supply the superficial or deep portions of the abdominal wall in the vicinity of any of our possible incisions.

Previous to making the incision it is wise to test out all these areas for anæsthesia and if necessary, reinjection may be made. Patients will often say that they feel a cold sponge, when they cannot feel a needle prick. After the patient is found ready to proceed, the head should be well screened off, and the patient's attention be kept diverted as much as possible during the operation by a competent attendant.

The incision should be made as carefully as possible so as not to jar or startle the patient. All tearing or rough dissection should be avoided as it is difficult to anæsthetize against that. When the renal pedicle is reached traction often occurs and when this causes pain which may be of a nauseating type, it may be advisable to inject a little novocaine around it. In patients who are extremely nervous, the sight of an ether can and a mask with a few drops on it will often work wonders. These patients are usually ready for operation a few moments after the injections are completed. The total amount of novocaine used should rarely be over eighty cc. or at the most one hundred and fifty cc. of a 1 per cent solution.

When the patient leaves the table there is no evidence of any shock and as a rule he is quite comfortable.

In 1920 the author performed six operations under sacral anæsthesia. These were as follows: one Young-Punch operation, one suprapubic operation, one perineal prostatectomy for carcinoma, three perineal prostatectomies for adenomatous hypertrophy of the prostate.

The results of the anæsthesia were so unsatisfactory that they were given up, but were resumed again on February 3rd, 1923, the sacral being reinforced by parasacral infiltration in accordance with the method of Labat. Since that time there have been 210 major operations done in the Department of Urology, New York Hospital, as follows: prostatectomies, prostatotomies,

nephrectomies, neperotomies, seminal vesiculectomies, perineal sections for stricture, litholopies, other operations.

#### POST-OPERATIVE CARE

This care is interpreted to begin immediately after the actual removal of the gland. The wise surgeon puts a stop to the hemorrhage before beginning to sew the wound. This is easily accomplished in the perineal prostatectomy because bleeding points can and are observed, clamped and ligated in a satisfactory surgical manner. The general ooze which always occurs is controlled by packing the cavity of the prostatic capsule lightly with gauze strips. If one packs any cavity too tightly the viscus exerts its well known quality of attempting to expel the foreign body and the spasmodic contractions resulting tend to cause continued hemorrhage. Suprapubically a very different problem presents itself. The cavity of the former site of the enlarged prostate is in a most inaccessible spot. It is possible in case of severe hemorrhage to put the patient in trendelenburg position and expose the area, clamp and tie off bleeding vessels, and this should always be done when the hemorrhage is not controlled by light gauze packing.

The use of such appliances as inflated rubber bags to control hemorrhage, or very tight packing of any sort seems to be particularly contraindicated because of the resulting pain, tenesmus and continued hemorrhage.

Any steps that are to be taken to prevent hemorrhage should be instituted at the time of operation, and the hope that further packing or other manipulations might be accomplished in case the patient continues to bleed for several hours after operation usually results in disaster, because any manipulation causes great pain, and very little pain administered at a time when the patient is in a state of depressed blood pressure will have a profound effect and often throws the patient into shock.

It is important to keep the patient dry and warm and for him to be transported to his bed with as little delay as possible.

Blood pressure estimation is the most important single item in the observation of the patient for the first 24 hours. This should be taken every two hours or oftener until it has passed entirely through its period of depression and has arisen to a safe level again.

The two most gratifying features of operations under regional anæsthesia have been the facts that the hemorrhage is very much less than it is under any inhalation anæsthesia and the subsequent drop in blood pressure is not nearly so great. In only three cases has the post-operative blood pressure been less than 100 mm. out of 210 operations performed by this method in the past eleven and one-half months.

It is well to avoid post-operative pain by any

the other hand, if one waits until a thorough anæsthesia occurs the patient goes through the operation without protest

#### TECHNIQUE OF ADMINISTERING PARAVERTEBRAL ANÆSTHESIA FOR RENAL OPERATIONS

It is of the utmost importance that all nervous excitation be reduced to a minimum. The procedure should be briefly explained to the patient and he may be informed as well of the advantages to be gained by a painless operation without a general anæsthetic. The lessened danger and post operative discomfort should also be called to his attention. The patient must be apprised of the fact that he will feel a half dozen or so little needle pricks when the first injections are made. That after these perhaps a few pulling sensations may be felt, which will at once be relieved on his calling attention to them.

The confidence of the patient is as absolutely essential here, as it is in all regional procedures. Naturally more difficulty will be experienced in highly nervous individuals than in those of a more stolid type.

In the Illyes clinic, morphia and atrophine are rarely used in the preparation of the case for operation, and they believe their patients do better without it. Our fellow countrymen are as a rule quite different from the European. They have as a general thing either been living under high nervous tension, or a more or less protected existence. We prefer to give morphine in fractional doses as recommended by Gwathmey.

When the patient is taken to the operating room, he should be lying comfortably on his back on the carriage. Avoid all unnecessary display of instruments and appliances, or signs of haste or flurry. Position. The best possible position for administering the anæsthetic is to place him sitting on the side of the table, body bent slightly forward with shoulders also rolled a little anteriorly and the head slightly bowed. The patient's feet should rest on chairs, placed at such a height that they just allow the thighs to form a right angle with the abdomen. An attendant should stand in front of the patient, and provide the necessary support.

In paravertebral anæsthesia applied to renal operations it is only necessary to use the nerve blocking on one side, as our procedures are usually unilateral. To achieve success in this anæsthesia we must successfully block the eighth, ninth, tenth, eleventh and twelfth dorsal nerves. These nerves all send off branches which in one way or another reach the anterior, lateral and posterior parts of the abdominal wall, supplying one or all of its cutaneous and muscular planes. With the lumbar plexus we are chiefly concerned with the first lumbar and its two main branches, the Ilio-hypogastric and the Ilio-inguinal nerves. A few branches from some of the other lumbar nerves may appear, but even though they are

unimportant, will be well covered by our regional block of that area.

After the patient is comfortably posed, we proceed to the location of our landmarks, and as each one is reached, it should be daubed with iodine or some other fairly indelible antiseptic substance. For our intercostal injections we locate a spot for needle puncture starting in its eighth space, usually opposite the angle of the scapula, and then down in each successive space, till we reach the twelfth nerve below the last costal border. These punctures are about three and a half to four centimeters from the midline of the back, roughly a little over two fingers breadth from the spinous process. One must be fairly sure that he has the right spinous process as they sometimes are quite irregular.

We now look for the landmarks of our lower abdominal block or as some call it, the Quadratus block. For this purpose take a point about three centimeters from the spine of the first lumbar vertebral extending anteriorly. Then a point opposite the anterior end of the twelfth rib and above the anterior superior spine of the ilium. The lower landmarks are the interior and posterior spines of the ilium. Over each one of these points we have noted we raise a weal with a medium size Luer type syringe and needle, using one per cent novocaine. For nerve blockings the European clinics use what is known as an eight to ten cm Schieber canula. In this country the Labat needles of about a length similar to those we use in our parasacral anæsthesia answer the purpose quite well.

The injections are started by inserting our needle first through the weals in the intercostal spaces at right angles to the surface of the rib, down to its lower border, injecting as we go. When the lower edge of the rib is struck we withdraw the needle a little and then incline it to an angle of forty to forty-five degrees in the direction of the vertebral column. The needle is then forced over close along the lower inferior border of the rib until we impinge upon the body of the vertebra. This brings us close to the intervertebral foramen, and between the ribs and transverse processes.

Hartel advises at this point that we proceed with caution, as here there is the possible danger of toxic symptoms from rapid absorption of the anæsthetic or its entrance into the Dural Sack. However, in this particular technique the anæsthetic does not reach this point in such a massed amount as recommended by Kappis, Ziegel, Jentzer and others. Our injection is continuous from the time the puncture is first made until we impinge upon the vertebra, so that there is no concentration anywhere or is it necessary. Five cc of the novocaine is used in each dorsal nerve block, from the eighth to the eleventh. As the twelfth nerve is below the rib and its branches



# EDITORIALS



The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions, published in the Journal. Views expressed in the various departments of the Journal represent the views of the writer.

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N. Y.  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication.

*Editor-in-Chief*—NATHAN B. VAN ETEN, M.D.,  
New York  
*Associate Editor*—ORRIN SAGE WIGHTMAN, M.D.,  
New York  
*Executive Editor*—FRANK OVERTON, M.D.  
Pachogue

### COMMITTEE ON PUBLICATION

E. ELIOT HARRIS, M.D., *Chairman* New York  
ORRIN SAGE WIGHTMAN, M.D. New York  
EDWARD LIVINGSTON HUNT, M.D. New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

*President*—OWEN E. JONES, M.D. Rochester  
*First Vice President*—GEORGE A. LEITCHER, M.D. Piermont  
*Second Vice President*—LUTHERNE COVILL, M.D. Ithaca  
*Speaker*—E. ELIOT HARRIS, M.D. New York  
*Vice-Speaker*—GEORGE M. FISHER, M.D. Utica  
*Secretary*—EDWARD LIVINGSTON HUNT, M.D. New York  
*Assistant Secretary*—WILBUR WARD, M.D. New York  
*Treasurer*—CHARLES GORDON HEND, M.D. New York

### CHAIRMEN, STANDING COMMITTEES

*Arrangements*—FREDERICK H. FLAHERTY, M.D. Syracuse  
*Public Health and Medical Education*  
JOSHUA M. VAN COTT, M.D., Brooklyn  
*Scientific Work*—ANDREW MACFARLANE, M.D. Albany  
*Medical Economics*—HENRY LYLE WINTER, M.D. Cornwall  
*Legislation*—JAMES N. VANDER VEER, M.D. Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex-President and the Councilors of the District Branches

*First District*—EDWARD C. RUSHMORE, M.D. Tuxedo Park  
*Second District*—FRANK H. LASHER, M.D. Brooklyn  
*Third District*—ARTHUR J. BEDELL, M.D. Albany  
*Fourth District*—CHARLES C. TREMBLEY, M.D. Saranac Lake  
*Fifth District*—NELSON O. BROOKS, M.D. Oneida  
*Sixth District*—GEORGE H. FOX, M.D. Binghamton  
*Seventh District*—WILLIAM I. DEAN, M.D. Rochester  
*Eighth District*—HARRY R. TRICK, M.D. Buffalo

### COUNSEL

GEORGE W. WHITESIDE, Esq., 27 William St. New York  
Telephone, Broad 1744

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St. New York

### EXECUTIVE OFFICER

JOSEPH S. LAWRENCE, M.D. 51 Chapel Street, Albany

### SECTION OFFICERS

*Medicine*  
*Chairman*—ROBERT L. LEVY, M.D. New York  
*Secretary*—L. WHITTINGTON GORHAM, M.D. Albany  
*Surgery*  
*Chairman*—MARSHALL CLINTON, M.D. Buffalo  
*Secretary*—EDWARD S. VAN DYKE, M.D. Syracuse  
*Obstetrics and Gynecology*  
*Chairman*—HAROLD C. BAILEY, M.D. New York  
*Secretary*—NATHAN P. SEARS, M.D. Syracuse  
*Pediatrics*  
*Chairman*—JOSEPH C. PALMER, M.D. Syracuse  
*Vice-Chairman*—ROGER H. DENNETT, M.D. New York  
*Secretary*—ARTHUR W. BENSON, M.D. Troy  
*Eye, Ear, Nose and Throat*  
*Chairman*—ARTHUR G. BENNETT, M.D. Buffalo  
*Secretary*—EUGENE E. HINMAN, M.D. Albany  
*Public Health, Hygiene and Sanitation*  
*Chairman*—PAUL B. BROOKS, M.D. Albany  
*Secretary*—ARTHUR D. JACQUES, M.D. Lynbrook  
*Neurology and Psychiatry*  
*Chairman*—EUGENE N. BOUDREAU, M.D. Syracuse  
*Secretary*—CLARENCE O. CENEY, M.D. Utica

## PERIODIC HEALTH EXAMINATIONS

How to interest physicians in making periodic health examinations has been widely discussed during the past year. The physicians of New York State have done pioneer work in actually preparing themselves for the examinations. The group which composes the Medical Society of the County of Kings was the leader in the movement (see this Journal, 1924, pages 739 and 905), and now New York County is working out the same problem, but along slightly different lines. Both, however, confine their activities to the education of physicians, and leave the question of reaching the people to lay organizations.

The general features of the Brooklyn campaign for periodic health examinations has been as follows:

1 Preliminary lectures at the meetings of the Medical Society of the County of Kings

2 The formation of the Brooklyn Health Examination committee of representative physicians and laymen in order to reach both physicians and laymen

3 The examination of one hundred medical men and a discussion of the findings by experts, as the first step in educating physicians how to make the examinations

4 The preparation of four-page leaflets,—the so-called gray leaflets,—setting forth the principles of making the examinations. Leaflets have already been prepared on Venereal Diseases, and on Cancer, and a copy has been sent to every physician in Brooklyn.

means possible. With inhalation anæsthesia the patient recovers consciousness in from 10 minutes to 2 or 3 hours after the completion of the operation. The patient then begins to suffer pain which is much more severe if he is too tightly packed, and this has frequently been the cause of bringing on shock, because it occurs at just the time when the reaction period is at its lowest ebb, as shown by the blood pressure level.

A particularly great advantage of the regional anæsthesia as induced by novocaine is that its effect continues from six to 10 hours to a certain extent and tides the patient over this trying period of depression so that he frequently does not have pain at all and usually sleeps well the night after operation.

### SHOCK

Shock is induced by loss of blood, traumatism of tissues with subsequent pain, and injury to the nervous mechanism. Certain toxic substances are also frequently a factor. It is marked by very low or imperceptible blood pressure, cold, clammy skin, rapid, shallow breathing and various other well known symptoms and signs. Since the adoption of regional anæsthesia in our operations upon the kidney and prostate, shock has almost disappeared from our wards. There has been one case of shock in the past year and that one was not fatal.

Before instituting regional anæsthesia we were well versed in the treatment of shock and felt called upon to write a paper on the subject.

The ordinary methods of combatting shock are familiar to everyone. They consist of raising the foot of the bed, keeping the patient warm, the administering of fluids and stimulants by mouth and rectum, salt solution administered intravenously raises the blood pressure for 30 minutes and in slight cases this is often enough to tide them over. We prefer, however, the use of gum-glucose solution as prepared by the New York Hospital Laboratory and described by us in 1921. This method is a slight modification of that successfully used by Ward and Farrar at the Woman's Hospital.

The physico-chemical principles involved in the use of this intravenous medium are fundamentally as follows: glucose being a crystalloid, like salt, will absorb water through a semipermeable membrane—and peripheral blood vessel wall is a semi-permeable membrane. Tatum noted that in shock and following hemorrhage there was increase in the dextrose content of the blood and he explained this as an effort on the part of the organism to combat the pathology. Hence the incorporation of the sugar substance with

the acacia. However, even though this deduction be not appropriate, the use of glucose intravenously is not new and when given according to Woodyatt's formula, viz., 0.8 grams per kilogram of body weight, it is utilized in toto. More rapid introduction leads to elimination with an excessive excretion of water through the kidneys. The gum is a colloidal substance, in 6 per cent solution it represents a viscosity equal to that of blood and the osmotic pressure of the blood colloids. Hence this solution cannot leave the circulatory system, and what is more, will hold in the circulation the fluid that the crystalloid glucose has attracted by osmosis. In summary, therefore, and by comparison with saline, similarly a crystalloid when introduced into the blood stream passes rapidly into the cell tissues and it, being a non-oxidizable substance, rapidly reverses the process and a subsequent waterlogging of tissues occurs. Clinically this may be expressed in terms of blood pressure that is elevated and maintained for an average thirty-maximum minute period by saline, at the end of which time it has left the circulation. With gum-glucose, on the other hand, the pressure is elevated and maintained for a minimum of three hours at the initial level with a slight subsequent fall, yet seldom to the danger threshold.

An important thing to remember in shock is that many a person has been killed by kindness. The proper procedure is to take all the measures possible for the benefit of the patient, then leave him strictly alone and do not allow internes, nurses or orderlies to bedevil him with unnecessary hospital routine measures. More patients have been brought out of shock by intelligent neglect after proper methods of stimulation have been instituted than have been by elaborate methods which perpetually annoy the shocked patient.

### CONCLUSIONS

The conclusions to be drawn from this study are:

- 1 Major operative procedures upon the kidney and prostate under regional anæsthesia are being done successfully.

- 2 There is much less bleeding by this method than by any inhalation anæsthesia.

- 3 The patient ordinarily suffers no pain for 7 or 8 hours after operation, hence avoiding this dangerous element in the production of post-operative shock.

- 4 The development of new and less toxic anæsthetic agencies and methods of administering them bids fair to mark the next great progress in urological surgery.





# LEGAL



By GEORGE W. WHITESIDE, Esq.  
Counsel, Medical Society of the State of New York

## THE NICOLL CHIROPRACTIC BILL

Assemblyman Nicoll has introduced a bill known as Introduction No 185, which is entitled "An Act to Define and Regulate the Practice of Chiropractic"

The effect of this bill, if passed, would be to permit upwards of a thousand chiropractors now practicing in this State, to be licensed without any test of their fitness. One of these persons so licensed, whose qualifications have not been the subject of any test by the State, is entitled to be appointed by the Regents an additional member of the State Board of Medical Examiners, and such appointee is given the right to summon witnesses and compel their attendance and to take testimony concerning any matter over which the Board of Medical Examiners has jurisdiction, whether it relates to chiropractic or any other subject with which the Board has to do.

Such additional member of the Board need have no educational qualification that the Regents may inquire into other than that of graduation from a chiropractic school requiring a minimum attendance of nine continuous months and a maximum attendance of eighteen months over a given period of time. And as to this attendance and this qualification, the certificate of a chiropractic school shall be *prima facie* proof.

In this bill, therefore, it appears, as in previous bills giving special privileges to chiropractors, that the chiropractic school is the judge of fitness for license rather than the officials of the State of New York. These institutions are primarily interested in the financial return obtained from tuition fees, as they are corporations organized and existing

for profit. In the main they are privately owned and are not essentially educational institutions, but business enterprises. The exemption from examination is further predicated upon the requirement that such a chiropractor shall have practised a given number of years in this State.

It has been held that chiropractors practice medicine in violation of the Medical Practice Act. A number have been convicted of this offense, and at least one during the last year, who would meet every requirement of the Nicoll bill for license as a chiropractor without examination, was convicted of manslaughter and sentenced to Sing Sing prison. Nevertheless, the Nicoll bill makes a virtue of such offenses against the law and rewards continuous practice in violation of the law by granting to the wrongdoer a license without examination.

The Regents, under this bill, are given no power over the chiropractic schools from which those seeking exemption have heretofore received diplomas. The diploma mill graduate must be exempted from examination if he can prove attendance upon a chiropractic school for the required time.

The exemption clause of this bill, therefore, is no part of any plan for the regulation of the practice of chiropractic, but is the grant of a special privilege to certain individuals now defying the law of this State, to whom the bill is to be a reward for their transgression rather than a test of their fitness. The vice of these provisions of this bill should be clearly exposed.

## PREGNANCY—COMPLICATED BY CYSTITIS—DRY LABOR —METASTATIC ABSCESES.

In the fourth month of her pregnancy a prospective mother consulted a physician and made arrangements with a maternity hospital for her pre-natal care and for attendance upon her at the time of her delivery. Periodic physical and urinary examinations were made. Examination of the urine revealed that the prospective mother was suffering from a chronic interstitial nephritis which was confirmed by the blood pressure findings, which were 148/82, and at a later date

160/80. Upon these findings the patient was ordered on a strict non-protein diet and other instructions were given her for her proper care and conduct. She was also advised to appear bi-weekly for routine examination until she became in active labor. Upon measurement the pelvis was found to be normal in size. During the pre-natal period, upon examination, the presentation, position and posture of the fetus were determined. Two weeks prior to her de-

5 The preparation of a form for recording the results of the examinations

6 Enlisting the cooperation of the Brooklyn Tuberculosis Committee in bringing the need of having the examinations made to the attention of the people of Brooklyn through the Brooklyn Health Examination Committee

7 The establishment of a clinic for the examination of those who are unable to pay for the service

The period of time since the plans have been put into operation has been too short to permit reports to be made regarding the success of the work. The plan is going forward satisfactorily.

The Medical Society of the County of New York formally voted to undertake a campaign for periodic health examinations at its meeting on May 26, 1924, and appointed committees to carry on the work. The general committee made its report at a meeting of the Society on December 9th. This report was printed on page 32 of last week's JOURNAL.

The New York County plan sub-divides the work into three subdivisions

1 The education of the physician

2 The technique and methods of securing and filing histories for physicians

3 Publicity for the physician and the public

The plan for the education of physicians has already been put into operation, and consists of a symposium of seventeen lectures as described in last week's JOURNAL. Each lecture is given by a prominent specialist who was chosen because of his teaching ability as well as his skill in his own line. We printed an abstract of the first lecture, that on Gastro-Intestinal Diseases, in last week's JOURNAL, and we are printing one on Genito-Urinary Conditions on page 93 of this issue.

This is pioneer work. The lecturers have had no precedent to follow, and are to be commended for responding to the call to prepare simple talks on the pre-clinical signs of diseases in their several specialties. We hope to be able to print abstracts of the whole series for the instruction and encouragement of physicians throughout New York State, and the Nation.

Physicians who attempt to make periodic health examinations are entering a field which is almost new and untried. When a research worker enters a new field of work, he usually does so quietly, and works upon his problem for months or years before he announces his find-

ings. But the very nature of the problem of making periodic health examinations requires a considerable amount of publicity. This is embarrassing to an ethical physician who is undertaking a new line of work, and who fears that he may either omit something essential or put too much stress on a minor sign. The requirement is that a physician shall have in mind the essential signs of approaching disease in practically all the specialties in medicine. It is not required that the examiner shall be a specialist in any of these lines, but it is required that he shall be keen to perceive a few symptoms to which he has previously given little thought. Dr. Chace, for example, in the first lecture, stressed heart-burn and other common signs of indigestion as the precursors of gastro-duodenal ulcer, appendicitis, cholecystitis, tuberculosis, and other grave conditions, and Dr. Keyes stressed the importance of frequent painful urination as a sign of an approaching genito-urinary disorder, and dwelt upon the necessity of including a rectal examination in every general examination of an adult patient. Now and then a physician may be found who habitually carries in mind a few common symptoms in each of the seventeen specialties on which lectures are given in the New York County symposiums, but we have our grave doubts that any considerable number of physicians have this knowledge at their finger tips, or that they can recall all the signs during the course of an examination. Our opinion is confirmed by hearing the remark frequently made by prominent physicians who heard the lectures, that they had not thought about this or that point before.

It is easy for an amateur examiner to tell a patient that he is threatened with gastric ulcer, or cancer, or heart failure, or Bright's disease, or insanity, and so give the patient a fright. The reaction of that patient will be to go to another doctor who will tell him to go home and forget his trouble, on the ground that there is nothing the matter. Another type of patient will seek the doctor who for a big financial consideration will claim to ward off the approaching disease by a long course of treatment. The best preventive of either of these results is a knowledge of the fundamental preclinical signs of disease in each specialty. This is the object of the lectures of the New York County Symposium.

The Medical Societies of the counties of Onondaga, Monroe and Albany, have already taken steps to promote the periodic examinations in their communities. We shall be pleased to print reports of the progress of the work in any county that undertakes it.



# LEGAL



By GEORGE W WHITESIDE, Esq  
Counsel Medical Society of the State of New York

## THE NICOLL CHIROPRACTIC BILL

Assemblyman Nicoll has introduced a bill known as Introduction No 185, which is entitled "An Act to Define and Regulate the Practice of Chiropractic"

The effect of this bill, if passed, would be to permit upwards of a thousand chiropractors now practicing in this State, to be licensed without any test of their fitness. One of these persons so licensed, whose qualifications have not been the subject of any test by the State, is entitled to be appointed by the Regents an additional member of the State Board of Medical Examiners, and such appointee is given the right to summon witnesses and compel their attendance and to take testimony concerning any matter over which the Board of Medical Examiners has jurisdiction, whether it relates to chiropractic or any other subject with which the Board has to do.

Such additional member of the Board need have no educational qualification that the Regents may inquire into other than that of graduation from a chiropractic school requiring a minimum attendance of nine continuous months and a maximum attendance of eighteen months over a given period of time. And as to this attendance and this qualification, the certificate of a chiropractic school shall be *prima facie* proof.

In this bill, therefore, it appears, as in previous bills giving special privileges to chiropractors, that the chiropractic school is the judge of fitness for license rather than the officials of the State of New York. These institutions are primarily interested in the financial return obtained from tuition fees, as they are corporations organized and existing

for profit. In the main they are privately owned and are not essentially educational institutions, but business enterprises. The exemption from examination is further predicated upon the requirement that such a chiropractor shall have practised a given number of years in this State.

It has been held that chiropractors practice medicine in violation of the Medical Practice Act. A number have been convicted of this offense, and at least one during the last year, who would meet every requirement of the Nicoll bill for license as a chiropractor without examination, was convicted of manslaughter and sentenced to Sing Sing prison. Nevertheless, the Nicoll bill makes a virtue of such offenses against the law and rewards continuous practice in violation of the law by granting to the wrongdoer a license without examination.

The Regents, under this bill, are given no power over the chiropractic schools from which those seeking exemption have heretofore received diplomas. The diploma mill graduate must be exempted from examination if he can prove attendance upon a chiropractic school for the required time.

The exemption clause of this bill, therefore, is no part of any plan for the regulation of the practice of chiropractic, but is the grant of a special privilege to certain individuals now defying the law of this State, to whom the bill is to be a reward for their transgression rather than a test of their fitness. The vice of these provisions of this bill should be clearly exposed.

## PREGNANCY—COMPLICATED BY CYSTITIS—DRY LABOR —METASTATIC ABSCESSES

In the fourth month of her pregnancy a prospective mother consulted a physician and made arrangements with a maternity hospital for her pre-natal care and for attendance upon her at the time of her delivery. Periodic physical and urinary examinations were made. Examination of the urine revealed that the prospective mother was suffering from a chronic interstitial nephritis which was confirmed by the blood pressure findings, which were 148/82, and at a later date

160/80. Upon these findings the patient was ordered on a strict non-protein diet and other instructions were given her for her proper care and conduct. She was also advised to appear bi-weekly for routine examination until she became in active labor. Upon measurement the pelvis was found to be normal in size. During the pre-natal period, upon examination, the presentation, position and posture of the fetus were determined. Two weeks prior to her de-

livery she entered the hospital complaining of labor pains. Upon examination it was found that the same were not true labor pains, and the patient was advised to return to her home and to come to the hospital again upon the appearance of the true labor pains.

Several weeks later she returned to the hospital, at that time in active labor. A vaginal examination revealed the cervix  $2\frac{1}{2}$  fingers dilated and that the membrane had ruptured prior to the examination. Upon examination the foetal heart could not be heard. After examination the patient was placed in bed to await further dilation. Repeated examinations by auscultation were made to determine the presence of the foetal heart, which, however, was not heard. On the following morning, about sixteen hours after the patient's entry into the hospital, the cervix was found fully dilated, but again the foetal heart could not be heard. An obstetrician was then called in consultation by the attending physician, who examined the patient and found the position of the fetus to be R O P, but he could not hear the foetal heart, and the patient was advised that her child was undoubtedly lifeless and it would be necessary to deliver her by forceps under a general anaesthesia. After catheterization a general anaesthesia was administered to the patient and with low forceps she was delivered of a still-born. The placenta was expelled intact. Pituitin was administered to the patient and she was returned to bed.

For several days after the delivery it was necessary to catheterize the patient and medication was also administered. On the fourth day after the delivery the patient had a sudden rise in temperature from practically normal to  $104^{\circ}$  with complaint of headache and pain on urination. During the next seven days the temperature ranged from  $101^{\circ}$  to  $104.2^{\circ}$  with her pulse about 120. The patient also complained of continuous headache and pain on urination. During this time medication was administered to the patient and repeated examinations made of the urine and blood. On the latter day a consultant was called in to examine the patient. For about a month the patient's condition did not improve, she continued to have a soaring temperature, with a continuance of the other complaints. Examination at this time disclosed swellings upon the left buttock and calf of the left leg. This was diagnosed as metastatic abscesses and incised on the following day by the consultant who had been called in. The pus was evacuated from the abscesses and the wounds packed and drained. The patient remained in the hospital for about six weeks thereafter. During part of the time the wounds were discharging profusely and were dressed and irrigated daily.

At the time the patient left the hospital there was an impairment of function in the left leg. A physical examination disclosed that this impairment of function of the left leg was not due to any nerve lesion, as her reflexes and muscular conformation were found to be quite normal, that while she was able to walk, her gait was rather awkward due to the fact that she was tremendously overweight above her hips, and because of the lack of use, her legs were becoming weaker. At the time of the physical examination the two scars caused by the incision of the abscesses on the buttock and calf of the leg had healed.

Shortly after leaving the hospital this patient caused a suit to be instituted against the hospital and the physicians who attended her, charging them with failure to furnish her with the necessary care and attention at the time she entered and was a patient in the hospital. In her complaint, as a specification of negligence, she claimed that no examination was made of her between the time she entered the hospital at about 6 P M and 7 A M the following morning, when she was informed that she had a dead child in her body. She also claimed that due and proper care were not taken in the delivery of the dead fetus, in that the instruments used were not properly sterilized, as she claimed her body, immediately after delivery, became unusually swollen, inflamed and diseased to an alarming extent. She claimed that by reason of the infection she was compelled to remain four additional months in the hospital. She also claimed that her pedal extremities were permitted to be without a fair and proper amount of circulation, exercise and massage during her confinement in the hospital, which condition caused a shrinkage of the muscles and cords and necessitated the subsequent use of wheel chairs and crutches for her means of locomotion.

Extensive preparation was made in this action and when the case came on for trial the court directed the impanelling of a jury for the trial of the action. Plaintiff's attorney sought to procure a settlement, even for a small amount. In carrying out the policy of the State Society in the defense of malpractice actions to make no settlement in an action where it does not appear that the defendant physician was guilty of any negligence or error in his treatment of the patient, the repeated attempts of the plaintiff's attorney to procure a settlement were refused. After the plaintiff's attorney had exhausted his endeavors to settle the action, he consented to its discontinuance, thus favorably ending another action against the physicians.



# LEGISLATION



By JAMES N VANDER VEER, M.D.  
*Chairman Committee on Legislation*

## EVOLUTION OF MEDICAL POLITICS \*

Medical politics may be defined as the study of the methods by which the services of the profession can most easily and suitably be made available to the community. As I have often said, in earlier and simpler days when the relation of the doctor to patient was that of individual dealing with individual, there was little or no need for collective organization of the profession. The doctor, who owed no duty except to the patient who employed him, simply did his best as a man and a doctor for that patient, and needed no organization to help him. But with the growth of collective employment of doctors by associations, corporations, and the State, the profession has been compelled to study sociological and

political problems and to adapt itself to new and constantly changing conditions.

All controversies relating to fees, ethics, conditions of service, and the like, resolve themselves on analysis into an attempt, by a process of "trial and error," to find new ways or improve the existing ways by which the services of the profession are made available to those who need them. Every employer knows that if a workman is compelled to work for insufficient wages or in surroundings which are unsuitable, that workman will not do the best work of which he is capable. In the same way, if the conditions of employment of medical men are repugnant to their feelings and traditions, or if their payment is inadequate, patients will not get the best of which the profession is capable.

\* From an address by Alfred Cox, M.A., B.D., Medical Secretary, British Medical Association in *British Medical Journal*. Reprinted from the *American Medical Association Bulletin*, December, 1924.

## LEGISLATIVE NOTES

The 1925 legislature is now in session and already it is being flooded by bills of every character, including a number that would have a direct bearing upon the practice of medicine. Among these are our familiar friends the narcotic bill, the chiropractic bill and the medical inspection bill.

We hope that the chairmen of the County Societies will impress their legislators with the importance of acting deliberately on matters that would affect the practice of medicine. We hope, also, that the efforts are not limited to the chairmen, but that every member of the Society will assist by accepting the opportunity, wherever presented, of placing squarely before the lay public the physicians' honest desire to protect the public

welfare, and the obligation upon the public to assist them with favorable legislation.

The Medical Practice Act which has been prepared by the Department of Education has been introduced into the Legislature, and will be printed in our next week's issue.

The following organization was effected in the Legislature:

In Senate—President, pro tem, John Knight, clerk, Ernest Fay, Democratic floor leader, James J. Walker.

In Assembly—Speaker, Joseph A. McGinnies, clerk, F. W. Hammond, Republican floor leader, Simon W. Adler, Democratic floor leader, Morris Bloch.

## SUMMARY OF BILLS IN SENATE

Senate Int. No. 11—A bill introduced in the Senate by Senator Seabury C. Mastick of Westchester County, concurrent Assembly Int. No. 64, introduced in the Assembly by Assemblyman Herbert R. Shonk of Westchester County, would amend sections 172, 181, Labor Law, by prohibiting employment of females over 16 years of age more than 48 hours a week in factories and mercantile establishments, except that for not exceed-

ing eight weeks in any year, divided into not more than two periods, females may be employed not more than six days or 54 hours a week or nine hours a day, provided notice of such extension of working hours be sent to Industrial Commissioner at least three days before.

Referred to Labor and Industries Committee or both Houses.

livery she entered the hospital complaining of labor pains. Upon examination it was found that the same were not true labor pains, and the patient was advised to return to her home and to come to the hospital again upon the appearance of the true labor pains.

Several weeks later she returned to the hospital, at that time in active labor. A vaginal examination revealed the cervix  $2\frac{1}{2}$  fingers dilated and that the membrane had ruptured prior to the examination. Upon examination the foetal heart could not be heard. After examination the patient was placed in bed to await further dilation. Repeated examinations by auscultation were made to determine the presence of the foetal heart, which, however, was not heard. On the following morning, about sixteen hours after the patient's entry into the hospital, the cervix was found fully dilated, but again the foetal heart could not be heard. An obstetrician was then called in consultation by the attending physician, who examined the patient and found the position of the fetus to be R O P, but he could not hear the foetal heart, and the patient was advised that her child was undoubtedly lifeless and it would be necessary to deliver her by forceps under a general anaesthesia. After catheterization a general anaesthesia was administered to the patient and with low forceps she was delivered of a still-born. The placenta was expelled intact. Pituitin was administered to the patient and she was returned to bed.

For several days after the delivery it was necessary to catheterize the patient and medication was also administered. On the fourth day after the delivery the patient had a sudden rise in temperature from practically normal to  $104^{\circ}$  with complaint of headache and pain on urination. During the next seven days the temperature ranged from  $101^{\circ}$  to  $104.2^{\circ}$  with her pulse about 120. The patient also complained of continuous headache and pain on urination. During this time medication was administered to the patient and repeated examinations made of the urine and blood. On the latter day a consultant was called in to examine the patient. For about a month the patient's condition did not improve, she continued to have a soaring temperature, with a continuance of the other complaints. Examination at this time disclosed swellings upon the left buttock and calf of the left leg. This was diagnosed as metastatic abscesses and incised on the following day by the consultant who had been called in. The pus was evacuated from the abscesses and the wounds packed and drained. The patient remained in the hospital for about six weeks thereafter. During part of the time the wounds were discharging profusely and were dressed and irrigated daily.

At the time the patient left the hospital there was an impairment of function in the left leg. A physical examination disclosed that this impairment of function of the left leg was not due to any nerve lesion, as her reflexes and muscular conformation were found to be quite normal, that while she was able to walk, her gait was rather awkward due to the fact that she was tremendously overweight above her hips, and because of the lack of use, her legs were becoming weaker. At the time of the physical examination the two scars caused by the incision of the abscesses on the buttock and calf of the leg had healed.

Shortly after leaving the hospital this patient caused a suit to be instituted against the hospital and the physicians who attended her, charging them with failure to furnish her with the necessary care and attention at the time she entered and was a patient in the hospital. In her complaint, as a specification of negligence, she claimed that no examination was made of her between the time she entered the hospital at about 6 P M and 7 A M the following morning, when she was informed that she had a dead child in her body. She also claimed that due and proper care were not taken in the delivery of the dead fetus, in that the instruments used were not properly sterilized, as she claimed her body, immediately after delivery, became unusually swollen, inflamed and diseased to an alarming extent. She claimed that by reason of the infection she was compelled to remain four additional months in the hospital. She also claimed that her pedal extremities were permitted to be without a fair and proper amount of circulation, exercise and massage during her confinement in the hospital, which condition caused a shrinkage of the muscles and cords and necessitated the subsequent use of wheel chairs and crutches for her means of locomotion.

Extensive preparation was made in this action and when the case came on for trial the court directed the impanelling of a jury for the trial of the action. Plaintiff's attorney sought to procure a settlement, even for a small amount. In carrying out the policy of the State Society in the defense of malpractice actions to make no settlement in an action where it does not appear that the defendant physician was guilty of any negligence or error in his treatment of the patient, the repeated attempts of the plaintiff's attorney to procure a settlement were refused. After the plaintiff's attorney had exhausted his endeavors to settle the action, he consented to its discontinuance, thus favorably ending another action against the physicians.

tion of any of them or any synthetic substitute of any of them identical in chemical composition, but not apomorphine and its salts

12 "Cannabis indica" or "cannabis sativa" shall include any compound, manufacture, salt, derivative or preparation thereof and any synthetic substitute of any of them identical in chemical composition

13 "Habit forming drugs" shall mean coca leaves, opium, cannabis indica or cannabis sativa

14 "Manufacturer" means a person who by compounding, mixing, or other process of manufacture, produces or prepares habit forming drugs for sale on written orders and does not include an apothecary who compounds habit forming drugs to be sold or dispensed on prescription

15 "Wholesaler" means a person who supplies habit forming drugs on written orders

16 "The Harrison act" means the act of Congress, entitled "An act to provide for the registration of, with collectors of internal revenue, and to impose a special tax upon all persons who produce, import, manufacture, compound, deal in, dispense, sell, distribute, or give away opium or coca leaves, their salts, derivatives or preparations and for other purposes," approved December seventeenth, nineteen hundred and fourteen, as heretofore or hereafter amended

§ 422 Acts dangerous to public health Any unauthorized possession, control over, sale, distribution, prescribing, administering or dispensing of habit forming drugs is hereby declared to be dangerous to the public health, and a menace to the public welfare

§ 423 Acts prohibited It shall be unlawful for any person to possess, have under his control, sell, distribute, administer, dispense, or prescribe any habit forming drug except as provided in this article

§ 424 Sale on written orders 1 By whom and to whom sold A manufacturer, wholesaler, or apothecary may sell or distribute habit forming drugs only to any of the following persons and upon his written order

a To a manufacturer, wholesaler or apothecary

b To a physician, dentist or veterinarian

c To a public or private hospital

d To a hospital or institution licensed for the treatment of drug addiction

e To a person in charge of a laboratory where habit forming drugs are used for scientific or medical research work, but only for use in such laboratory

f To a person in the employ of the United States or of this state or of any political sub-

division thereof purchasing or receiving the drug by reason of his official duties

g To a captain or proper officer of a ship upon which no regular physician is employed, for the actual medical needs of the officers and crew when not in port Provided, however, that both parties to the transaction in each of the above cases are registered under the Harrison act if required by such act to be so registered

2 Order blanks A written order for the supply of any habit forming drug shall be signed in duplicate by the person giving it or by his duly authorized agent, one duplicate of which shall be presented to the person who sells or distributes such habit forming drugs and in the event of his acceptance of such order, each party shall preserve his duplicate of such order for a period of two years in such a way as to be readily accessible for inspection and it shall be subject to inspection by any public officer or employee engaged in the enforcement of this article Provided, however, that it shall be deemed a compliance with this sub-section if the person giving the order shall have complied with the provisions of the Harrison act respecting the requirements governing order blanks under said act

3 Possession lawful Possession of or control over habit forming drugs, obtained as provided in this section, shall be lawful if in the regular course of business, occupation, profession, employment, or duty of the possessor and in an amount necessary therefor

4 This section shall not apply to the supply of habit forming drugs on prescription or administered or dispensed by a physician, dentist, or veterinarian

§ 425 Preparations and remedies exempted The provisions of this article shall not apply to preparations or remedies which do not contain more than two grains of opium, or more than one-fourth of a grain of morphine, or more than one-eighth of a grain of heroin or more than one grain of codeine, or any salt or derivative of any of them in one fluid ounce, or, if a solid or semi-solid preparation, in one avoirdupois ounce, or to liniments, ointments, or other preparations which are prepared for external use only, except liniments, ointments, and other preparations which contain cocaine or any of its salts or alpha or beta eucaine or any of their salts or any synthetic substitute for them, provided that such remedies and preparations are sold, distributed, dispensed, or possessed as medicines and not for the purpose of evading the intentions and provisions of this article

§ 426 Professional use of habit forming drugs 1 Veterinarians A veterinarian may prescribe, administer or dispense habit forming drugs in

## THE NARCOTIC BILL

Senate Int No 115—A bill introduced in the Senate by Senator Morton J Kennedy of New York, concurrent Assembly Int No 215, introduced in the Assembly by Assemblyman Morris Weinfeld of New York, would add new article 22, and amend section 4-b, Public Health Law, and repeals section 1746, Penal Law, relative to habit-forming drugs

Referred to Public Health Committee of both Houses

Int 215

IN ASSEMBLY

January 15, 1925

Introduced by Mr Weinfeld—read once and referred to the Committee on Public Health—committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee.

## AN ACT

To amend the public health law, in relation to habit forming drugs, to provide for the control, possession, sale, prescribing, dispensing, dealing and and distribution of such drugs

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," is hereby amended by inserting therein a new article, to be article twenty-two thereof, to read as follows

## ARTICLE XXII

## HABIT FORMING DRUGS

Section 420 Short title

" 421 Definitions

" 422 Acts dangerous to public health

" 423 Acts prohibited

" 424 Sale on written orders

" 425 Preparations and remedies exempted

" 426 Professional use of habit forming drugs

" 427 Prescriptions

" 428 Record to be kept

" 429 Labels

" 430 Authorized possession of drugs by individual

" 431 Physical examination required

" 432 Instruments for injection of habit forming drugs

" 433 Exemption from restrictions

" 434 Drugs delivered to the state hospital commission

" 435 Notice of conviction of professional man sent to licensing board

" 436 Records confidential

" 437 Fraud or deceit

" 438 Commitment of addicts, procedure, discharge

" 439 Exceptions and exemptions not required to be negatived

" 440 Enforcement

" 441 Possession at time article goes into effect

" 442 Penalties

" 443 Constitutionality

§ 420 Short title This article shall be known as the narcotic drug control law

§ 421 Definitions As used in this article

1 "Person" includes any corporation, association, copartnership or one or more individuals

2 "Physician" means a licensed practitioner of medicine as defined by article eight of this chapter

3 "Apothecary" means a licensed pharmacist or druggist as defined by article eleven of this chapter

4 "Dentist" means a licensed practitioner of dentistry as defined by article nine of this chapter

5 "Veterinarian" means a licensed practitioner of veterinary medicine as defined by article ten of this chapter

6 "Medicine" means a drug or preparation of drugs in suitable form for use as a remedial or curative substance

7 "Sale" includes barter, exchange or giving away, or offering therefor and each such transaction made by any person whether as principal, proprietor, agent, servant or employee

8 "Dispense" includes distribute, leave with, give away, dispose of, and deliver to a person or to his agent to be delivered to him

9 "Administer" means only administration by a person authorized to administer habit forming drugs

10 "Coca leaves" includes coca leaves, cocaine, or any compound, manufacture, salt, derivative or preparation thereof, including alpha or beta eucaine, or any of their salts or any synthetic substitute of any of them, identical in chemical composition, but shall not include decocanized coca leaves, or preparations made therefrom or other preparations of coca leaves which do not contain cocaine

11 "Opium" (includes opium, morphine, codeine, diacetyl-morphine heroin) or any compound, manufacture, salt, derivative or prepara-



magistrate, be delivered to the state hospital commission unless destroyed according to law or by regulation of the commission. The commission may receive drugs surrendered to it subject to the rights of any person lawfully entitled thereto, and all drugs in final possession of the commission may be disposed of or destroyed under its direction. The commission shall keep a record of the receipt and disposition thereof.

§ 435 Notice of conviction of professional men sent to licensing board. 1 On conviction of any physician, dentist, veterinarian or apothecary for wilful violation of any of the provisions of this article, a copy of the sentence and of the opinion of the court or magistrate if any be filed, shall be sent by the clerk of the court, or by the magistrate, to the board or officer having power to suspend or revoke the license or registration of the person convicted, for such action as the board or officer deems proper.

2 At the request of such board or officer, the clerk or magistrate shall send to such board or officer a transcript of the record or of the proceedings in a court not of record, and such portion of the evidence as may be requested.

§ 436 Records confidential. Prescriptions, orders, or records required under this article shall not be open to inspection nor shall any information contained therein be divulged except for the purpose of enforcing the laws of this state or the Harrison act, or on the direction of the Department of State Police or of the police department of any city to an officer of another state, for the purpose of enforcing the law of such state.

§ 437 Fraud or deceit. Any fraud, deceit, misrepresentation, subterfuge, concealment of a material fact or the use of a false name or the giving of a false address in obtaining treatment in the course of which habit forming drugs shall be prescribed or dispensed, or in obtaining any supply of such drugs, shall constitute a violation of the provisions of this article and shall not be deemed a privileged communication. The wilful making of any false statement in any prescription, order, report, or record required under this article shall constitute a violation of this article. No person shall for the purpose of obtaining any habit forming drug falsely assume the title or represent himself to be a manufacturer, wholesaler, apothecary, physician, dentist, veterinarian, or make or utter any false or forged order or prescription for or label for a container of or for habit forming drugs, or affix such label, or alter, detach or remove any such label.

§ 438 Commitment of addicts, procedure, discharge. 1 At request of addict. A magistrate upon the voluntary application to him of any habitual user of any habit forming drug, may commit such person to any correctional or

charitable institution maintained by the state or any political subdivision thereof.

2 Person accused of crime. Any trial court having jurisdiction of a defendant who is a prisoner in a criminal action or proceeding, if it appears that the defendant is an habitual user of any habit forming drug and is suffering as a result of such use, may likewise so commit such defendant, at any stage of such action or proceeding and direct a stay of proceedings or suspend sentence pending the period of such commitment but not exceeding sixty days without a further order of the court.

3 Discharge. Whenever the medical officer of the institution, or if there be no medical officer, the superintendent, shall certify to the committing magistrate or court that any person so committed has been sufficiently treated, or give any other reason which is deemed by the magistrate or court to be adequate and sufficient, he may in accordance with the terms of commitment discharge the person so committed, or return such person to await the further action of the court, provided, however, that when such commitment is to an institution under the jurisdiction of the Department of Correction, or other similar department in a city of the first class, where there is a parole commission established pursuant to law, such commission shall act in the place and stead of a chief medical officer for the purpose of making such a certificate.

§ 439 Exceptions and exemptions not required to be negatived. In any complaint, information, indictment, or other writ or in any action or proceeding brought for the enforcement of any of the provisions of this article, it shall not be necessary to negative an exception or exemption, and the burden of offering proof of any such exception or exemption shall be upon the defendant.

§ 440 Enforcement. This article shall be enforced by the judicial and police authorities of the state and of the political subdivisions thereof engaged in the enforcement of the law. Such authorities and their agents shall have access at all times to all orders, prescriptions or records to be kept under this article.

§ 441 Possession at time article goes into effect. Habit forming drugs lawfully in the possession or under control of any person at the time this article goes into effect, may be possessed by him with the same effect as if obtained lawfully under this article.

§ 442 Penalties. A violation of any provision of this article shall constitute a misdemeanor.

§ 443 Constitutionality. If any provision of this article is declared unconstitutional or the application thereof to any person or circum-

good faith and in the course of his professional practice only, and not for use by a human being

2 Dentists A dentist, in good faith and in the course of his professional practice only, may administer or dispense habit forming drugs to patients under his immediate treatment

3 Physicians A physician, in good faith and in the course of his professional practice only, may prescribe, administer, or dispense habit forming drugs

§ 427 Prescription Any apothecary may sell or dispense habit forming drugs to any individual upon a written prescription of a physician, or veterinarian, dated and signed on the day when issued and bearing the full name and address of the patient and the name, address and registry number of the practitioner under the Harrison act if he is required by it to be so registered. The person filling the prescription must write the date of filling and his own signature upon the face of the prescription, and the prescription must be retained on file by the apothecary filling it for two years so as to be readily accessible for inspection, and it shall be subject to inspection by any public officer or employee engaged in the enforcement of this article. The prescription shall not be refilled

§ 428 Record to be kept 1 Physicians, dentists, veterinarians Every physician, dentist and veterinarian shall keep a record of all habit forming drugs administered or dispensed by him, except such as may be administered or dispensed to a patient upon whom he shall personally attend, showing the amount administered or dispensed

2 Manufacturers and wholesalers Manufacturers and wholesalers shall keep a record of the habit forming drugs received and disposed of by them

3 Exempted preparations and remedies Every manufacturer of exempted preparations or remedies shall keep a record of the amount of habit forming drugs received and of all sales of exempted preparations or remedies and every dealer therein shall keep a record of all sales of exempted preparations and remedies

4 Form and preservation Every such record shall be kept for a period of two years from the date of the transaction recorded, and a record required by or under the Harrison act, containing substantially the same information, shall be a compliance with this section. All records required by this section shall be readily accessible for inspection and shall be open to inspection by the proper authorities

§ 429 Labels Whenever an apothecary, pursuant to a written prescription, shall sell or dispense habit forming drugs or whenever a physician, dentist or veterinarian shall dispense any

of such drugs, he shall securely affix to the container of such drug a label stating in legible English the name and address of the physician or veterinarian prescribing or dispensing and of the apothecary or dentist dispensing, the date and the name and address of the person for whom or the owner of the animal for which the drug is dispensed

§ 430 Authorized possession of drugs by individual A person to whom or for whose use any habit forming drug has been sold or dispensed by an apothecary, physician or dentist, or the owner of an animal for which any such drug has been prescribed or dispensed by a veterinarian, may lawfully possess it in the container delivered to him by the person selling or dispensing same.

§ 431 Physical examination required A physician, dentist or veterinarian shall not administer, dispense or prescribe any habit forming drugs except after a physical examination of the person for whom or the animal for which the drug is intended

§ 432 Instruments for injection of habit forming drugs No person except a manufacturer or a wholesale or retail dealer in surgical instruments, apothecary, physician, dentist, veterinarian, nurse or interne shall at any time have or possess a hypodermic syringe or needle or any instrument or implement adapted for the use of habit forming drugs by subcutaneous injections and which is possessed for the purpose of administering habit forming drugs, unless such possession be authorized by the certificate of a physician issued within the period of one year prior thereto

§ 433 Exemption from restrictions 1 Common carriers, employees, public officers The provisions of this article restricting the possessing or having under control of habit forming drugs shall not apply to common carriers or warehousemen or their employees engaged in lawful transportation or storage of such drugs, nor to public officers or employees while engaged in the performance of their official duties, nor to temporary incidental possession by employees or agents of persons lawfully entitled to possession, or by persons whose possession is for the purpose of aiding public officers in the performance of their official duties

2 Interstate commerce This article shall not apply to acts done, or to habit forming drugs possessed in the course of interstate or foreign commerce

§ 434 Drugs delivered to the state hospital commission All drugs which have been seized and judicially determined to have been unlawfully possessed or the title to which has ceased and which have come into the hands of a peace officer shall upon the direction of a court or

the institution and opportunity for it to be heard, the commission having made a record of the proceeding upon such hearing, may, if the interest of the inmates of the institution so demand, for just and reasonable cause then appearing and to be stated in its order, amend or revoke any such license by an order to take effect within such time after the service thereof upon the licensee, as the commission shall determine. Any determination of the commission in respect to the revocation of a license shall be reviewable under certiorari proceedings by the supreme court or a justice therein instituted in the judicial district in which such institution is located. Violation of the provisions of this section shall constitute a misdemeanor, punishable on conviction by a fine of not less than one hundred dollars and not more than five hun-

dred dollars or by imprisonment for not less than sixty days or more than one year or by both such fine and imprisonment. The commission shall have power and authority over all such institutions as provided in this chapter in relation to private institutions for the insane.

§ 2 This act shall go into effect on the first day of January, nineteen hundred and twenty-six, except that applications for licenses may be made to the commission and the commission may make all necessary examinations and grant such licenses from the date on which this act becomes a law.

\* EXPLANATION—Matter in *italics* is new matter in brackets [ ] is old law to be omitted.

*Comment*—Later

## IN ASSEMBLY

Assembly Int No 64—Concurrent Senate Int No 11 See Senate Bill for digest

Assembly Int No 120—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would add new section 213, Labor Law, requiring employers to furnish nursing and first aid service in factories, mercantile and other establishments (Same as A Int No 309 of 1924)

Referred to Labor and Industries Committee

Int 120

IN ASSEMBLY,

January 13, 1925

Introduced by Mr Reich—read once and referred to the Committee on Labor and Industries—committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee.

### AN ACT

To amend the labor law, in relation to furnishing nursing and first aid service in factories and in mercantile and other establishments

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Article seven of chapter fifty of the laws of nineteen hundred and twenty-one, entitled "An act in relation to labor, constituting chapter thirty-one of the consolidated laws," is hereby amended by inserting therein a new section to follow section two hundred and twelve, to be section two hundred and thirteen to read as follows:

§ 213 Nursing and first aid service In addition to the specific requirements prescribed by any provision of this chapter or of the industrial code in relation to the safety and sanitation of factories, mercantile establishments, mines, quarries, tunnels and other places, it shall be the duty

of every employer to furnish in or near any such factory, mercantile establishment, mine, quarry, tunnel or other place in which twenty-five or more persons are employed, nursing and first aid service under medical supervision for such length of time daily as may be prescribed by rule of the board. All nurses so furnished shall be registered nurses who have demonstrated their qualifications in industrial nursing to the satisfaction of the board of health of the city or town where they are employed. As part of such service medicines, dressings, bandages and implements sufficient to render first aid in cases of injury shall be supplied. The board shall adopt rules and regulations to carry into effect the provisions of this section.

§ 2 This act shall take effect immediately.

*Comment*—Inasmuch as this bill is the same as Assembly Int No 309 of last year, we repeat the comment that the bill is impractical as it burdens the populace directly and indirectly with a large tax. The medical profession is antagonistic in that its individual members could not enter into contracts to be present for certain fixed hours at the numerous manufacturing and other establishments which the law would require.

There are not enough registered nurses in the State nor could they be furnished before a number of years to be present even part of a day in more than a small percentage of the employments specified, to say nothing of physicians being tied up for a certain number of hours each day in compulsory attendance, according to their contract with the employers, by the terms of this bill.

Emergencies in health and accident cases in such establishments are now adequately provided for throughout the State within a reasonably short time.

stances is held invalid, the validity of the remainder of the article and the application thereof to other persons and circumstances shall not be affected thereby

§ 2 Section four-b of such chapter, as added by chapter five hundred and fifty-nine of the laws of nineteen hundred and thirteen is hereby amended to read as follows

§ 4-b Duties of commissioner with respect to laboratories 1 The commissioner of health shall establish and maintain one or more laboratories with such expert assistants and such facilities as are necessary for routine examinations and analyses, and for original investigations and research in matters affecting public health He shall have authority to make, at the expense of the state, such examinations and analyses at the request of any health officer or of any physician He may enter into contracts with laboratories in localities accessible to the various portions of the state for the prompt examination of specimens received from local health officers or physicians and for the immediate report thereon, at the expense of the state, provided that all such laboratories shall conform to standards of efficiency established by the public health council, and that no obligation shall be incurred by the commissioner in excess of the sums available therefor

*2 There shall be at least one laboratory analyst who shall examine and analyze all habit-forming drugs as defined in this chapter, submitted to him by an official of the state or of any political subdivision thereof, engaged in the enforcement of the narcotic drug control law or any law of similar purpose and who shall be detailed by the commissioner to aid any such official of the state and to give evidence in any proceeding on behalf of the state in connection with such enforcement*

§ 3 Section seventeen hundred and forty-six of the penal law as added by chapter one hundred and thirty of the laws of nineteen hundred and twenty-three and any and all acts inconsistent with provisions of this article are hereby repealed

§4 Article twenty-two of the public health law is renumbered article twenty-three

§5 This act shall take effect immediately

*Comment*—This is the same bill that was introduced last year and which was then favorably received by the medical profession Comment on the part of the individual members of the Medical Society of the State of New York is invited

Senate Int No 116—A bill introduced in the Senate by Senator Morton J Kennedy of New York, concurrent Assembly Int No 216, introduced in the Assembly by Assemblyman Morris Weinfeld of New York, would add new section 177, Insanity Law, requiring the licensing of private institutions for treatment of narcotic drug addiction

Referred to General Laws Committee of both Houses

Int 216

IN ASSEMBLY,

January 15, 1925

Introduced by Mr Weinfeld—read once and referred to the Committee on Judiciary

AN ACT

To amend the insanity law, in relation to licensing private institutions for the treatment of narcotic drug addiction

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Chapter thirty-two of the laws of nineteen hundred and nine, entitled "An act in relation to the insane, constituting chapter twenty-seven of the consolidated laws," is hereby amended by adding thereto a new section, to be section one hundred and seventy-seven, to read as follows

§ 177 Private institutions for the treatment of narcotic drug addiction No person, association or corporation shall establish or keep an institution for the care, custody or treatment for compensation or otherwise of any person for the habit of taking or using any narcotic drugs, including cocaine, opium, morphine, codeine, diacetyl morphine (heroin), cannabis indica, cannabis sativa, or any compound, manufacture, salt, derivative or preparation of any of them or any synthetic substitute of any of them identical in chemical composition, unless such institution holds a license for such purposes issued by the commission Every application for such a license shall be accompanied by a plan of the premises proposed to be occupied, describing the capacity of the buildings for the uses intended, the extent and location of grounds appurtenant thereto, and the number of patients proposed to be received therein, with such other information and in such form, as the commission may require The commission shall not grant any such license without first having made an examination of the premises proposed to be licensed, and being satisfied that they are substantially as described, and are otherwise fit and suitable for the purposes for which they are designed to be used, and that such license should be granted The commission may, at any and all times, examine and ascertain how far a licensed institution is conducted in compliance with the license therefor, and after due notice to

employment [Any such board of trustees may employ one or more school nurses, who] *Nurses so employed* shall be registered trained nurses and authorized to practice as such. Such nurses when so employed shall aid the medical inspector of the district and shall perform such duties for the benefit of the public schools as may be prescribed by such inspector.

[A medical inspector or school nurse] *Such physicians, surgeons, dentists or nurses* may be employed by the trustees or boards of education of two or more school districts, and the compensation *thereof* [of such inspector], and the expenses incurred [in making inspections of pupils] as provided herein, shall be borne jointly by such districts, and be apportioned among them according to the assessed valuation of the taxable property therein.

[In cities and union free school districts having more than five thousand inhabitants, the board of education may employ such additional medical inspectors as may be necessary to properly inspect the pupils in the school in such cities and union free school districts.]

[The trustees of a common school district or the board of education of a union free school district whose boundaries are coterminous with the boundaries of an incorporated village shall, in the employment of medical inspectors, employ the health officer of the town in which such common school district is located or the health officer of such union free school district, so far as may be advantageous to the interests of such district.]

§ 2 This act shall take effect immediately.

\* EXPLANATION—Matter in *italics* is new matter in brackets [ ] is old law to be omitted.

Comment—This bill has been introduced for a

number of years and has always died in committee and we can hope that it will have no better luck this year, but the unexpected sometimes happens so therefore, let us urge that every reader of this article get busy immediately and advise his legislative representative that unless the bill be revised so as to eliminate those features which provide for "advising, directing or providing for the correction and prevention of such disease or defects and of providing treatment for the same," the physicians cannot support it. We will advise you if the bill makes any progress, but do not wait for such advice before registering your opposition to it as it is now written.

Assembly Int No 152—A bill introduced in the Assembly by Assemblyman Morris Weinfeld of New York, would amend section 13, Workmen's Compensation Law, by striking out provision that claim for medical treatment shall not be valid against employer unless physician within 20 days following first treatment furnish report of injury.

Referred to Labor and Industries Committee  
(Same as A Int No 717 of 1924)

Comment—Later

Assembly Int No 184—A bill introduced in the Assembly by Assemblyman F A Miller of Kings County, would amend section 118, Workmen's Compensation Law, by authorizing physical examinations and practical tests of claimant to determine loss of use and proportionate loss of use of a member, result and test to be part of record. (Same as Senate Int No 468 of 1924)

Referred to Labor and Industries Committee

Comment—Later

## THE CHIROPRACTIC BILL

Assembly Int No 185—A bill introduced in the Assembly by Assemblyman William M Nicoll of Schenectady, to define and regulate the practice of chiropractic.

Referred to Public Health Committee

Int 185

IN ASSEMBLY,

Introduced by Mr Nicoll and referred to Public Health Committee

January 14 1925

AN ACT

To define and regulate the practice of chiropractic

Section 1 Definitions

" 2 The New York State Chiropractic Society, Incorporated

3 Board of Examiners, organization

4 Powers of board

5 Present practitioners exempt from examination

6 Qualifications of applicants for examinations and license

" 7 Examination of applicants

" 8 Licenses

" 9 Waiver of examination

" 10 Registry of license

Assembly Int No 123—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would add new subdivision 10a, section 3601, Tax Law, by permitting deductions from income for tax purposes of all expenses paid during the year for medical, surgical or dental services (Same as A Int No 65 of 1924)

Referred to Taxation and Retrenchment Committee

Int 123

IN ASSEMBLY,

January 13, 1925

Introduced by Mr Reich—read once and referred to the Committee on Taxation and Retrenchment.

#### AN ACT

To amend the tax law, in relation to deductions from income of expenses paid or incurred for medical, surgical or dental services

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section three hundred and sixty of chapter sixty-two of the laws of nineteen hundred and nine, entitled "An act in relation to taxation, constituting chapter sixty of the consolidated laws," as added by chapter six hundred and twenty-seven of the laws of nineteen hundred and nineteen and amended by chapter four hundred and seventy-seven of the laws of nineteen hundred and twenty-one, is hereby amended by adding a new subdivision, to be subdivision ten-a, to read as follows

10-a All expenses paid or incurred during the taxable year for medical, surgical or dental services

§ 2 This act shall take effect immediately

EXPLANATION—Matter in *italics* is new, matter in brackets [ ] is old law to be omitted.

Comment—None

### THE MEDICAL INSPECTION IN SCHOOLS BILL

Assembly Int. No 127—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would amend sections 570, 571, Education Law, by providing that boards of education and trustees shall appoint physicians and dentists and may employ nurses for service in schools

Referred to Public Education Committee

Int 127

IN ASSEMBLY

January 13, 1925

Introduced by Mr Reich—read once and referred to the Committee on Public Education

#### AN ACT

To amend the education law, in relation to medical services in the schools of the state.

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Sections five hundred and seventy and five hundred and seventy-one of chapter twenty-one of the laws of nineteen hundred and nine, entitled "An act relating to education, constituting chapter sixteen of the consolidated laws," as such chapter was amended by chapter one hundred and forty of the laws of nineteen hundred and ten, and as such sections were added by chapter six hundred and twenty-seven of the laws of nineteen hundred and thirteen section five hundred and seventy-one having been amended by chapter one hundred and eighty-two of the laws of nineteen hundred and sixteen, are hereby amended to read respectively as follows

§ 570 Medical [inspection] *services* to be provided Medical [inspection] *services* shall be provided for all pupils attending the public

schools in this state, except in cities of the first class as provided in this article Medical [inspection] *services* shall include the services of [a trained registered nurse, if one is employed, and shall also include such services as may be rendered as provided herein in examining pupils for the existence of disease or physical defects and in testing the eyes and ears of such pupils] *physicians, surgeons and dentists for the purpose of ascertaining the existence of disease or physical defects, of advising, directing or providing for the correction and prevention of such disease or defects and of providing treatment for the same* The *services of trained registered nurses shall be rendered in aid of such services*

§ 571 Employment of medical inspectors The board of education in each city and union free school district, and the trustee or board of trustees of a common school district, shall [employ, at a compensation to be agreed upon by the parties, a competent physician as a medical inspector, to make inspections of pupils attending the public schools in the city or district,] *appoint at such salary as such board of education, trustee or board of trustees shall determine, such physicians, surgeons, dentists and nurses as may be required to carry out the provisions of this article* One of the *physicians* so appointed shall be known as the *medical inspector of such city or district* It appointed by a board of education of a city such physician, surgeon, dentist or nurse shall reside within the city The *physicians, surgeons and dentists* so employed shall be legally qualified to practice *as such* [medicine] in this state, and shall have so practiced for a period of at least two years immediately prior to such

For the period of six months after the appointment of the additional member of the State Board of Medical Examiners, as provided by this act, upon application made in writing and the payment of a fee of ten dollars, the regents shall issue a license, without examination by the board of examiners, to such persons who are twenty-one years of age, of good moral character, and otherwise qualified in any one of the following

(a) Graduate after a resident course of two years of six months each, or twelve months altogether, in a school teaching chiropractic, who during the last five years immediately preceding and at the time of taking effect of this act have been actually engaged in the practice of chiropractic in this state

(b) Graduates after a resident course of three years of six months each, or eighteen months altogether, in a school teaching chiropractic, who during the last three years immediately preceding and at the time of taking effect of this act have been actually engaged in the practice of chiropractic in this state, and who have had a preliminary education of three years in high school work or its equivalent

(c) Graduates after a resident course of two years of four months each, or not less than nine months altogether, if taken continuously, in a school teaching chiropractic, who during the last ten years immediately preceding, and at the time of taking effect of this act, have been actually engaged in the practice of chiropractic in this state

Proof of the course of study, age and period of practice of each applicant, under subdivisions "a," "b" and "c" of this section, shall be made by the affidavit of the applicant filed with the regents, proof of the good moral character of such applicant shall be made by the affidavit of two reputable citizens, the certificate of the chiropractic school as to such applicant's resident course of study and graduation shall be *prima facie proof thereof*

§ 6 Qualifications of applicants for examination and licenses The board shall admit to the examination for license any applicant who shall have paid to the board of examiners an examination fee of twenty-five dollars and submitted satisfactory evidence verified by oath or affirmation that he possesses the following qualifications

1 That he is more than twenty-one years of age, and

2 That he is a person of good moral character, and

3 That he has a preliminary education equivalent to graduation from a four-year high-school course registered by the regents, or an education accepted by the regents as equivalent, provided

such course shall have included elementary biology, elementary physics, elementary chemistry as taught in secondary schools, and

4 That he has actually taken a resident course and graduated from a chiropractic school which maintained, during the time of his attendance, a resident course of study extending over a period of twenty-four months, during which course at least two thousand and one hundred hours of sixty minutes each of actual instructions were given, and which included in its curriculum all of the subjects specified in the next section

§ 7 Examination of applicants All applicants for examination for license shall be required to pass a written examination conducted in the English language in the following subjects Anatomy, including histology and embryology, hygiene and sanitation, including bacteriology, physiology, biological chemistry, including dietetics, diagnosis and symptomatology, pathology, chiropractic analysis, and science and practice of chiropractic The board of examiners shall submit to the regents, as required, a list of questions for examination in the subjects enumerated From these lists the regents shall select questions for all the subjects To entitle the applicant to a license he must pass the examination with a rating of at least seventy-five per centum in each subject

§ 8 Licenses On receiving from the board of examiners an official report that an applicant has successfully passed the examination and is recommended for license, the regents may issue to him a license to practice chiropractic in this state Every license shall be issued by the regents under seal, and shall be signed by the president and secretary of the board of examiners and by an officer of the regents Before any license is issued, it shall be numbered and recorded in a book kept in the regents' office and its number shall be noted in the license This record shall be open to public inspection and in all legal proceedings shall have the same weight as evidence that is given to a record of conveyance of land Any license under this act shall entitle the holder thereof to the use of the degree D C, or doctor of chiropractic

§ 9 Waiver of examination The regents may waive the examination of any applicant for license hereunder who presents satisfactory proof that he has been duly licensed as a practitioner in any other state of the United States having licensing requirements equal to New York State, upon such waiver and the payment of the fee of twenty-five dollars the regents may issue to him a license as provided in section eight of this act

§ 10 Registry of license Every licensed practitioner shall before beginning practice under his license, cause such license to be registered in the office of the clerk of the county in which his

- " 11 Display of license and evidence of registration
- " 12 Rights of licensed practitioners
- " 13 Revocations and cancellation of licenses
- " 14 Proceeding for revocation
- " 15 Fines and penalties
- " 16 Violations

Section 1 Definitions As used in this act, "Regents" means board of regents of the University of the State of New York "Society" means New York State Chiropractic Society, Incorporated

"Board" means the state board of medical examiners of the State of New York, as provided in section one hundred and sixty-two of the public health law, as modified by this act

"Chiropractic school" means any school, college or department of a university teaching and giving instructions in the subjects required for a proper chiropractic standard as herein defined, which schools, upon making proof of giving such teaching and instruction may be registered and approved by the regents

"Proper chiropractic standard" means a course of study extending over a period of twenty-four months, during which an aggregate of at least two thousand one hundred hours of sixty minutes each of instruction is given in the following subjects Anatomy, including histology and embryology, hygiene and sanitation, including bacteriology, physiology, biological chemistry, including dietetics, diagnosis and symptomatology, pathology, chiropractic analysis, and science and practice of chiropractic

"Practitioner" means one who practices chiropractic

"License" means a license granted and issued by the board of regents of the University of the State of New York under this act to practice chiropractic within this state

"Licensed practitioner" means one who has received a license and is entitled to practice chiropractic within this state under the provisions of this act

The practice of chiropractic is defined as follows A person practices chiropractic within the meaning of this act, who holds himself out as being able to locate and to adjust by hand misaligned or displaced vertebrae of the human spine, for the purpose of relieving nerve pressure caused thereby

§ 2 The society The New York State Chiropractic Society, Incorporated, is continued, and the officers thereof shall be entitled to hold offices until the expiration of their respective terms and the elections and qualification of their successors, but the existence of said society shall in no way affect the validity of this act

§ 3 Board of examiners, organization Within twenty days after the first one hundred licenses have been issued under this act, the regents shall appoint one of such licensees as an additional member of the State Board of Medical Examiners Such appointee shall not be a medical doctor Before entering upon his term of office such examiner shall file with the Secretary of State his oath of office The terms of office shall be three years Before the day when the official term of a member of the board shall expire, the regents shall appoint his successor to serve for the term of three years Such appointment shall be made from the licensed and registered chiropractors of the state The regents in the same manner shall also fill vacancies in the board Such appointee shall not be a doctor of medicine Cause being shown before them, the regents may remove an examiner from office on proven charges of gross misconduct or neglect of duty

§ 4 Powers of the board 1 Any member of the board may administer oaths, summon witnesses and compel their attendance, and take testimony concerning any matter within the jurisdiction of the board

2 The board of examiners shall, by a majority vote of its members, subject to the approval of the regents, make such rules and regulations, not inconsistent with law, as may be necessary for the proper performance of its duties

3 The board of examiners shall have charge of the preparation and grading of examination papers required by this act, which examination shall be uniform in respect of subjects required of applicants for license to practice medicine, and shall hold examinations in at least four places in the state during each calendar year

4 The board shall, after a hearing, upon notice given, recommend to the regents the suspension or revocation of the license of a practitioner and the suspension or annulment of his registration, for any misrepresentation or false or fraudulent statement in his application or examination for a license, for his conviction of a crime involving moral turpitude or for a violation of any of the provisions of this act Upon such recommendation being made the regents may suspend or revoke such license and may suspend or annul such registration Whereupon the practitioner must surrender his license to the regents, who shall certify the facts to the county clerk of each county in which the practitioner is registered

5 The board may investigate violations of the provisions of this act and conduct hearings in respect thereto, when, in its discretion, it appears to be necessary, and to bring the same to the notice of any state or county official

§ 5 Present practitioners exempt from examination



registration has been annulled, and said clerk shall upon receipt of said certificate, file the same and forthwith mark said registration "annulled." Any person who shall practice chiropractic after his registration has been marked "Annulled" shall be deemed to have practiced without registration.

§ 15 Fees and penalties All fees, fines, penalties and other moneys derived from the operation of this act shall be paid into the state treasury and the legislature shall annually appropriate for the department an amount sufficient to pay all proper expenses incurred by them in administering this act, including the salary and expenses of the board.

§ 16 Violations Any person who shall violate any of the provisions of this act shall be guilty of a misdemeanor. Any person not duly licensed under this act who engages in the practice of chiropractic shall be guilty of a misdemeanor.

§ 17 In effect This act shall take effect January first, nineteen hundred and twenty-six.

*Comment*—This is the same bill, with a few modifications, that was introduced last year. The comment that was then made is, therefore, still forcibly applicable. In addition, however, it might be well to notice that in Section 3 it specifically states that the member of the society who is to be appointed to the examining board, *shall not be a doctor of medicine*. In Paragraph 3, under Section 4, an effort is made to represent the qualifications of the applicant for examination as equal to those of the applicant for examination for a license to practice medicine, when they use this sentence—"Which examination shall be uniform in respect of subjects required of applicants for license to practice medicine." In Section 5, three classes of persons now engaged in the practice of chiropractic are described and listed to be licensed without examination. The distinction between the classes is not clear in each instance, but the description is interesting, as is also the statement of the qualifications to be

presented by the applicant for examination as shown in the next Section.

We would also have you note the variety of subjects the applicant is to be examined in, as outlined in Section 7. Among these you will see bacteriology listed, and you may wonder how a knowledge of this subject will aid one in becoming a practitioner of chiropractic which they define as follows: "A person practices chiropractic within the meaning of this act, who holds himself out as being able to locate and to adjust, by hand, misaligned or displaced vertebræ of the human spine, for the purpose of relieving nerve pressure caused thereby."

Of course, to those succeeding in passing the examination, the bill would grant degree of "D C" or doctor of chiropractic, and to continue their semblance of regularity, in Section 10 it is provided that "Chiropractors shall annually register under the provisions of the amendment to the medical act requiring all licensed physicians to annually register." But finally, after having so diligently outlined the course of study that applicants for a degree must take, in anatomy, including histology and embryology, hygiene and sanitation, including bacteriology, physiology, biological chemistry, including dietetics, diagnosis and symptomatology, in Section 13, paragraph "C," they state that "The regents may revoke the license of a practitioner, or annul his registration, or both, *who prescribes or administers drugs or practices surgery or obstetrics*."

It now behooves every practitioner who reads this comment, to get in touch immediately with his legislative representatives and impress upon them the necessity of killing a bill that would thus admit most inadequately prepared persons to engage in a form of medical practice, even though it may be limited to manipulation of bony protuberances.

---

## THE NARCOTIC BILL

Assembly Int No 215—Concurrent Senate Int No 115 See Senate bill for digest and comment

Assembly Int No 216—See concurrent Senate Bill Int No 116 for digest and comment

practice is to be principally carried on, in a book to be provided by the clerk for such purpose, in which shall be entered the name, residence, place and date of birth, number and date of license and an affidavit signed by such licensed practitioner verified before such clerk to the effect that he is the person named in the license, and has complied with all of the provisions of this act. The clerk shall indorse upon such certificate the date and his name, preceded by the words "registered to practice chiropractic, in the clerk's office of \_\_\_\_\_ County".

The clerk shall thereupon give to the licensed practitioner so registered a certified transcript under his official seal of the entries in the register. The county clerk shall be paid a fee of one dollar for registration, affidavit and certificate. If the registration of the practitioner be suspended or annulled by the regents, upon receipt of a certificate to that effect the clerk shall stamp upon the record of registry "registration suspended" or "registration annulled" as the case may be, with the date of suspension or annulment. If such registration be thereafter reinstated the clerk shall note that fact on the registration record. If a registered practitioner remove his office or maintain an office in another county he shall register also in such county and notify the board of such fact. He shall present a transcript of registration and pay a fee of twenty-five cents, whereupon the clerk shall indorse thereon "registered also in \_\_\_\_\_ county". "Chiropractors shall annually register under the provisions of the amendment to the Medical Act requiring all licensed physicians to annually register."

§ 11 Display of license and evidence of registration. Each licensed practitioner must at all times keep conspicuously displayed in his principal business office his license and registration certificate and in any office in which he practices chiropractic his county registration certificate. Every unrevoked license with indorsement of registry thereon shall be presumptive evidence in all courts and places that the person named therein is legally licensed and registered under the provisions of this act.

§ 12 Rights of licensed practitioners. Each duly licensed practitioner who shall have fully complied with all provisions of this act, shall have the right to practice chiropractic within this state and shall be subject to all the disabilities, limitations and restrictions and entitled to the civil rights, privileges and immunities imposed upon and granted to all professional persons by the civil practice act and the judiciary law.

§ 13 Revocation and cancellation of license. The regents may revoke the license of a practitioner or annul his registration, or both, in any of the following cases:

(a) A practitioner who is guilty of any fraud

or deceit in his practice, or who is guilty of any fraud or deceit by which he was admitted to practice, or

(b) To an habitual drunkard or habitually addicted to the use of morphine, opium, cocaine, or other drugs having similar effect, or

(c) Who prescribes or administers drugs, or practices surgery or obstetrics, or

(d) Who undertakes to engage in any manner or by any ways or means whatsoever, to procure or perform any criminal abortion as the same is defined by section eighty of the penal law, or

(e) Who offers or undertakes by any manner or means to violate any of the provisions of section eleven hundred and forty-two of the penal law.

§ 14 Proceeding for revocation. Proceedings for revocation of a license or the annulment of registration shall be begun by filing a written charge or charges against the accused. Those charges may be preferred by any person or corporation, or the regents may on their own motion direct a member of the board of examiners to prefer said charges. Said charges shall be filed with the secretary of the board of examiners. The board of examiners shall hear and determine said charges. A time and place for the hearing of said charges shall be fixed by said board as soon as convenient, and a copy of the charges, together with a notice of the time and place when they will be heard and determined, shall be personally served upon the accused or his counsel, at least ten days before the date actually fixed for said hearing. Where personal service upon counsel cannot be effected, and such fact is certified on oath by any person duly authorized to make legal service, the board shall cause to be published, in the manner prescribed for the service by publication of a summons, a notice to the effect that at a definite time and place a hearing will be had for the purpose of hearing charges against the practitioner upon an application to revoke his license. At said hearing the accused shall have the right to cross-examine the witnesses against him and to produce witnesses in his defense, and to appear personally or by counsel. The said board shall make a written report of its findings and recommendations and the same shall be forthwith transmitted to the executive officer of the board of regents. If the said board shall find that said charges, or any of them are sustained, and shall recommend that the license of the accused be revoked or his registration be annulled, the regents may thereupon, in their discretion, revoke said license or annul said registration, or do both. If the regents annul such registration they shall forthwith transmit to the clerk of the county or counties in which said accused is registered as a practitioner, a certificate, under their seal, certifying that such

# NEWS NOTES

## PERIODIC HEALTH EXAMINATIONS IN NEW YORK COUNTY

Lectures in a symposium on Periodic Health Examinations are held in the Academy of Medicine, New York City, on Tuesday and Thursday afternoons at four o'clock, as announced on page 34 of the last week's JOURNAL.

Eight lectures have already been given, with an average attendance of over two hundred. We printed the first lecture in last week's issue, and are now printing the seventh one of the series. F O

## PRE-CLINIC SIGNS OF DISEASE OF THE GENITO-URINARY SYSTEM

By EDWARD L. KEYES, M.D.,

Abstract of the seventh lecture in the symposium on Periodic Health Examinations given in the New York Academy of Medicine on January 15, 1925, under the auspices of the Medical Society of the County of New York.

The term "Pre-clinical" as applied to signs of disease is somewhat contradictory, unless we mean the recognition of a disease before it reaches a state that sends the patient to bed. What we mean by the term "Pre-clinical Signs" is the earliest possible signs by which we can recognize approaching disease. In one sense a sign that is present at all is already a sign of clinical disease. What we try to do is to recognize the disease while it is in the curable stage.

Why are so many diagnostic mistakes made? The answer is *insufficient examinations*.

Two time-honored diagnostic procedures are now often omitted, first, a rectal examination, and second, what the old physicians called uromancy, or the inspection of the urine.

Dr. Osler insisted that a general physical examination always includes an exploration of the rectum with the finger. This procedure is of special importance in making a genito-urinary examination. Not only will it reveal conditions in the prostate, but a bimanual examination made after the manner of that in gynecology will reveal tumors of the bladder.

The appearance of the urine is often overlooked as the physician receives a sample that is camouflaged in a pretty wrapper, and is viewed by the laboratory technician through various glasses. Looking carefully at the urine is of the first importance in making a genito-urinary examination.

A successful examiner has a gift for choosing those examinations which will reveal the essential facts of the case. For example, a man recently had what appeared to be grippe, but his urine had a bad odor and a muddy appearance. After a week of treatment he was referred to the specialist for a cystoscopic examination. There were 300 c. c. of

residual urine, but nothing special was found in the bladder, and the ureters were not catheterized. A diagnosis of cystitis was made, and bladder washings were advised. On the insistence of the family physician the ureters were afterward catheterized, and very little wrong was found. The urine was then cultured, and paratyphoid bacilli in pure culture were found. In this case the clinical conclusion was right, although the diagnosis was wrong. This is an illustration of wabbling judgment until the right key to the condition is found.

A skilled examiner will get at a diagnosis by seeing the striking symptoms of a condition. Take tuberculosis, for example. Twenty years ago a demonstrator would have had to put up a long argument to convince even a specialist that painful and frequent urination, long continued, pointed directly to tuberculosis of the kidney, but now that fact is so well known that few cases of kidney tuberculosis reach the genito-urinary specialist, because the general surgeons recognize the symptoms and get the cases. These signs would have been called pre-clinical signs twenty years ago, but they are now recognized as those of a fully developed disease.

Hematuria that is transient and brief, and occurs in an adult, may be classed as a pre-clinical sign that suggests a malignant tumor of the kidney or bladder. Our knowledge of urinary tumors is now in the same stage that our knowledge of tuberculosis of the kidney was twenty years ago. A malignant growth of the genito-urinary tract diagnosed early can be cured by surgical means. There is no need that a patient who passes blood should run away from the doctor in a deadly fear.

While casts are of great importance in the diagnosis of toxic nephritis, they are of little



# State Department of Health



## INFECTIOUS JAUNDICE

District State Health Officer Sayer reports an investigation of a small outbreak of infectious jaundice in the town of Denmark, Lewis County. Five cases were called to his attention, all in children of 5 to 14 years. Three of the children attended a single school and the two other cases were in the family of one of the three school children. None were very sick. All had the characteristic symptoms—nausea, vomiting, abdominal pain and jaundice. One had hiccough lasting several hours.

This outbreak is of interest, as Dr. Sayer states that there have been cases in the locality for the past two or three years.

## "PTOMAININE POISONING" AGAIN USED INCLUSIVELY

On questioning a death reported as due to "ptomaine poisoning," the Division of Communicable Diseases learned that the patient, a boy of 16, on returning from a Boy Scout Camp and finding nobody at home, ate a large dish of yellow beans which had turned sour. That night and the following day he vomited frequently and had cramps. The next day, bile, mucus, water and particles of food (beans) were vomited. Abdomen was tender, but not distended. In the evening of the following day there was an "offensive bowel movement." On the next afternoon he was able to retain a little fluid, and became more cheerful. At 11 P. M. he had severe intermittent cramp-like pains in his abdomen and was suffering with shock. He died a few hours later. Autopsy revealed volvulus of small intestine close to caecum, causing obstruction. The volvulus was stated to have been caused by a diverticulum of the ileum 60 cm above the caecum. In spite of these findings the death was certified as being due to "ptomaine poisoning."

## DEATH REPORTED FROM MUSHROOM POISONING

An unusual type of mushroom poisoning has been reported by the Grasslands Hospital, Valhalla.

The patient, an Italian, age 29, ate mushrooms at dinner on August 31. The next morning, at 6 A. M., he began to cough, then had pain in epigastrium (left upper quadrant) and vomited. On September 5 he entered the hospital and reported that he had been short of breath and very thirsty since the onset, had been continually nauseated and had vomited a few times.

Physical examination showed an intense jaun-

dice. The patient complained of a good deal of pain and nausea on pressure over the mid-epigastrium. The liver was felt 2 cm below the costal border, but not tender. Knee jerks were absent. On September 7 he became weaker. Blood was present in the stools and bile in the urine. Red cell count was 4,500,000. He was treated by hypodermoclysis of normal salt solution and 5 per cent glucose. Blood was typed and a donor secured for transfusion. The patient died before the operation could be undertaken.

Autopsy showed diffuse and coalescent liver necrosis, multiple punctiform subserous hemorrhages of peritoneum, pleura, epicardium and endocardium, hemorrhage into rectus muscle, cloudy swelling of kidney, congestion of viscera and icterus.

According to Ford's classification, the picture presented in this case most nearly fits the rare variety of mushroom poisoning known as *Mycetismus Sanguinarius*. The only mushroom producing this type of poisoning is said to be the "*helvella esculenta*" (*gyromyza esculenta*) which contains a heat resistant hemolytic poison, "helvellic acid."

\* Transactions of Assn. of Am. Phys., Vol. XXVIII, 1923 p. 225

## AN UNUSUAL CASE OF ANAPHYLAXIS

The following instance of anaphylaxis, reported by a city health official, is of unusual interest because of the length of time intervening since the previous administration of antitoxin.

"Last Wednesday, about 9 P. M., I was called by a physician to see a girl of 13 that he had just been called to see, and that he thought might have diphtheria. I gave a clinical confirmation and took cultures and smears, both of which were positive the following morning. As the doctor was unprepared, he asked me to proceed with the administration of antitoxin. On taking a brief history, I learned that the child had had an immunizing dose of antitoxin about ten years previously. Accordingly, I did an intracutaneous test first with a drop or two of antitoxin. In fifteen minutes, there was an area of marked erythema about five centimeters in diameter around the point of injection. I therefore proceeded to desensitize her and administered 6,000 units subcutaneously in about two hours. Because of the presence of membrane on both tonsils, I wanted to give her 12,000 units and, it being near midnight, and having had no trouble with the first 6,000, I thought it would be safe to give her the remaining 6,000 at one time. I injected it slowly, intramuscularly, in the usual way. I had no more than gotten to the bathroom to wash out my syringe when I heard the girl cry to her father that her face felt 'funny.' By the time I reached her bedside in the front room, she was as red as a broiled lobster from head to foot, was dyspneic, and nauseated, and the pulse was slow and intermittent. Luckily, I had some epinephrin solution in my bag and I immediately injected 1 cc. of a 1-10,000 solution. In about five minutes, everything was calm again."

## MEDICAL SOCIETY OF THE COUNTY OF MONTGOMERY

The annual meeting was held at the Elks' Building, Amsterdam, N Y, on the evening of December 10, 1924

Present Drs Phillips, Ormsby, Hicks, Qua, Bing, Timmerman, Tomlinson, Homrighouse, Canna, Pierce, LaPorte, Simpson, FitzGibbons, Stover, Walton, Wilson, Bouton, Seward, Lombardi, Schiller, Collier, Sherburne, of Amsterdam, N Y, and Dr Howard of Minaville, Dr Fox of Canajoharie, Drs James N Vander Veer and Joseph S Lawrence, of Albany

Dr C F Timmerman, who had been treasurer for some number of years, had an extensive report showing that all members of the County Society had paid up in full, and a splendid balance was in the treasury On motion of Dr R R Canna of Amsterdam, N Y, a rising vote of thanks was given Dr Timmerman for the able manner in which he had conducted the office of treasurer

Dr Bing, the chairman of the Censors, reported the following names for applications for membership Dr Baron Shults, of St Johnsville, N Y, and Dr Douw S Myers, of Tribes Hill, N Y They were acted upon favorably by the Censors and a motion made by Dr Julius Schiller, of Amsterdam, N Y, that Dr Myers and Dr Shults be made members of the Medical Society of the County of Montgomery

On motion of Dr E Harrison Ormsby, of Amsterdam, N Y, a motion was made and seconded that we dispense with the regular order of business and proceed with the scientific program, which consisted of an informal talk on the "Opportunity of the County Society," by Joseph S Lawrence, M D, executive officer of the Medical Society of the State of New York, "Function of the Legislative Committee," by James N Vander Veer, M D, chairman of the Legislative Committee of the Medical Society of the State of New York

The report of the committee on Periodical Examination was quite an exhaustive report The committee was composed of Drs Stover, LaPorte, Collier and Simpson, of Amsterdam, N Y, and Dr Howard of Minaville, N Y

On motion of Dr H M Hicks, which was duly accepted, a vote of thanks was extended to the committee for the excellent report presented to the Society

The following officers were elected for 1925 James S Walton, president, E Harrison Ormsby, vice-president, William R Pierce, secretary, Seymour L Homrighouse, treasurer, Censors, Drs Timmerman, LaPorte and Bing, of Amsterdam, N Y

---

## OTSEGO COUNTY MEDICAL SOCIETY

The annual meeting of the Otsego County Medical Society was held in the Elk's Home, Oneonta, N Y, on Tuesday, December 9, 1924

In the absence of both president and vice-president, Dr J C Smith was made chairman of the meeting

The following officers were elected for 1925 President, John Walter Swanson, M D, Springfield Center, vice-president, Rupert W Ford, M D, Otego, secretary, Arthur H Brownell, M D, Oneonta, treasurer, Frank L Winsor, M D, Laurens, delegate to State Society meeting, Addison H Bissell, of Cooperstown

An important change was made in the time and number of meetings Four meetings will be held each year, the second Tuesday of March, June, September and December The hour to be at 4 30 P M, in place of the morning and afternoon meetings as heretofore The first two meetings of the year to be in Cooperstown, and the second two in Oneonta

Drs Marv, Parish and Bissell submitted the following resolution in regard to the death of Dr Cutler

"The Otsego County Medical Society desires to record permanently its sense of great loss in the death of Dr

Arthur W Cutler The Society feels his death affects not only the Society and the medical profession, but the community at large, and offers this tribute to his memory"

Dr J C Smith gave a report of the Sixth District Convention Dr J S Lawrence, executive officer of the State Medical Society, addressed the meeting in behalf of better co-operation between the State and County societies

Lunch was served in the Palm Room, with twenty-four men present

In the scientific session, Dr M E Brownell presented the subject of "Herpes in Relation to the Face and Eyes," showing that there has been in and about Oneonta an epidemic of this condition for some months A general discussion followed, as many physicians had met with a similar condition

Dr Bissell gave a paper on "The More Common Symptoms of Urological Conditions"

Dr Herman F Senftner, of the State Health Department, gave a very helpful talk on "Prophylactic Immunization," showing the great advance that is being made along the lines of preventive medicine

Dr L W Hubbard, of the State Department of Health, was a guest of the Society

importance in surgical nephritis. A kidney in which bacilli grow does not seem to form casts, but the toxic substances may cause nephritis with casts in the other kidney.

It is important to recognize cancer of the prostate early, for it can be cured by surgery in its early stages. An accidental symptom may lead to an examination and a correct diagnosis. For example, several years ago a man 60 years of age complained of painful, frequent urination, but an examination, including a rectal one, revealed nothing. Recently he returned with the same symptoms, and a finger in the rectum felt a small lump. The cystoscope showed a slight old granulation of the verumontanum, which was harmless, and yet had caused all the symptoms which impelled the patient to go to his doctor, and which led to a cure of his cancer.

There is need that all available means of diagnosis be used. A diagnosis of cancer of the prostate was made on a prominent patient as the result of a rectal examination, but the relations with the patient were such that the physician feared to tell the patient, and so he suggested a further examination with the X-ray. This revealed several stones in the prostate, and their removal resulted in a complete cure.

Stones or concretions in the prostate are nearly always composed of lime, and so cast clear-cut X-ray shadows.

A general rule in the interpretation of the results of rectal examinations is that hard lumps that are felt are not located in the prostate, but are around it, while soft spots are likely to be located in the prostate itself.

## BRONX COUNTY MEDICAL SOCIETY

The annual meeting of the Bronx County Medical Society, held at Concourse Plaza, on December 17, 1924, was called to order at 9 P M, the President, Dr Podvin, in the chair.

The minutes of the last regular meeting and of the annual meeting of the Comitia Minora were read for the information of the society.

The following applicants for membership were elected: Louis Breinin, Charles E Haynes, C Austin Kosik, Michael J Lynch, Solomon Just Rosenberg, Philip Sacks, Abraham B Tamis, Dorean D Wyser.

It was moved and carried that Dr Allen K Krause, of Johns Hopkins University, be elected honorary member.

Election of officers, censors and delegates for the year 1925 being in order, the president declared the polls open at 9 15 P M. Drs Landy, Hayward, Burstan and Keller were appointed as tellers.

A ten minute recess was ordered.

The reports for the year 1924 of the following officers and committees were presented:

Treasurer, Dr Keller

Committee on Audit, Dr Bookman

Secretary, Dr Landsman

Board of Censors, Dr Leimer

Counsel, Mr McChristie

Committee on Membership, Dr Nisselson

Committee on Public Health, Dr Friedman

Committee on Medical Economics, Dr Lukin

Milk Commission, Dr Rost

Committee on Legislation, Dr Cunniffe  
Special Committee on New Members, Dr Smiley

Bulletin Committee, Dr Eichler

It was moved and carried that a vote of thanks be extended to our counsel, Mr McChristie, for his work on behalf of the society.

The president declared the polls closed at 10 30 P M. The tellers reported, and the following candidates were then declared elected: President, Simon M Jacobs, First Vice-President, Edward R Cunniffe, Second Vice-President, I H Goldberger, Secretary, I J Landsman, Corresponding Secretary, Samuel F Weitzner, Treasurer, J Adlai Keller, Board of Censors, Harry Aranow, Joseph H Gettinger, Delegates, J Lewis Amster, William Meddaugh Dunning, Cornelius J Egan, Edmund E Specht, Alternates, Vincent S Hayward, J Adlai Keller, Nicholas Lukin, Irving Smiley, Alternate (1 year), William Klein.

The scientific program then proceeded as follows:

1 "Cutaneous Tuberculosis" (with lantern slides demonstration), Adolph Rostenberg. Discussion by Drs Feldman and Horwitt.

2 "Local Anæsthesia" (with lantern slides), William Klein. Discussion by Drs Amster, Diem and Solkow.

3 "Ocular Headaches," David A Newman. Discussion by Drs Jaffe and Rosenbluth.

The meeting adjourned at midnight.

## RICHMOND COUNTY MEDICAL SOCIETY

A regular meeting of the Richmond County Medical Society was held at the Staten Island Academy on Wednesday, November 12, 1924. The meeting was called to order at 9 p m with Dr Presley in the chair. Those present were Drs Presley, Catalano, Walsh, O'Reilly, Hetzel, Lucy, Smith, Jessup, Rieger, Pearson, Washington, Kingsley, Kreuger, Freidel, Craig, McGowan, Mord, Coonley, Reigi, Klauber, Timpone, Harwood, Law, Halbert, Buntin, Walrath.

Dr Pearson spoke on the inconvenience of attending meetings of the Compensation Commission, from the standpoint of the patient and physician. A motion was made that a committee be formed to petition in proper form that the Compensation Commission hold meetings periodically in this Borough. Dr Pearson, Chairman, assisted by Drs Hetzel and Lucy.

Dr Lavender, of the Public Health Service, spoke on the plans for the enlargement of the Marine Hospital from three hundred to five hundred beds. A motion was made that the Richmond County Medical Society go on record as approving the plans of the Public Health Service for enlarging the Marine Hospital at Stapleton.

James Alexander Miller, M D, spoke on the "Treatment of Pulmonary Tuberculosis by Artificial Pneumothorax and Surgical Collapse." Dr Miller laid marked emphasis on the fact that one must not forget the patient is being treated primarily for tuberculosis, therefore the treatment is rest, adding to that the immobilization of the lung. Pneumothorax is used in selective cases, particularly extensive active unilateral tuberculosis, but it may also be used for the control of hæmorrhage, acute unilateral pneumonic phthisis (where it gives the only hope), and unilateral cases which do not respond to bed rest. It may also be used early for short periods to

get rid of constitutional symptoms. An active lesion below the level of the second rib contraindicates pneumothorax of the opposite side.

Among the accidents attending pneumothorax mentioned by Dr Miller are puncture of the lung, collections of fluids going to tuberculous empyema, which, except in a few cases, does no harm, secondary infection of the fluid, which is serious, sudden death in a few cases, probably due to shock.

Adhesions in chronic cases of tuberculosis constitute a great difficulty as it prevents the full collapse of the lung. In these cases the adhesions may be cut by cautery under a cystoscopic-like instrument or the paralysis of half of the diaphragm may be brought about by cutting the phrenic nerve, or a more radical operation may be done.

Dr Miller showed a series of lantern slides illustrating some of his cases and the methods of treatment. Discussion was opened by Dr Timpone. A vote of thanks was tendered to Dr Miller for his interesting and instructive paper.

Dr Kingsley and Dr Harwood gave case reports of patients treated by artificial pneumothorax. Dr Kremer, superintendent of Seaview Hospital, spoke of his experience with pneumothorax at that hospital. Dr Patton spoke on the use of heliotherapy at Seaview Hospital.

The following officers were nominated for the year 1925: President, E W Presley, Vice-President, Wm R Janeway, Secretary, Charles Rieger, Treasurer, E D Wisely, Censors, Wm Bryan, Frederick Schwerd, George Walrath, Delegates, E W Presley, Charles R Kingsley, Alternate Delegates, Charles Nichols, D V Catalano.

The meeting adjourned at 10 45 to the Staten Island Club.

---

## CHENANGO COUNTY MEDICAL SOCIETY

The 120th annual meeting of the Chenango County Medical Society was held at Guernsey Memorial Library, Norwich, on Tuesday, December 9, 1924.

The following officers were elected for 1925: President, James B Noyes, M D, New Berlin, vice-president, Thomas F Manley, M D, Norwich, secretary-treasurer, John H Stewart, Norwich.

President's address: William E Hartigan, M D, Norwich.

"Relation of Hospital to Community," Miss Frances Higgins, Superintendent, Norwich Memorial Hospital.

"Sepsis," Thomas Manley, M D, Norwich.

"Diphtheria Prevention," F O Rinehard Oneonta.

## THE MEDICAL SOCIETY OF THE COUNTY OF QUEENS

At the annual meeting of the Medical Society of the County of Queens, held November 25, 1924, the following officers were elected for 1925: Henry C. Courten, president, Dennis Edward McMahon, vice-president, Joseph S. Thomas, secretary-treasurer, Edward Albert Flemming, Thomas Clark Chalmers, and Henry W. Kemp, censors, J. Howard Morse, Henry C. Courten, and Thomas C. Chalmers, delegates to the State Society, Ernest E. Smith, James Risley Reuling, Jr., Charles W. Martin, and George J. J. Lawrence, alternate delegates, Carl Boettiger, trustee, and Duncan Macpherson, historian.

The following members were elected: Otto Gitlin, M.D., Jamaica, and E. J. Carey, M.D., Flushing.

Dr. H. C. Courten, for the Comitia Minora, offered a resolution intended to put the Society on record as opposed to the exhibition, in connection with physicians' signs, of the specialty in the practice of which they may be engaged. This resolution aroused an active discussion, and the final decision was postponed until the next meeting, and the secretary was instructed to print

the resolution in the notices of the next meeting. The secretary-treasurer read his annual report, which showed 242 members. The trustees reported that owing to delay in grading of the Boulevard, it is impossible to form definite plans for the new building.

At the scientific session, the first paper, entitled "Topographic Changes in the Thorax of the New-born," by G. J. Noback, M.D., Assistant Professor of Anatomy at the New York University and Bellevue Hospital Medical College, was an analytical study of 65 cadavers of fetuses and new-born with special reference to the anatomy of the Thymus gland. The second paper, by John Van Doren Young, M.D., entitled "The Present Status of Retroversion," was an able and thorough exposition of the author's views on the subject. He emphasized the importance of careful study of patients and in the matter of operative technique attached great importance to the utero-sacral ligaments, in shortening the round ligaments preferred one of modifications of Gillian's operation, and advised the preliminary treatment of the cervix, where indicated, by means of intermittent hyperemia or by means of the cautery.

## ROCKLAND MEDICAL SOCIETY

The annual meeting and dinner of the Rockland County Medical Society was held in The Elms at New City, the County Seat, on Wednesday afternoon, December 3, 1924, with practically every member present. The total number of those who sat at the tables was forty-seven, including guests. The meeting was enlivened by two song leaders and entertainers from New York City.

Dr. Ralph O. Clock, in his presidential address, suggested that the annual dues be raised from two dollars, as at present, to five dollars, in order to provide funds for an extension of the work of the Society, especially publicity and education of the people. The meeting unanimously adopted the raise in dues.

Dr. E. A. Whitney, of Suffern, was duly elected to membership.

The former officers were re-elected, as follows: President, Dr. R. O. Clock, vice-president, Dr. Royal Sengstacken, secretary, Dr. R. R. Felter, treasurer, Dr. Dean Miltemore.

The following chairmen of standing committees were also elected: Membership, Dr. G. F. Blanvelt, legislation, Dr. C. D. Kline, civic policy, Dr. J. C. Dingman.

The principal address was given by Dr. S. Dana Hubbard, Director of the Bureau of Public Health Education of the Department of Health of New York City, who told of the constant work of the department in the control of vendors of proprietary and patent medicines, and in the detection and exposure of illegal practitioners and quacks. He emphasized the necessity that the health department and the prosecuting attorney should have the backing of a people who are educated by the physicians to know quackery when they see it.

Dr. Frank Overton, executive editor of the NEW YORK STATE JOURNAL OF MEDICINE, gave some suggestions for the education of the people in medical subjects.

F O



## RICHMOND COUNTY MEDICAL SOCIETY

A regular meeting of the Richmond County Medical Society was held at the Staten Island Academy on Wednesday, November 12, 1924. The meeting was called to order at 9 p m with Dr Presley in the chair. Those present were Drs Presley, Catalano, Walsh, O'Reilly, Hetzel, Lucy, Smith, Jessup, Rieger, Pearson, Washington, Kingsley, Kreuger, Freidel, Craig, McGowan, Mord, Coonley, Reigt, Klauber, Timpone, Harwood, Law, Halbert, Buntin, Walrath.

Dr Pearson spoke on the inconvenience of attending meetings of the Compensation Commission, from the standpoint of the patient and physician. A motion was made that a committee be formed to petition in proper form that the Compensation Commission hold meetings periodically in this Borough. Dr Pearson, Chairman, assisted by Drs Hetzel and Lucy.

Dr Lavender, of the Public Health Service, spoke on the plans for the enlargement of the Marine Hospital from three hundred to five hundred beds. A motion was made that the Richmond County Medical Society go on record as approving the plans of the Public Health Service for enlarging the Marine Hospital at Stapleton.

James Alexander Miller, M D, spoke on the "Treatment of Pulmonary Tuberculosis by Artificial Pneumothorax and Surgical Collapse." Dr Miller laid marked emphasis on the fact that one must not forget the patient is being treated primarily for tuberculosis, therefore the treatment is rest, adding to that the immobilization of the lung. Pneumothorax is used in selective cases, particularly extensive active unilateral tuberculosis, but it may also be used for the control of hæmorrhage, acute unilateral pneumonic phthisis (where it gives the only hope), and unilateral cases which do not respond to bed rest. It may also be used early for short periods to

get rid of constitutional symptoms. An active lesion below the level of the second rib contraindicates pneumothorax of the opposite side.

Among the accidents attending pneumothorax mentioned by Dr Miller are puncture of the lung, collections of fluids going to tuberculous empyema, which, except in a few cases, does no harm, secondary infection of the fluid, which is serious, sudden death in a few cases, probably due to shock.

Adhesions in chronic cases of tuberculosis constitute a great difficulty as it prevents the full collapse of the lung. In these cases the adhesions may be cut by cautery under a cystoscopic-like instrument or the paralysis of half of the diaphragm may be brought about by cutting the phrenic nerve, or a more radical operation may be done.

Dr Miller showed a series of lantern slides illustrating some of his cases and the methods of treatment. Discussion was opened by Dr Timpone. A vote of thanks was tendered to Dr Miller for his interesting and instructive paper.

Dr Kingsley and Dr Harwood gave case reports of patients treated by artificial pneumothorax. Dr Kremer, superintendent of Seaview Hospital, spoke of his experience with pneumothorax at that hospital. Dr Patton spoke on the use of heliotherapy at Seaview Hospital.

The following officers were nominated for the year 1925: President, E W Presley, Vice-President, Wm R Janeway, Secretary, Charles Rieger, Treasurer, E D Wisely, Censors, Wm Bryan, Frederick Schwerd, George Walrath, Delegates, E W Presley, Charles R Kingsley, Alternate Delegates, Charles Nichols, D V Catalano.

The meeting adjourned at 10 45 to the Staten Island Club.

---

## CHENANGO COUNTY MEDICAL SOCIETY

The 120th annual meeting of the Chenango County Medical Society was held at Guernsey Memorial Library, Norwich, on Tuesday, December 9, 1924.

The following officers were elected for 1925: President, James B Noyes, M D, New Berlin, vice-president, Thomas F Manley, M D, Norwich, secretary-treasurer, John H Stewart, Norwich.

President's address: William E Hartigan, M D, Norwich.

"Relation of Hospital to Community," Miss Frances Higgins, Superintendent, Norwich Memorial Hospital.

"Sepsis," Thomas Manley, M D, Norwich.

"Diphtheria Prevention," F O Rinehard, Oneonta.

## MEDICAL SOCIETY OF THE COUNTY OF SULLIVAN

The Medical Society of the County of Sullivan held its regular meeting at the Hall House, Liberty, on Wednesday evening, January 7th.

The newly elected President, Dr Charles Rayevsky, appointed the following committees to serve during 1925: Scientific Program A J Peters, Chairman, J P Dworetzky and J C Gain, Public Health E Singer, Chairman, C Duggan and J W Davis, Law and Legislation L C Payne, Chairman, S W Wells and J B Amberson, Publicity J B Amberson, Chairman, H C Van Keuren, V C Bourke, J R Kuhn, and L C Payne.

At the suggestion of the President, the Society intends this year to interest itself in the dissemination of knowledge of health matters through the newspapers of the county, and especially to urge upon the public the advisability of periodic health examinations.

In line with this program, Dr Frederick W Sears of Syracuse was present and read a paper on the subject of "Periodic Medical Examinations—the method of making them and their importance as a health measure." By tables of vital statistics Dr Sears showed that, while the

average length of life is now greater than ever before, deaths from diseases of middle and later life is now increasing at a rather alarming rate. These include heart and kidney disease, cancer, hardening of the arteries and diabetes. Most of these start and advance without causing definite symptoms, and usually it is only in a routine examination once a year or oftener that the maladies can be discovered in their early stages. Early diagnosis enables the physician to advise the patient regarding the proper mode of life and consequently much suffering may be avoided and the life of the patient lengthened.

The subject was discussed also by Dr Joseph S Lawrence, Executive Officer of the Medical Society of the State of New York, and proper committees of the local society were instructed to study further the mode of procedure.

Dr J A Miller of Roscoe, read a paper on "The Operative Treatment of Carcinoma of the Breast" and presented patients who had been cured of cancer by surgical treatment.

The meeting was well attended by physicians from various sections of the county.

## THE MEDICAL SOCIETY OF THE COUNTY OF TIOGA

At the annual meeting of the Medical Society on December 2nd, the following officers were elected for 1925: President, Guy S Carpenter, M D, Waverly, Vice-President, Edward S Beck, M D, Owego, Secretary-Treasurer, W A Moulton, M D, Candor, Censors, L S Betowski, M D, of Waverly, L J Osborne, M D, of Nichols, F A Carpenter, M D, of Waverly.

The President appointed the following com-

mittees: Public Health—E E Bauer, M D, of Owego, L S Betowski, M D, of Waverly, Eugene D Holly, M D, of Candor, Legislation—M B Dean, M D, of Candor, R D Eastman, M D, Berkshire, L J Osborne, M D, of Nichols.

Dr Willard M Hilton, of Waverly, was elected to membership.

## DR GRANT C MADILL, GUEST OF HONOR.

Dr David E Hoag, president of the St Lawrence County Society, of New York City, announces that Dr Grant C Madill, of Ogdensburg, former president of the Medical Society of the State of New York, is to be the guest of honor at the twentieth annual banquet of the St Lawrence County Society, of New York, to be held Thursday evening, February 19, 1925, at the Hotel Astor, New York City.

The after dinner speakers will be Rev Dr S Parkes Cadman, Dr George D Stewart, and Hon George W Sisson. The society has nearly 1,000 members made up of former residents of

St Lawrence County. The membership lists contain the names of Irving Bacheller, Wallace Butrick, of the Rockefeller Foundation, Hon Frank B Kellogg, Ambassador to the Court of St James, Hon Owen D Young, chairman, Dawes Reparations Commission, Herbert F Gunnison, Stanley E Gunnison, Dr Wendell C Phillips, Dr Roger H Dennett, Dr Victor C Pedersen, Dr David R Rodger, and many others. Physicians may secure tickets at \$5.00 each by making application to Dr David E Hoag, president, 15 East 48th Street, New York City.



# THE DAILY PRESS



While half of our clippings during December were on the Christmas Seal campaign, only half a dozen were on that subject since the holidays. It would seem that the expenditure of the money would interest those who give it. People have a hazy idea about the fight against tuberculosis. Articles on the local work, scattered throughout the year, would arouse the interest of the donors to the anti-tuberculosis fund. Publicity is welcomed by both the newspapers and the public.

By far the leading subjects of the clippings this week are the outbreaks of typhoid fever and of the chicken plague in Greater New York. There are also a number of clippings about an outbreak of para-typhoid fever that apparently started in a bakery.

It is difficult to follow the course of the typhoid outbreak from the newspaper reports. The cause of the outbreak that is featured prominently is alleged to be raw oysters from New York harbor. This publicity regarding oysters has resulted in the almost total destruction of the oyster industry on Long Island. The warnings sent out by the Departments of Health of New York State and New York City were directed against *raw* oysters only, but the result has been that people do not buy oysters at all, and the oyster men have had to close their establishments. This has resulted in great financial loss. The *Sayville News* of January 2nd comments on the situation as follows:

"Some of our oystermen, whose business is being seriously hurt and their employees, scores of whom have been thrown out of employment in mid-winter, are asking some very pertinent questions. They are indignantly inquiring why it is necessary to employ a man to make this inspection. They want to know just what we pay a health officer for anyhow? Why are not the health authorities of the town of Islip, ready now or at any time to answer promptly and positively, any questions which may be put to them by the State or New York City health boards?"

"The shell fish industry of the Great South Bay is a great deal bigger than any one man and is of vastly more importance than any one man's job. In this Year of Our Lord 1925, the business of this great and rapidly growing township which has within its boundaries State institutions of vast importance, cannot be handled as it was in grandad's day.

"It needs a man who is able at any time to declare that the law which has been framed to absolutely protect the shellfish industry of our bay is being rigidly enforced. He must be able to prove to any State or City health officer by his records that frequent and careful inspections are being made."

The inference is that the shellfish from the Great South Bay, on which Sayville is situated, have been permitted to become polluted with sewage because of the inefficiency of the Board of Health.

Oysters from the Great South Bay, or Blue Points, as they are called, have not been condemned by the Health Departments. Some sewage has been allowed into the Great South Bay, but the Board of Health has discouraged action and publicity on the ground that the oyster industry might be injured. But now, since the oyster industry is almost ruined by publicity in the Metropolitan papers, and the oystermen are complaining, the Board of Health is acting vigorously on economic grounds. Still, the final result will be good, for all sewage will be removed from the waters, and the Blue Point oysters will be approved.

The oyster industry is probably the most sensitive of all industries to criticism. Milk supply may be condemned, but the people change dairymen. But when oysters are mentioned, the people simply stop eating oysters regardless of where they come from. The oyster dealers, therefore, have objected to a campaign of education at any time, and above all they have censored attempts to promote a control of sewage. A campaign of education carried on through the year would probably go far to remove the senseless fear of the people when typhoid fever and oysters are mentioned on the same page.

The chicken plague has come in for a vast amount of publicity in the daily papers during the past few weeks. The newspapers say that the cause of the disease is unknown, but one poultry dealer has ascribed it to feeding pepper to the fowl after they have been exhausted by a trip of several days in a poultry car. It is alleged that the pepper is given to increase the appetite and weight, and their engorgement with food is credited with producing a sort of food poisoning.

We have taken pains to learn just what the disease is. It is called "fowl plague," and is

caused by a filterable virus. It is exceedingly deadly and rapid in its course. Outbreaks have occurred on Long Island, and have been studied by the New York State Institute of Agriculture in Farmingdale. It is a rare disease, and has been reported only a few times in Europe, and not at all in this country previous to the present outbreak.

When fowl plague attacks a large flock, a few birds escape, and these are immune to virus injections that are invariably fatal to non-immune fowl. Studies are being made to develop a strain of immune birds, and also to discover a protective serum. In the meantime few chickens come to Greater New York, but the demand keeps up, and the people have no such fear of diseased fowl as they have of infected oysters.

---

The New York City papers reported about twenty families ill with so-called ptomaine poisoning as the result of eating cream puffs that were bought at a Brooklyn bakery. The reports state that a paratyphoid organism was found in the pastry, but no details were given in any of our clippings.

We recall a similar outbreak two years ago which was traced to an organism of the paratyphoid group that was peculiar to mice and rats. The same kind of organism, if not the identical one, was found in the droppings of mice in the bakery. We looked up the reports of similar outbreaks at that time, and found that very little definite work had been done on these organisms, but it is an accepted fact that several strains are toxic to human beings, and that human beings are in danger from the toxins of the organisms that have grown in food. There is great need that intensive research be made into the relation of mice and rats to food poisoning.

---

The Brooklyn *Times* of December 29th contains the following account of red worms that have appeared in the city water:

"Brooklynites today are watching their faucets for the bloodworm, a new species of animal life that has made its appearance in the Catskill water supply.

"Tie a piece of cloth over your faucet to trap the visitor, for the red worm can slide through the ordinary filter.

"There is no cause for worry, according to Dr. Frank Hale, chief chemist of the Department of Water Supply, except that you may experience the disagreeable sensation of swallowing a worm.

"The bloodworms are absolutely harmless, and, if swallowed, are readily digested, Dr. Hale asserts.

"When alive the worms squirm perceptibly and are easily visible in a glass of water. The worm is called the chironomus, and is the larva of a small fly of the ditтера family.

"The worm was first noticed in Manhattan, then it passed through Brooklyn, and today several complaints come in from Queens. This, Dr. Hale says, indicates the worm is passing right through the water system and will soon be eliminated. A similar appearance of worms was found in the water system a year ago, appearing more numerous in Staten Island than elsewhere.

"It may be a little unpleasant to see a red worm squirming in your glass of water, but no one would drink water in which animal life is noticed. If the worm is swallowed, however, it will not hurt you."

---

A new form of publicity is reported in the New York *Sun* of December 24th:

"Under the auspices of the East Harlem Health Shop of the New York Tuberculosis Association a Christmas carol party consisting of twenty boys from the Public School 39 Glee Club and five boys from that school's orchestra are traveling through Harlem on a bus this afternoon calling attention to the need of a 'Healthy New Year' and singing and playing holiday carols at various points. The bus is decorated with American flags and a large placard around the top rail with the message, 'A Merry Christmas and a Healthy New Year'.

"Free health examination coupons were distributed by Boy Scouts throughout Harlem, inviting the community to avail itself of the offer of a free medical examination at the East Harlem Health Shop."

# BOOK REVIEWS

**MANAGEMENT OF DIABETES, TREATMENT BY DIETARY REGULATIONS AND THE USE OF INSULIN, MANUAL FOR PHYSICIANS AND NURSES BASED ON THE COURSE OF INSTRUCTION GIVEN AT THE PRESBYTERIAN HOSPITAL, NEW YORK** By GEORGE A HARROP JR., M.D., Associate in Medicine, College Physicians and Surgeons Introduction by Walter W Palmer, M.D., Bard Professor Medicine, College Physicians and Surgeons Paul B Hoeber, Inc, New York. 1924 \$2.00 net

This book is a very well-written and easily readable treatise on the treatment of diabetes containing information valuable to any physician treating such cases.

The chapter on food recipes is excellent, giving a great variety of foods that may be used and also the caloric value and chemical constitution of each.

It also contains tables of food values and a chapter on the blood and urine examinations of the diabetic patient.

It well repays reading and careful study.

C. E. HAMILTON

**EAT YOUR WAY TO HEALTH A SCIENTIFIC SYSTEM OF WEIGHT CONTROL** By ROBERT HUGH ROSE, A.B., M.D., Instructor, Post-Graduate Medical School, New York. Thoroughly revised and enlarged Funk & Wagnalls Co, New York, 1924

The motto of the author in his text is "Right eating, normal weight, normal blood pressure and the prolongation of youth," and while it is impossible always to attain this Utopian ideal there is a great deal of common sense in the methods advised for use in its quest. The style is so simple and non-technical that it must have been intended mainly for the lay reader, although the long list of diets and menus with caloric values and vitamin content cannot fail to be of service to the physician or trained nurse. Stress is laid on the vital importance of protein in the diet, a point which was not generally known, or at least not often heeded, by the gastro-enterologists a few years ago when it was quite the style to put patients with intestinal toxemia on almost a protein free diet. Insurance companies have for years been impressed by the evil influence of overweight in the production of disease and the shortening of life and any source of spreading knowledge of how to control weight without undermining strength should be welcomed.

WM. HENRY DONNELLY

**MODERN METHODS OF TREATMENT** By LOGAN CLENDENING M.D., Assistant Professor Medicine, Medical Department University of Kansas With Chapters on Special Subjects by H. C. ANDERSON M.D., J. B. COWHERD M.D., CARL O RICATER M.D., F. C. NEFF M.D., E. H. SKINNER M.D., and E. R. DEWESSE M.D. Illustrated C. V. Mosby Co. St. Louis 1924 Price, \$9.00

The author has given us a careful survey of the present use and indications for drugs and other therapeutic measures. The volume is divided into two parts, the first on general therapeutics with methods used in treatment the second on special therapeutics including the application of therapeutics to particular diseases. The book is well written and embodies the writer's experience in teaching and in the care of the sick.

Part I contains not only a description of the commoner drugs used, but a careful resume of the use of sera and vaccines of gland therapy with its indications and contra-indications. Food values and the principles of dietetics are carefully reviewed and we have presented a complete set of tables of food values. Hydrotherapy, medical gymnastics, massage, exercise, electro-

therapeutics, radiotherapy and psychotherapy are discussed in the first part. The chapter on miscellaneous procedures describes many useful measures used in the care of patients which are not clearly understood during our early years and is a valuable chapter.

In Part II the author gives his methods of treatment of diseased conditions in the different systems or the body. The subject matter is presented in a concise, clear, rational manner and will be useful to one who studies this author's methods.

The volume is one which is much needed to make clear in the minds of many, some of the modern procedures and theories. It is instructive. The book is printed on excellent paper, in large type and the illustrations are excellent.

H. M. MOSES

**DIABETES, ITS TREATMENT BY INSULIN AND DIET** A Handbook for the Patient By ORLANDO H. PETTY, B.S., A.M., M.D., F.A.C.P., Professor Diseases Metabolism, Graduate School Medicine, University Pennsylvania, Physician in Charge of Department of Metabolism, Philadelphia General Hospital. Illustrations F. A. Davis Co, Phila., 1924 Price, \$1.50 net.

This book of 111 pages is, as the author states, a handbook for the patient. It contains the simplest statements concerning the disease and its cause. Instructions are carefully given concerning the abuse of foods, and the proper foods to be eaten, upon the examination by the patient of the urine and upon the technique of hyperdermic administration of insulin. Excellent tables upon food values are given and many diabetic meals are outlined. While instructive, this book is almost too much of a short cut to proper treatment to be of great value. It has been presented most attractively by large print with good illustrations upon the best quality of paper.

HENRY M. MOSES

**CALORIMETRY IN MEDICINE** By WILLIAM S. MCCANN, M.D. Octavo of 98 pages Baltimore, Williams & Wilkins Co, 1924 Cloth, \$2.25

Basing his views upon a comprehensive review of the recent literature, the author has attempted to evaluate the importance of the contributions of calorimetry to medicine and of the clinical use of the basal metabolism determination. He points out the broader fields of usefulness of calorimetry in medicine, in the belief that such studies have added to a better understanding of the mechanism of symptoms and of the action of therapeutic agents. However the review of the extensive literature of the basal metabolism in health and disease indicates that, except for its sphere of usefulness in disease of the thyroid gland, the diagnostic value of the basal metabolism test, as clinically used, is slight.

HENRY M. FEINBLATT

**COLLECTED PAPERS OF THE MAYO CLINIC AND THE MAYO FOUNDATION** Vol. XV, 1923 Octavo of 1377 pages with 410 illustrations Phila. and London, W. B. Saunders Co, 1924 Cloth, \$13.00

As in all previous editions, there is hardly a topic on surgery and the related sciences that is not touched upon in this well-known, yearly publication. A radical change however has been introduced in the present volume owing to the unusually large number of papers published from the Clinic last year. The material has been selected so that only those articles which are of practical interest to the general physician or general surgeon are published in full, while those contributions which are of a purely technical nature or relate to research work only are abbreviated, abstracted, or referred to by title.

HERMAN SHANN



# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 3

NEW YORK, N Y

JANUARY 30, 1925

## THE OCULAR SIGNS OF SOME BRAIN TUMORS ~

By ARTHUR J BEDELL, M.D., F.A.C.S.,

ALBANY N Y

**T**UMORS of the brain have been recognized for many years. The more exact routine ophthalmoscopic study has opened many a dark symptom complex to the bright light of neurological examination, so that no case of suspected intracranial growth is thoroughly examined until the ophthalmoscope has been skillfully used, X-ray carefully applied and the profound knowledge of the neurologist brought into action. The subject has been so widely heralded that there is little excuse for some of our late diagnoses. In the last twenty-five years, the literature has been teeming with case histories. Many extremely valuable monographs dealing with several features of a general problem have also added much to our knowledge. In this clinical paper, it is impossible to even mention them by title. For the purpose of this it seems unwise to enter the correlation to the cause of optic nerve atrophy. The work in this country of Cushing, E. D. Cushing, Bordley, Frazier, Heuer, Parker and others is so recent and so familiar to you that it would be a waste of your time to listen to a summary.

The cases that are here reported have been proven by operation or autopsy and are, therefore, removed from the realm of conjecture.

### TEMPORAL LOBE GLIOMAS

By comparing the fields of vision you will note their similarity. The fundi even in the presence of very large tumor masses showed no gross deviation from normal.

Through the kindness of Dr. LaSalle Archambault I am able to give the following history of J. M., a man 23 years old.

"First seen December 10, 1920, for peculiar attacks lasting only a few seconds during which he gets up, becomes intensely pallid, walks around the room uneasily with an anxious expression and dilated pupils. Such attacks may come on several times a day or he may go several days without

any. I saw two such attacks and they were characteristic of 'le petit mal.' The objective findings at this time were absolutely negative throughout, including eyegrounds. He was given a combination of bromide and luminal and returned for examination January 5, 1921, but stated that no improvement had taken place and, although urged to faithfully continue under observation, decided January 18th to stop the medication."

My examination September 17, 1923, showed vision of the right eye 20/20 and Type 1 with moderate degree of hyperopic astigmatism. Pupil 4 mm regular, active, media clear. Fundus negative except venous engorgement. The right eyeball was 15 mm more prominent than the left. The left eye 20/20 Type 1. Pupil reactions and fundus appearance similar to the right. Because

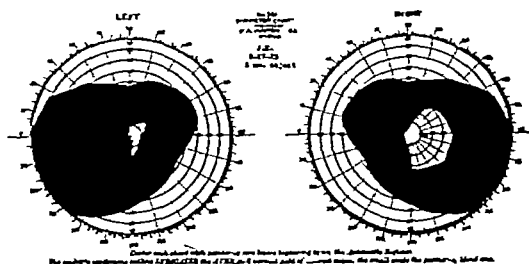


FIG. 1

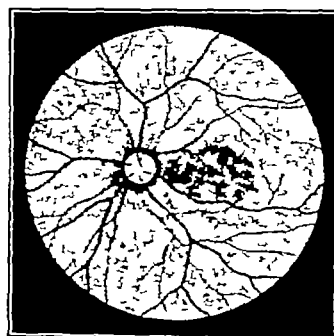


FIG. 2

ght  
a con-  
a marked

\*Read at the Annual Meeting of the Medical Society of the State of New York, at Rochester April 23 1924

enlargement of the sella turcica with erosion of the posterior clinoids. The patient was told that "there was something inside of his head that should be investigated," and was advised, therefore, to enter the hospital for observation. His physician would not consent to such a detailed examination.

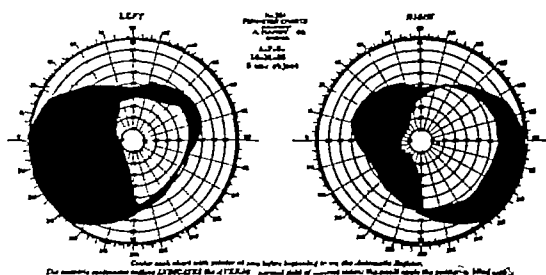


FIG 8

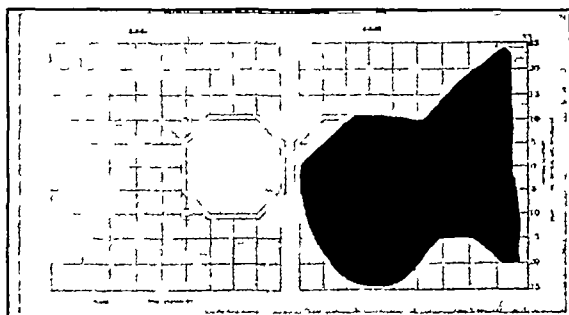


FIG 9

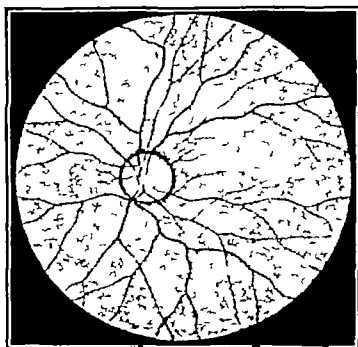


FIG 10

Dr Archambault saw the patient February 22, 1924, and found that the right frontal headache was less severe than formerly but that he was having attacks of somnolence, was increasing in weight and had a voracious appetite. The right pupil did not react to light but did respond to consensual stimulation. He had a marked grayish-white atrophy of the right disc, the left was normal. The other cranial nerves were negative and the extremities aside from the generally hyperactive tendon jerks exhibited no functional disturbance. The diagnosis was hypophyseal tumor or Rathke pouch cyst. The similarity be-

tween this and the next proven case is so striking that I think there can be no question as to the diagnosis.

A V F, a 13 year old girl, was first seen on November 11, 1922. Two years before she had complained of pain in her right ear and right side of her neck, which was said to be a symptom of nervousness. Four weeks before her visit she had been successfully vaccinated and four days after the "take," it was noticed that her writing was not on a straight line. This was followed by severe headache which became so intense that she was taken from school and an eye physician seen. Her vision steadily failed. She frequently complained of feeling as though she were going to be sick to her stomach. These attacks were followed by trembling and were ascribed to nervousness, particularly as they lasted only a short time, and as it was especially noted that they increased in severity as soon as she returned to school.

Vision of the right eye fingers at one foot. Pupil 5 mm regular, active, media clear, disc distinctly outlined, definitely pale without loss of substance. The left eye was divergent without fixation and fingers were seen at one foot. Pupil 5 mm regular, active, media clear, disc distinctly outlined, definitely pale without loss of substance. She had no spells of unconsciousness, no polyuria, polydipsia or appreciable change in weight.

Dr Archambault examined her on the 14th of November and reported that all of his findings except ocular were negative. She had no motor, sensory or co-ordination deficit in the extremities. The provisional diagnosis was tumor of the retrochiasmatal region either hypophyseal or floor of third ventricle.

Her field of vision showed contraction for form, in the right, with a large ring scotoma. In the left an isolated area for form in the lower nasal side. X-ray examination disclosed an immense cauliflower-like tumor in the hypophyseal

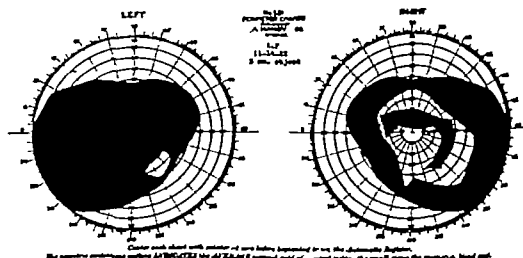


FIG 11

region. The parents were advised to take her to Dr Cushing. The following is a summary of his report.

"The child has an unusually distinct and extensive suprasellar shadow caused by calcareous depositions in a Rathke's pouch cyst. Operation



performed December 11, 1922, consisted of the osteoplastic procedure, evacuation of the cyst, and extirpation of large portions of calcareous pharyngeal duct tumor. Immediately beneath the dura there was a large cyst containing a slightly milky fluid with an abundance of cholesterol crystals, 70 cc of this fluid was collected. A soft tumor mass with gritty material lay between the right and left optic nerves in the region of the sella. A large mass of tumor and cyst wall was removed from the region of the carotid and middle cerebral arteries. After an extensive dissection the cavity was filled with salt solution, the flap replaced and the wound closed in layers without a drain.

"Following operation she was very well with great improvement in vision. Three or four days later, however, she developed a left-sided hemiplegia and died February 26, 1923."

The analysis of these two cases supports the view held by many that the seeming atrophy of optic nerve resulting from pressure is frequently a pallor and not a destruction of nerve fibers. This point has been discussed by several and is of considerable prognostic importance. It is certain that cases of this type tumor often show very marked improvement following operation, which could not result if the nerve fibers had been destroyed.

#### ACOUSTIC TUMORS

Acoustic tumors have, according to Cushing, probably been accurately diagnosed since 1777. Most of you have read the enlightening work by Cushing on "Tumors of the Nervus Acusticus" and in this short communication it would be unwise to even attempt the review of the development of this particular phase of brain diagnosis and operative relief. The subject can best be summarized in the words of Dr. Cushing: "That the acoustic tumors, owing to the characteristic chronology of their symptoms may as a rule be sharply distinguished from all other tumors of the cerebellopontile angle." The case here detailed is typical.

Mrs. L. J., 44 years of age, seen on January 14, 1924, said she had been well until October 1922, with the exception of an attack of influenza in 1918. During the winter of 1922 she had severe left frontal headaches which were worse in the afternoon. With this pain she had noises in her ears. These discomforts, however, lasted for only two months. She seemed perfectly well until October, 1923, when she had difficulty in seeing at a distance especially with the right eye. She also noticed that she could not hear well with her right ear and that the noises had returned on that side of her head. These symptoms were accompanied with intense epigastric pain referred to the back, extending into the occiput and along the spine, usually with nausea. The pain steadily increased in severity and at times she was given

morphin. In November, 1923, she had an attack of weakness of her right arm and right leg with the drawing up of the right side of her mouth and twitching of the right facial muscles. Her vision had steadily decreased.

I saw her in consultation in the Albany Hospital with her attending physician, Dr. Arthur H. Stein, and Dr. LaSalle Archambault. At that time, the right eye was blind, no light perception, pupil 4.5 mm reacting consensually, media clear, the papilla extremely swollen 7 diopters with rounded margin, few blood vessels, no hemorrhage or exudate, a classical choked disc. Tension Schiötz instrument 15.

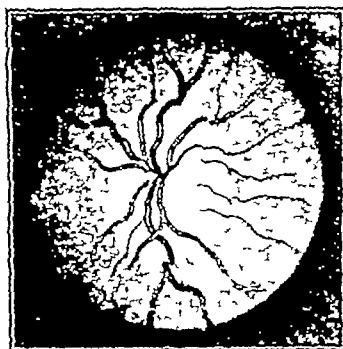


FIG 12

The left eye, pupil 4 mm regular, active, media clear, disc swollen 7.5 diopters, with several flecks of exudate and faint striae of blood extravasation. Schiötz tension 13. Field showed an inferior nasal contraction.

It is particularly noteworthy that she was absolutely deaf in her right ear, whereas her left ear showed no change in function. Both drum membranes were retracted, thin, without scar or vascularization. Because of the intense involvement of both papillas, the blind right eye and the loss of hearing in the right ear, a diagnosis of acoustic tumor was made. Through a T-shaped occipital

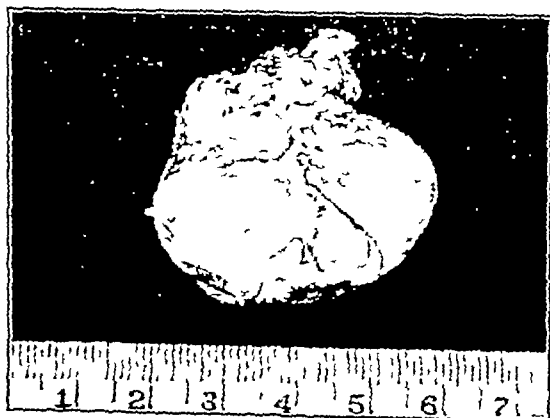


FIG. 13



## THE PEDIATRICIAN AND PREVENTIVE PEDIATRICS \*

By HENRY L K SHAW, M.D

ALBANY, N Y

SIR JAMES MacKENZIE in his illuminating book on *The Future of Medicine*, pictures disease as consisting of four stages. First, the predisposing stage, where the individual is free from disease, but is liable to be attacked either from some inherent weakness or from an outside source.

Second, the early stage, when the disease has entered the human system but has not produced any objective signs, and the symptoms are chiefly subjective. The third and fourth stages are respectively the advanced stage and the final stage.

Preventive medicine is concerned with the first two stages. Curative medicine with the third and fourth. MacKenzie argues that physicians in their zeal to relieve suffering have overlooked and neglected the first two stages. Medical science has revealed much knowledge on many factors involved in the third and fourth stages. Now we have reached a point when attention must be focused on the problem of understanding the factors involved in the first and second stages. The problems, therefore, of preventive medicine.

The objects of preventive medicine as outlined by Sir George Newman are

- 1 To develop and fortify the physique of the individual and thus to increase the capacity and powers of resistance of the individual and the community

- 2 To prevent or remove the causes and conditions of disease or of its propagation

- 3 To postpone the event of death and thus prolong the span of life

He feels that the correlation of preventive and curative medicine should be realized in the well-equipped and trained physician of today, and that the physician should concern himself with measures for the maintenance of health as well as the cure of disease.

There is no reason why preventive and curative medicine cannot be brought together and practiced in perfect harmony.

One of the direct results of the recent advances in medical science is that preventive medicine now plays a very important part in the daily practice of the physician.

There is no branch of medicine in which the preventive side has been so fully developed and practiced as in pediatrics. Garrison in his *History of Pediatrics* in Abt's System says that pediatrics was elevated in the 20th

century from its ancillary status as a dependent dwarf of ordinary medical practice, into the larger atmosphere of social or preventive medicine, of which it is now one of the most important independent branches.

In this connection permit me to quote at some length from a paper read by Escherich of honored and revered memory, over twenty years ago. He spoke with the vision of a prophet.

"The greatest difference between the therapeutic problems of the pediatricist and those of the internist lies in the overwhelming importance and development of prophylaxis. The word prophylaxis in this sense is to some extent synonymous with care, inasmuch as in the education of the child on account of its lacking self determination, experience, and regulating methods, care must not only satisfy its bodily needs, but also guard it from all threatening dangers. To bring this about the experience of adults and the general rules of hygiene, however, do not suffice.

"It requires special individual instruction which can only be given by a pediatrician cognizant of the laws of child development and carried out by persons trained in them. Clinical experience and medical statistics show that nothing influences the mortality and liability to disease in children as much as a carefully conducted management by experts, and in this way, most if not all sicknesses may be kept away, at least in young children. Pediatricians have always known the great importance of protecting care and prevention even if only the magnificent acquisitions of the last few decades have shown them the proper way. The main point is the constant and careful watching over the course of the child life as a whole, but especially during the first period of growth, the care and furthering of normal development, the taking care of those backward in development, improvement of the already developed functions, special attention of the rapidly growing organs, prevention of the tendencies to acquired or inherited diseases, protection from injurious agencies, especially infections.

"Disease with which the medical care generally begins is here to a certain extent a failure of preventive care, an interruption disturbing the normal process of development. But why," he asks, "should we hesitate to place individual prophylaxis, based on raising the power of resistance and avoidance of disease, as the ideal aim of our efforts?"

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester April 23 1924

Dr Holt in his presidential address before the American Pediatric Society last May discussed the pediatrician of the future, and described three distinct types that would be needed

"First, a research man who is likely to be a full-time head of a department in a university medical school

"Second, the man who applies our best science in the treatment of sick children in the home or in the hospital or dispensary, and third, the public health pediatrician who organizes and directs this special department in the state, city or county" He considers them all equally essential, but that at this present time the public health or preventive pediatrician is in most demand

This same thought was brought out by Veeder in his address on the "Trend of Pediatrics" last October before the American Child Health Association and the Central States Pediatric Society He claims, and rightly, that the problem of the future is how best to correlate these three types, all of which are so important to the health of the child, so that we can go ahead with a unity of purpose which is necessary in order to obtain the best results The tendencies of each type of pediatric activities have in the past been to diverge from each other, but it is hoped that in the near future they will converge or at least run in parallel lines

The clinician has looked with distrust and sometimes with *ridicule on the child hygienist* He feels that curative medicine and remedial measures are of the utmost importance, and pays but scant attention to the claims of preventive medicine The child hygienist on his part feels that prevention is of greater importance than the treatment of disease Both are concerned with the health of the child and their aims are identical It is the old story of the shield The clinicians see only the silver side, while the child hygienists see the gold side

It is no doubt unnecessary for me to make a plea to the members of this Section to combine the remedial and preventive branches of pediatrics The successful pediatrician is a counselor of health as well as a purveyor of pills An increasing number of mothers consult him on matters of diet, management and general hygiene of her child Such advice can only be given intelligently after a careful examination of the well child, and some knowledge of the conditions surrounding the child at home It requires skill, patience and special experience to make a thorough examination of a well child, and be able to detect signs of potential disease in the first stages, and to

give simple and scientific advice concerning health habits and diet which will correct any abnormal tendencies or incipient physical and psychical defects

Medical colleges in the past neglected the teaching of preventive measures and the study of the well child Medical students were quizzed and drilled on pathologic conditions and were taught almost exclusively in hospitals and dispensaries Today there is beginning to dawn a new era in the teaching of pediatrics The student is given practical work in child hygiene at the Welfare Stations, Schools and Health Centers He is taught the physical and mental development of the child as well as its care and nutrition Decided progress has now been made along these lines, both in the medical colleges and post graduate courses that the physicians as well as pediatricians of the near future will be trained as practitioners of preventive medicine

As a result of the indifference of the average pediatrician to child welfare work his domain has been encroached upon by outsiders, not trained in medicine, but keenly alive to the necessity and opportunity for this line of work. The social worker, the nutrition expert and the public health nurse have entered in and in some instances monopolized the field One result has been to show the public that the physician is not the only one to whom they may turn for advice in health matters On account of lack of training and lack of interest a pediatrician skilled in curative and diagnostic measures, may show up at a great disadvantage when asked questions regarding health habits, mental development, etc., by parents who have read the popular literature on these subjects and want more specific and detailed information

There is a feeling of distrust and perhaps jealousy on the part of some pediatricians toward the child welfare clinics They learn that one of their little patients has been taken to a child welfare conference That the visiting nurse has followed the case in the home and that the mother has become a regular attendant The family physician feels and justly so, that he has lost a patient It is true that if the child becomes ill he will be referred back to him, but the advice given and the better care received will prevent illness, and therefore the need of his services

We are only on the threshold of preventive medicine and in the enthusiasm of those interested in child hygiene great efforts are made to popularize maternity, infancy and child hygiene clinics and little or no restriction is made of the social and financial condition of the patients The children of the poor should and must receive the best possible care and

attention and no restriction or curtailment of this service is desired. The work with this class of patients should be extended and improved. The same legal requirements, however, should apply to child hygiene clinics as to dispensaries. The parents should be obliged to sign a card giving the amount of their income and stating they cannot afford to pay for the services of a physician. A clever satire on this situation was written by Dr. Bryant, Secretary of the Maine State Medical Association which he calls *The Free Road to Health*.

"The prenatal clinic cares for the child in its mother's womb and guides it into a hostile world. It is received into the motherly lap of the baby welfare clinic and tenderly cared for. It receives its nourishment from a warm and hygienic bottle, prepared in the baby milk laboratory. Its tottering steps are guided by the helping hand of the child welfare society. In due time the child enters school, where he is welcomed on the threshold by the school nurse and introduced to the school physician. He is vaccinated against smallpox, inoculated against typhoid, is given the Schick test and made immune to diphtheria. His teeth are looked over at the dental clinics, and his tonsils and adenoids are removed at some hospital out-patient department. His eyes are examined and possibly fitted to glasses. Thus equipped and prepared he at once starts to do his health chores. Found underweight he enjoys for a time the luxury of an open air school under the supervision of the nurse and physician of the Anti-Tuberculosis Association. Thus he is guided through school and may take a chance at college. If he escapes here for a moment from his guardians and falls to evil ways there are free clinics provided for even these emergencies.

"Safely passing his health inspection and eugenic society examination, wedlock is entered. In due time his wife becomes an attendant of the maternal welfare clinic. His health is guarded by his periodic health examinations. He is looked after at his work by the industrial nurse and then is prescribed for by the industrial physician. It sick at home he has the care of the visiting nurse and the social worker. His future is provided for by his industrial insurance and old age pension. In his declining years he enters some rest home for the aged. His dying pillow is smoothed by the institution nurse and his room brightened by the home visitor. Some burial society looks after his funeral. At last he lies at rest after a long and pleasant journey along the free health road. A high ideal to strive for, and a pleasant journey—we wish him well."

It behooves the medical profession to offset

and hold back a rising tide of popular demand and sentiment for free examinations and advice. Dr. Eugene Kelley, State Commissioner of Health of Massachusetts, says that we must take the letter R out of free and place hygienic work on a fee basis.

No pediatrician can support himself and his family without receiving adequate compensation for the examination of a healthy child and for advice regarding his diet, habits, exercise, play, sleep, and matters concerning the preservation and betterment of health and prevention of disease.

Unfortunately our medical brethren are in a large measure responsible for the situation. They give advice along health lines and regarding health measures gratuitously in their offices and on the street corners. The public must be educated to an understanding that the service and advice rendered by the physician in regard to health betterment and prevention of disease is just as important and just as valuable as that rendered in restoring the sick to health, and should be paid accordingly. It is an inherent human trait to get something for nothing and this is not confined to any one creed or race.

As an illustration of the attitude of the medical profession let me quote from a letter sent recently to each of the parents of over 200 boys attending a well-known private day school:

"No expense will be incurred in having this work (the Schick test and T.A.T. injections) done, as two physicians, Drs. Blank and Blank have generously offered their services. Both these gentlemen have had much experience in performing this test and in reading the arm, and in giving the toxin-antitoxin injections. The material will be furnished by the State Department of Health."

The object of this letter was most desirable and commendable as the Head Master and Trustees desired to have all the boys immunized against diphtheria. The part played by the physicians is open to criticism, as the parents of these boys are abundantly able to pay for such service.

Dr. Howe, Director of Medical Inspection of Public Schools in the State Department of Education, told me the other day that it was not the policy of the Department of Education to have medical and preventive work performed in the schools. They strongly oppose it and advise against it. The function of the schools is education in health and health matters, and all vaccinations, immunizations, corrective work, etc., should be done outside the school by the family physician, or at a dispensary.

Preventive pediatrics is advancing by leaps and bounds. Popular health propaganda and education is showing results by the increasing demands of parents to have complete periodic physical and mental examinations made of their children, and they should be made to pay well for such services. The difficulty today is that many pediatricians are not fitted or interested in making such examinations. A thorough physical examination should include at least hearing and visual tests, relation of weight to height and age, examination of teeth, nose, ears, throat, heart, lungs, spine, posture, feet, nervous system, mental and emotional state and general tone. Analysis of the urine and blood should be made. It should also include inquiry and advice as to diet, clothing, exercise, sleep, habits and training. These examinations should be made at least twice a year and careful records and charts made. The physician's office should be more of a service station than repair shop.

These examinations should be made by the family pediatrician, who should also be the family health counselor. He knows better than a clinic pediatrician the intimate relation between the physical condition and the home environment. He is acquainted with the parents and their shortcomings. He is familiar with the child in sickness as well as in

health. He is the one to vaccinate and immunize the child against smallpox, typhoid and diphtheria. For this and much other health service he should receive financial compensation much greater than in the ordinary treatment of diseases as it occasionally develops.

The dental profession has shown with what ease and success the public can be educated to have an examination made of the teeth once or twice a year. Dentists will tell you as they have me that their work has been increased and has been made more pleasant on account of this dental prophylaxis.

Dr. Forbush, an eminent doctor of divinity, in an article published in a recent number of the *Journal of the American Medical Association* on "How the Doctor Looks to the Layman," says that the doctor's "greatest duty today is to educate us. With a popularization of medicine we shall learn to call the doctor more often when we are well, so that we shall less often be sick. We shall engage him to teach us the regime of living and how to prolong life joyously instead of to eke it out. We shall then understand the peril of substituting the soda fountain clerk for the physician in dealing with human lives. And we shall learn the difference between St. Luke, the good physician, and St. Vitus, the back-bone manipulator."

## ATROPHIC RHINITIS\*

By CHESTER C. COTT, M.D.,

BUFFALO, N. Y.

**A**TROPHIC rhinitis is a disease characterized by abnormally broad nasal passages and the presence of purulent secretion and crusts. It is usually first noticed at puberty, seldom appearing later than twenty-five years of age.<sup>1</sup> When the disease has the additional symptom of fetid odor it is called *ozena*.

There is no single cause of atrophic rhinitis. Syphilis as a cause has never been proven, neither has tuberculosis, although both classes of cases occasionally develop the disease. Opinion seems settled upon the fact that the basic cause is an interference with the blood supply of the nose. This may be due to a chronic inflammation or suppuration or chronic venous congestion.

That there is an actual trophic disturbance is evident upon gross and microscopic examination of the diseased area. The nasal chambers are broadened by an actual absorption of the mucous membrane and turbinates. They

often appear one-third the normal size. The membrane is no longer erectile in type, but hugs the bone closely. The microscope reveals a rarefaction of the nasal bones and sclerosis of the blood vessels (2).

The bacterial infection is usually mixed, with staphylococcus predominating. Many attempts have been made to isolate the causative bacteria and some claims have been made that certain ones have caused the disease. In tuberculosis cases, who have atrophic rhinitis, the TB bacillus is frequently present, although Linthicum after exhaustive examinations concludes that the acid fast bacillus found in these cases is not identical with the tuberculosis bacillus (3). Perez *ozena bacillus* is stated to be an etiological factor in at least fifty per cent of cases by Hofer and Sternberg (4). The fact remains that there is no specific bacterial cause present in every case.

Chronic suppurative sinusitis appears to me to be the cause in most cases which have come under my notice. When we realize that

\*Read at the Annual Meeting of the Medical Society of the State of New York, at Rochester, April 23, 1924.

infants and young children have this disease (5) and that many go without care for years, it can easily be understood what damage this purulent discharge can do to the nasal mucosa and then the underlying bone. Many such cases are cured of their sinusitis by the removal of tonsils and adenoids, some heal spontaneously, but that many are affected in this manner was proven by White, who examined fifty children as they presented themselves for tonsillectomy at the clinic and found evidences of pathological sinuses in forty-one of the fifty (6).

The symptoms of atrophic rhinitis are quite characteristic. Persistent dull headache, nasal discharge, profuse and heavy, occasional removal of scabs, post-nasal catarrh, and fetid odor are the usual complaints. Upon examination the nasal fossae are broad, due to the absorption of the ethmoid and inferior turbinated bones which has occurred. Pus lies in the hollows of the bones and scabs adhere to the membranes, occasionally forming a cast of the passage. Upon removal slight bleeding may occur. When the pus has been cleansed away, more may be seen coming from the visible sinus openings. Upon suction, more pus may be obtained, although occasionally cases may have no sinus involvement, at least none seem to be involved. It seems probable that such cases had suppurative sinusitis, but due to the better drainage secured by the bone absorption, the individual sinuses healed, leaving only the external evidences of the disease. I have found that the antrum is rarely involved, the sphenoid occasionally and the ethmoid most frequently. Examination should be complete until one has definitely learned which if any sinus is affected, for these will need drainage before a cure will be obtained.

Since atrophic rhinitis is such a persistent disease and has been well recognized for many years, many types of treatment have been employed. These may be classed as surgical, non-surgical and treatment with vaccine.

The nasal chambers are too broad in this disease. Therefore attempts at cleaning the nose are unsuccessful, because the air expelled does not pass through with enough force. Narrowing of the passages has been attempted by various means, the simplest of which has been the injection of paraffin. This has been placed under the perichondrium of the septum or periosteum of the turbinate. In recent years, many of these cases developed paraffinoma of the face, a fatal disease which occurs several years after injection, so that this method is now seldom used. Botey advised the use of white vaseline 10 gm and sulphate of baryta 20 gm in place of the paraffin (7). The lateral nasal wall has been severed from its attach-

ments and moved bodily toward the septum. Several men have described methods for this purpose. Hinsberg (8) after moving the maxillary walls toward the septum, holds them in place with metal plates, which should be removed in several months. With somewhat different technique Max Halle (9) accomplishes the same result, retaining the wall in position by packing within the antrum. These operations so narrow the nasal passages that the purulent secretion may be expelled by the patient, thus eliminating the odor, which they say is checked immediately. However, G. Liebault (10) calls attention to the fact that such procedures do not take into account the trophic disturbance present in this disease, and that they correct only the lower part of the nose, leaving untouched the posterior group of cells, which must not be neglected if a permanent cure is to be obtained.

Under surgical treatment must be mentioned the drainage of all suppurating sinuses. The antrum may be attacked as radically as desired or as necessary and also the sphenoid, as the openings made into these two sinuses in time become very much smaller and the nasal chambers are not increased in width by radical operations upon them. The ethmoid, however, should be treated gently. No more bone than absolutely necessary to obtain drainage should be removed. The middle turbinate, which is very much reduced in size, should never be removed. All necessary operative work can be done external to this bone. A case of atrophic rhinitis with frontal sinus suppuration has not come to my attention.

Non-surgical treatment consists in careful and frequent nasal cleansing. This should be done as often as necessary to keep the secretion from drying upon the membrane and causing an odor. For office treatment the suction apparatus run by an electric motor is efficient. The suction tube is led to a bottle from which another tube goes to the patient's nostril. A second tube leads from the other nostril to an irrigating can containing an alkaline solution. With the patient's head well forward and the alkaline solution a little lower than his head, the motor is turned on and the solution sucked into one and out of the other side of his nose carrying with it most of the secretion. Glass tips are used for insertion into the nose. Patients need a little practice to do the irrigating correctly, but I have an eight-year-old girl who does very well. Some will have to swallow or say "k" to start the suction. Scabs may be blown out or easily picked out with forceps after such treatment. Iodine 5% in glycerine or ichthyol 10% in glycerine and water should be applied when the nose is clean. Of course,

the postnasal space and pharynx should be inspected and treated the same if required

Home treatment is absolutely necessary. I have never seen an atomizer or nasal douche type of treatment do any good whatever. They do not get out the crusts or thick pus. After the patients have seen the office suction apparatus at work, they should be instructed to make a similar one at home. This can be accomplished by two methods. A water tap suction pump may be used instead of the office motor or the suction may be obtained by the weight of the irrigating solution passing out of the nose through a long tube. In using the latter method a douche bag containing the irrigating solution is hung at the level of the head. The hose with nasal tip is put into one nostril and another tip with hose attached is held in the second nostril. With the patient in a standing position, the head is lowered slightly to start the flow. As it runs into and out of the nose, it fills the long tube and the weight of water in this hose is sufficient in most cases to obtain good results. Irrigation should be done twice daily at home. Some cases may be taught to apply medication to themselves, after washing.

Sugar has been used both by intravenous injection and locally to the nasal membranes. Wiethe (11) injected a 20% solution intravenously, 40 cc every other day during a week and then a few days rest when 50 to 60 cc were injected repeatedly. He claimed rapid relief of symptoms. Tarneaud (12) uses glucose in two strengths, the weaker to be used in an atomizer and the stronger to be poured into the nostril with a spoon. He believes the glucose allows the growth of common bacteria in the nasal fossae, thus interfering with the growth of the pus-producing organisms, and by their hypertonicity, producing greater serous nasal secretion which is desirable in these cases.

Vaccine treatment has been tried by many with various results, perhaps because of the variety of bacteria present. When a particular

one predominates, good results may be expected. For instance Linthicum (3) used tuberculin in a series of cases with excellent results, although he was quite satisfied that the bacillus obtained from the nose, although closely resembling the tubercle bacillus was in fact not the same. Clinically, the nasal disease in these cases responded to the treatment. In his series of 126 cases definite tuberculosis was found in 52.

You will gather from the foregoing varieties of treatment, that just as there is no single cause of atrophic rhinitis, so there is no sure cure. Still, it is not very difficult to keep our patients comfortable and inoffensive to their associates. The principles of treatment are definite: make the nasal fossae as narrow as possible, clean up all localized sinus infection, keep the nose as free of pus as possible by frequent, thorough cleansings.

#### BIBLIOGRAPHY

- 1 W. C. Phillips, *Diseases of the Nose and Throat*
- 2 A. Lautenschlager, *Arch f Lar u Rhin* 34-280, No 2-3, Berlin, 1921
- 3 F. H. Linthicum, *Am J M Sc* 162 216, Aug 1921
- 4 G. Hofer and H. Sternberg, *Arch f Lar u Rhin*, 34-164, Berlin, 1921
- 5 L. W. Dean, *South Med Jour* Oct 1922
- 6 F. W. White, *Ann Otol Rhin & Laryn* Mar 1921
- 7 R. Botey, *Ann d mal de l'oreille, du larynx, etc*, Jan 1922
- 8 V. Hinsberg, *Monatsch f Ohren u Laryngo-Rhin Suppl* 1, 1921
- 9 Max Halle, *Jour Laryn & Otol* Edinburgh, Dec 1921
- 10 G. Liebault, *Rev de Laryngol etc*, Bordeaux, Oct 15, 1923
- 11 C. Wiethe, *Monatsch f Ohren u Laryngo-Rhin*, Dec 1921
- 12 J. Tarneaud, *Paris med*, Sept 30, 1922

#### ACUTE ETHMOIDITIS\*

By FRANK M. SULZMAN, M.D.,

TROY, N. Y.

IT seems to be a general rule in papers of this character to begin with a general description of the anatomic parts under consideration. For the sake of brevity you will allow me to omit a great part of this description which would become a tiresome repetition. Instead, I shall emphasize certain points which a review of the

literature shows to be of special value in the study of the anatomy of this very important part of the nose.

The great complexity of the adult ethmoid labyrinth and the variations in size, shape and disposition of the individual cells composing it are in accord with the early anatomy and development. For example, The table given by Loeb of the size of this ethmoid labyrinth will range in the

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester, April 23, 1924.



anterior posterior diameter from 22 to 55 mils, the superior inferior from 17 to 59, and the lateral from 19 to 28, according to Pratt, the anterior cells will vary from 2 to 8 in number and the posterior from 1 to 7

With such a wide variation as these tables show it is easy to see why many difficulties are encountered when we attempt a description and why many more are met when surgical measures are being taken to eradicate diseased conditions in these cells

It is common to describe these cells as belonging to an anterior and a posterior group but if you will study the work of different men who have gone over hundreds of these skulls you will become impressed with the theory that a posterior cell may be anterior and an anterior cell may be posterior. It is impossible in very many instances to judge merely from its position whether a cell belongs to the anterior or posterior ethmoidal group. The location of the ostium in the body of the cell determines the cell's classification

The anterior group drains into the middle meatus and the posterior group into the superior meatus or along the posterior border of the middle turbinate. These cells may encroach upon the lumen of the frontal, sphenoidal and maxillary sinuses, changing their size and lumen. The cells will also encroach upon the orbital wall and when infected add grave danger to the sense of sight and to an infection within the orbit itself.

Those of you who have had the good fortune to hear Professor Schaeffer of Philadelphia and to see his wonderful collection of slides describing the embryology and development of these cells must have been impressed with the enormous amount of work he has done.

In connection with this work it would only be fair to mention the names of two distinguished members of this section, Doctors Phillips and Coakley of New York, Mosher of Boston, Skilern of Philadelphia and the studies of Sluder, men who have done much to enrich our knowledge of the physiology and anatomy of these parts.

With the aid of a few slides I shall later try to show you why we sometimes have failure even after the most careful operative work in the ethmoid labyrinth, why we should not be discouraged if, after several attempts, we fail to attain the result we desire, and why it is not by direct injury alone that we have a possible extension and cause of meningitis, which is one of the dangers to be feared and always respected in operating in this region.

In the acute type of infection of these cells, the subject of this paper, we have the classification of the catarrhal type and the suppurative

type. In the acute stages the mucous membrane presents the ordinary symptoms of acute inflammation. Any acute cold in the head is accompanied by infection of these cells which disappears because drainage is not interfered with and with the subsidence of the primary trouble no further work is necessary. But when the cells are not properly drained, accompanying any acute condition in the nose or general condition causing infection in these cells, we have symptoms which are quite characteristic and which need attention at our earliest possible moment.

Two fairly constant symptoms always accompany an infection of the ethmoid. First, a feeling of stuffiness in the nose itself, second, pain either in the nose frontal or occipital regions, made worse by change in posture or any attempt to clear the nose.

Pressure over the region of the ethmoid usually elicits pain and an examination will show the swollen condition of the mucosa of the entire nose as most of our sinus troubles are caused by repeated colds which cause the mucous membrane to become oedematous and hyper-plastic.

When the patient is lying down the blood pressure is higher in this locality with consequent swelling and temporary occlusion of the ostium. The sinus mucosa in the meantime is absorbing the oxygen which is contained in the sinuses but as no more can enter there results within a condition of negative pressure with swelling and transudation through the mucous membrane, after a time, however, the ostium again becomes patulous but the membrane does not have time to fully regenerate before the ostium again becomes occluded through the same causes. This irritation and swelling produce inflammatory tissue changes that make it a suitable culture medium for bacteria the first time the patient contracts a severe cold.

A discharge seen in the middle meatus would aid us in locating our trouble in either the anterior, ethmoidal or frontal sinus. A discharge along the posterior portion of the middle turbinate or in the superior meatus would be from the posterior cells but I should not entirely base my diagnosis on the presence or absence of discharge insofar as I could see it. You must take into consideration the other symptoms found on examination before excluding ethmoiditis. A large majority of the acute type of ethmoidal infections subside without much difficulty by treating the primary trouble. To a certain percentage, however, this does not apply and it is necessary to do more, opening and draining as conditions warrant.

The X-ray is of much greater value than transillumination in the diagnosis of these conditions.

Trans-illumination is not always very satisfactory

Certain symptoms, I should like to bring to your attention, of these the most prominent, headache

Headaches resulting from sinus infection are among the most frequent and at the same time the least understood of all the symptoms of the disease. Many cases of sinus disease with slight nasal symptoms go through their entire life with chronic headaches taking all manner of cures without it occurring to the doctor that headache might be caused by disease in the accessory sinuses. Headaches of this type are intensified by constipation, sudden jarring, stooping, use of the eyes, mental work and loss of sleep. In ethmoiditis the patient speaks of dull pain between the eyes usually accompanied by a sense of weight over the vertex. Dizziness and vertigo are also frequent symptoms.

Extension of the infection from the ethmoid condition to the tissues of the orbit causing orbital cellulitis is a second symptom. When the optic nerve is involved in these cases there follows loss of vision in varying degrees.

Third in the list of symptoms, a possible meningitis by extension through normal opening or by breaking down nature's barrier and causing it by either direct trauma or an extension of an infection.

This was clearly shown by two speakers at the meeting of the Academy of Ophthalmology and Oto-Laryngology held in Washington last fall. It is the neglect of many of these acute cases with subsequent reinfection that lead to the chronic type and with this condition present our problems are many and require the utmost patience to carry us through to a satisfactory result.

A treatment of the general cold together with the shrinking of the nasal mucous membrane and use of the suction pump with any of the ordinary nasal oils usually gives great comfort and may be all that is necessary. Some cases require operative work and we should not wait too long before giving relief if the ordinary measures already spoken of do not relieve. Have in mind that you are dealing with an infection.

A review of the literature regarding operative procedure shows the difference of opinion. Some will tell you not to touch the middle turbinate, keeping external to this. Others will advise opening and removing portions of or the entire middle turbinate. Here again we must remember our anatomical relations and the finding of those who have studied and examined many skulls. If

ethmoid cells are sometimes found in the middle turbinate and this view is substantiated by competent observers, they must be opened when infected—whether it is turbinate or not must be forgotten.

### CONCLUSION

Age does not exempt from this infection.

Expect to find wide variation in the size and position of the cells. Many of the conclusions as given by Davis I feel I should emphasize as they are in accord with most of our findings. "Ethmoiditis is far more frequent than has been generally recognized, the milder forms, particularly those of childhood, being the class most frequently overlooked and its importance greatly underestimated."

"The apparent greater frequency in adult years and the greater severity of effects are largely due to neglected acute attacks in childhood, which, with each recurrence leaves an added predisposing factor toward other attacks or toward the perpetuation of a process already begun."

"So-called bronchial asthma is principally a result of ethmoidal disease, particularly the type productive of polyp formation."

"More headaches and various neuralgic pains are due to processes developed from chronic ethmoiditis than from all other sources combined—the majority of which can be relieved by surgical treatment."

"A large percentage of ocular pains owe their origin to ethmoidal disease and must be relieved by treatment directed to the intranasal causal factor."

"Ethmoidal infections are frequent sources of both catarrhal and purulent aural disease, and in every aural infection careful treatment directed to the accessory sinuses is of equal importance to treatment of the ear itself."

"Radical operations on the sinuses should be employed only where conservative measures faithfully applied prove inadequate."

The advice of Skillern should always be before us: "Better to do too little than too much."

### BIBLIOGRAPHY

- Phelp. Orbital Cellulitis in Children.
- Ethmoiditis. Pratt's Journal Lancet.
- Schaeffer. The Nose and Olfactory Organ.
- Skillern. Accessory Sinuses of the Nose.
- McCullagh. Larval Ethmoiditis, *Laryngoscope*.
- Davis. Ethmoiditis, *Penn. Medical Journal*.

## COMPLETE ECTOPIA LENTIS—REPORT OF CASE \*

By E W KENNEDY, M.D.,

ROCHESTER N Y

**E**CTOPIA lentis is of infrequent occurrence and is a congenital malposition of the crystalline lens, as distinguished from luxatio lentis or traumatic dislocation. The condition is invariably bilateral, and usually displacement is symmetrical, and said never to be directly downward. The upward tendency of the displacement suggests some relationship to the closure of the secondary optic vesicle. There exists a marked tendency toward transmission and frequent association with other defects as coloboma of iris, lens, choroid, etc.

Most observers unite in the belief that ectopia lentis is due to defect in development of the suspensory ligament, occasioned by failure or late closure of the ocular cleft in the ciliary region. In considering the development of this suspensory ligament or Zonule of Zinn, we recall that the primitive lens remains in contact at its sides with the portion of the secondary ocular vesicle destined subsequently to become the ciliary body. The lens becomes encircled by what is termed its fibro-vascular sheath, which forms adhesions from contact with portion of secondary optic vesicle and as the eyeball enlarges, it does so at a greater rate than the lens, so that a portion of the ciliary body which was in contact with the lens grows away from it and adhesions which have formed between them become stretched, leaving only the delicate fibres of the suspensory ligament as seen in the adult eye.

The absence of the fibres in the Zonule of Zinn in the inferior region allows the lens to be drawn in an upward direction, rather than directly downward. Displacement might also be occasioned by the adhesions between the ciliary body and the margins of the lens being denser on one side and less elastic than normal, so that they expand less readily than those on opposite side, this would account for those cases in which fibres of the suspensory ligament can be seen stretching across the aphakic area. Traction of the hyaloid artery and bands in the vitreous have been offered as causes.

In reviewing the causes of developmental defects permitting ectopia lentis to ensue, one is interested in the work in biology and notes the work of Guyer, Stockard and others. It is during the second week of embryonic life that the primary optic vesicles become visibly differentiated and appear as offshoots of one of the primary brain vesicles, the fore-brain. While there are different beliefs as to

the manner in which it comes about, we find the theory of Stockard quite well substantiated by experimental work. He considers that the cells or elements entering into the formation of the eyes have their origin in the median portion of the developing nervous system. He was able to excise portion of the median plate and prevent the formation of eyes, and the early removal of a lateral portion did not prevent development of two eyes, while if done later indicated that the optic vesicles were situated laterally.

In subjecting young fish eggs to exposure to heat, cold, chemicals, fumes, etc., he was able to arrest the development of the optic vesicles at various stages and obtain defects of many degrees, ranging from cyclopia through defects of varying degrees to practically normal eyes. Probably the effect of the various agents is much the same—acting upon the embryonic structure to inhibit its development. The type of anomaly depends upon the period of development at which the inhibiting agent is applied and the development arrested or retarded.

Guyer has injected pulverized rabbits' lenses into fowls and then injected this fowl serum sensitized to the crystalline lens into rabbits pregnant about ten days.

In the offspring he has observed abnormalities, such as lenticular opacities, coloboma of iris, choroid, displacement of lenses, variation in size and position of globe, etc. By mating these rabbits he has observed the defects appearing in the progeny, and noted that the defects tend to increase and appear in proportionally greater numbers in successive generations. He has been able to carry a defect through as many as nine generations, and feels that it can be transmitted indefinitely, once secured.

Wm N, age 47, laborer, presented October 5, 1919, stating that his eyes had always been poor, but that for about six months he had noted periods in which the vision of left eye had been greatly disturbed. He states that his father's eyes were "affected from birth," and his grandfather had "poor eyes all his life," finally blind when he died in old age. On mother's side were many children—none known to have any eye defects. Patient had one brother, age 50 at death, whose eyes were good, one brother, died at age of 8, had "poor eyes," and a sister died in infancy. Patient has four boys and one girl. In the eldest, age 14, crystalline lenses are displaced outward,

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester April 22 1924

the next three appear normal as to structures and vision. In the youngest, the girl of 5, the lenses are displaced outward.

Patient shows external structures normal, the corneas being 11 mm in diameter, deep anterior chambers, irides tremulous, pupils equal and active to light. No colobomata. Vitreous clear, fundus details very small and best seen with +10 D. In the center of each disc is a small greyish tag extending into vitreous for about 5 D, probably remains of hyaloid sheath. In the bottom of each vitreous chamber is a grayish lenticular-shaped body, with faint lines of segmentation converging toward center. No coloboma seen. Tension O D

15 mm, O S 52 mm (Schiotz). Vision (with glasses) O D = 20/50, O S = L P. Upon movements of eyeballs, we have been unable to detect any motion of the lenses lying upon the floor of the vitreous chambers. Through several years and by several observers, the lenses appear to be firmly situated in their positions.

Many cases of lenses floating about in the vitreous chamber are reported, invariably thought to be associated with trauma, but so far as I have reviewed the literature of 20 years I have not found a recorded case of completely displaced lenses in this position, which could be considered of congenital origin.

## DO ELDERLY PEOPLE HAVE INFANTILE PARALYSIS?\*

By A L HALL, M D,

FULTON, N Y

**A** PROPOS to this question, a brief history of a case occurring recently in a male patient eighty years of age is offered for your consideration.

On July 17th, 1924, P Q, of Fulton, N Y, an active workman of good habits and previous good health, was taken with severe headache and some nausea accompanied with chilliness, fever, sore throat, stiffness of the neck and upper dorsal region, difficulty in swallowing and systemic weakness, being unable to stand. Was ailing for about three days before taking to bed.

The following day, I was called to attend him and noted the following symptoms in addition to those given:

Temperature 103.5°, pulse 116, respiration 30. Was very nervous and apprehensive, eyes glassy and staring, unable to swallow food or liquids, extreme rigidity of the neck and upper dorsal spine with marked tenderness over these regions, sore throat, the mucous membrane being moderately congested and slightly swollen and indicative of a relaxed state of the throat structures rather than of acute inflammatory action, numerous small swollen glands of the cervical region, muscular tremor of face and upper extremities, erect in bed owing to a sense of suffocation and fear he would choke to death, patellar reflexes diminished, throat reflexes not easily excited, obstinately constipated for several days. For the next three days, these symptoms persisted and he could not be induced to take any food or

swallow liquids. The temperature slowly dropped and on the fifth day became normal, although the pulse and respiration rates were higher than usual.

Recovery was slow, being confined to the bed for three weeks. He has gradually improved in general strength, the tonicity of the lower extremities is increased, the patellar reflexes being now normal, but some leg weakness is evident. Throat reflexes are nearly normal and he can swallow solid food easily, but liquids are still swallowed with some difficulty. He has never presented any evidences of any organic paralysis—recent or remote, nor is there any history of previous motor impairment and, apparently, his difficulty in swallowing and other related symptoms were due to an acute systemic infection which I was unable to satisfactorily diagnose. However, several times, while in attendance, I remarked to the patient and members of his family that if he were not so old, I would unhesitatingly say that he had infantile paralysis. Within the past month, I have, several times, had my attention called to other cases having many symptoms similar to those of the case recited, occurring in elderly people, but lacking the severity of this one.

In the locality where I reside, there appears to be a growing popular belief that many cases of poliomyelitis of a very mild character do occur in elderly people, which are usually unrecognized and which may account for the mysterious spread of the disease.

Very recently, two physicians have mentioned seeing poliomyelitic symptoms in elderly persons.

\* Remarks introduced as a part of the discussion on poliomyelitis at a meeting of the Fifth District Branch of the Medical Society of the State of New York, at Oneida, N Y, October 2, 1924.

# EDITORIALS

The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

*Editor-in-Chief*—NATHAN B VAN ETEN, M D,  
New York  
*Associate Editor*—ORRIN SAGE WIGHTMAN, M D,  
New York  
*Executive Editor*—FRANK OVERTON, M D Patchogue

### COMMITTEE ON PUBLICATION

E ELIOT HARRIS, M D, *Chairman* New York  
ORRIN SAGE WIGHTMAN, M D New York  
EDWARD LIVINGSTON HUNT, M D New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

*President*—OWEN E JONES, M D Rochester  
*First Vice President*—GEORGE A. LEITNER M D Piermont  
*Second Vice President*—LUZERNE COVILLE M D Ithaca  
*Speaker*—E ELIOT HARRIS M D New York  
*Vice Speaker*—GEORGE M FISHER M D Utica  
*Secretary*—EDWARD LIVINGSTON HUNT M D New York  
*Assistant Secretary*—WILBUR WARD M D New York  
*Treasurer*—CHARLES GORDON REYD M D New York

### CHAIRMAN, STANDING COMMITTEES

*Arrangements*—FREDERICK H FLAHERTY M D Syracuse  
*Public Health and Medical Education*  
JOSHUA M VAN COTT M D Brooklyn  
*Scientific Work*—ANDREW MACFARLANE M D Albany  
*Medical Economics*—HELEN LYLE WINTER, M D Cornwall  
*Legislation*—JAMES N VANDER VEER M D Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer) the ex President and the Councilors of the District Branches.

*First District*—EDWARD C RUSHMORE M D Tuxedo Park  
*Second District*—FRANK H LASHER, M D Brooklyn  
*Third District*—ARTHUR J BEPELL, M D Albany  
*Fourth District*—CHARLES C TREMBLEY M D Saranac Lake  
*Fifth District*—NELSON O BROOKS M D Oneida  
*Sixth District*—GEORGE H FOX M D Binghamton  
*Seventh District*—WILLIAM J DEAN M D Rochester  
*Eighth District*—HARRY R. TRICK, M D Buffalo

### COUNSEL

GEORGE W WHITESIDE Esq., 27 William St New York  
Telephone, Broad 1744

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St New York

### EXECUTIVE OFFICER

JOSEPH S LAWRENCE, M D 51 Chapel Street, Albany

### SECTION OFFICERS

*Medicine*  
*Chairman*—ROBERT L LEVI, M D New York  
*Secretary*—L WHITTINGTON GORHAM M D Albany

*Surgery*  
*Chairman*—MARSHALL CLYNTON M D Buffalo  
*Secretary*—EDWARD S VAN DYKE M D Syracuse

*Obstetrics and Gynecology*  
*Chairman*—HAROLD C BAILEY, M D New York  
*Secretary*—NATHAN P SEARS M D Syracuse

*Pediatrics*  
*Chairman*—JOSEPH C PALMER, M D Syracuse  
*Vice Chairman*—ROGER H DENNETT M D New York  
*Secretary*—ARTHUR W BENSON M D Troy

*Eye Ear Nose and Throat*  
*Chairman*—ARTHUR G BENNETT M D Buffalo  
*Secretary*—EUGENE E HIXMAN M D Albany

*Public Health Hygiene and Sanitation*  
*Chairman*—PAUL B BROOKS M D Albany  
*Secretary*—ARTHUR D JACQUES M D Lynbrook

*Neurology and Psychiatry*  
*Chairman*—EUGENE N BOUGREAU M D Syracuse  
*Secretary*—CLARENCE O CHEVEL, M D Utica

## REPORTING COUNTY SOCIETY MEETINGS

We have frequently appealed to presidents and secretaries of county medical societies to send us reports of their meetings for publication in the JOURNAL. The response is progressively gratifying. It is with real pleasure and gratification that we received the following letter

"I have noted for some time that the proceedings of some County Societies are reported quite regularly while those of other counties are never seen printed in the STATE JOURNAL. Is the reporting of its proceedings a matter of option with each Society?"

"From your remarks before the Clinton County Medical Society reported on page 1021 of the December JOURNAL I deduce that you really like to see the County Society proceedings in print, so I shall take the matter up with our County Society. To the best of my recollection it has been a long time since our County

Society proceedings were seen in the JOURNAL reports"

To this we replied as follows

"We certainly want to publish a description of every meeting of every county medical society. The only reason why we do not publish more accounts is that the secretaries do not send us the reports of the meetings. We have published every item that has been sent to us. We have often gone to the meetings and written the reports ourselves.

"We will continue to publish the proceedings until we get so many that they crowd one another off the pages.

"It is up to your Secretary to send us the accounts of your meetings, but you or anybody else can do it."

It occurs to us that this makes a good editorial if we stop right here

F O

## OYSTERS AND TYPHOID FEVER

The newspapers continue to discuss the relation of oysters to typhoid fever, and are carrying reports of investigations by Department of Health and legislative committees. The reports are that one state requires a person ordering raw oysters in a restaurant to sign a paper releasing the restaurant and the Department of Health from all responsibility if the patron comes down with typhoid fever. Another state requires every buyer of oysters to sign a statement that the oysters will not be eaten raw. This wide discussion of danger from shell fish has nearly destroyed the oyster industry. The use of the word shell-fish has also led many people to refuse to buy fish of any kind, and the newspaper reports from New York City indicate that the consumption of fish has been reduced to half the normal amount.

There seems to have been an excess of typhoid fever cases in many of the larger cities in eastern United States, and the incriminating evidence against oysters is that from forty to sixty per cent of the patients have eaten raw oysters within the period of incubation of typhoid fever. Publication of the suspicion against oysters was sufficient to deter people from buying any kind of oysters, regardless of where they were grown.

The Department of Health of New York City has long kept close watch on all the oysters which were brought into the city, and have regularly had bacteriological examinations made on samples taken at random. Colon bacilli are permissible in the liquor of the oysters, the standard relates to the number that are allowed.

Oysters grow in shallow, muddy water, along the coast, their food consists of bacteria, diatoms and other microscopic organisms which they strain out from the water. Sewage acts upon

oysters in the same manner that fertilizer acts on wheat or other crop. Some of the best oyster grounds are in estuaries containing sewage.

Tests have been made to determine how long colon bacteria will remain alive in oysters, and the opinion is that they will disappear after lying about a week in water which is free from colon bacilli. On the contrary, the oysters will take up colon bacilli almost at once when they are put into polluted water, as they often were in years gone by, when the practice was to store them beside opening houses which were located in villages which sewered into the water.

An oyster closes its shell and keeps it closed in the fall when the temperature of the water falls to 40 degrees Fahrenheit. The oyster will then digest the colon bacilli and will be safe for eating even if it was taken from polluted water.

Many attempts have been made to prevent the discharge of sewage into waters in which oysters were grown, but the oystermen have discouraged all publicity along this line, on the ground that their industry would be threatened. Now they are crying loudly for the construction of sewers and the promotion of the purity of the water over the oyster grounds. No department of health can certify the freedom of oysters from pollution so long as sewage is discharged into the water in which they grew. The danger may be remote, but no one can truthfully say there is no danger at all so long as sewage is permitted in the water. Colon bacilli are likely to be found in the oyster liquor, for the drainage from roads and cultivated fields will enter the water, but colon bacilli of human origin can be excluded.

Panics and fear of sickness from eating oysters, and the ruination of the oyster industry will cease when the oystermen and boards of health get together to preserve the purity of the water over the oyster grounds.

---

## DR W DEWEY ELSEVER, AN APPRECIATION

Few men in our community have entered the medical profession with so many of the attributes which go to make up the ideal physician as did Dr W D Elsever. He was equipped with a lovable nature and imbued with the highest ideals. He possessed a noble character and a pleasing personality which he carried with a dignity that inspired affection and confidence among all of those with whom he became associated. He not only inspired his patients with confidence, but he gained their strongest friendship.

His counsel was sought by civic organizations engaged in public welfare work. He was a citizen of the highest type, interested in everything that pertained to the welfare of his fellow-man.

His professional vision was clear, and his judgment sound. Among his medical associates he was regarded as an able consultant and a genial associate. He was a conscientious student and an able teacher.

His untimely death was a great shock to his friends and a distinct loss to the entire community.

F W SEARS.



# LEGAL



By GEORGE W. WHITESIDE, Esq  
Counsel, Medical Society of the State of New York

## RETAINED PLACENTA—PUERPERAL SEPTICAEMIA—DEATH

In a recent case tried by your counsel the doctor sued was called upon to treat and care for a young married woman in her early twenties in the birth of her child. The child as born in a little farm house where there were no sanitary facilities of any kind to assist the doctor in his obstetrical procedure. A normal child was born and the two first stages of labor passed off satisfactorily. In the third stage, however, the placenta did not present itself. The doctor, after trying Crede's method for a considerable time, decided to adopt the expectant method rather than to exercise any surgical intervention. All aseptic precautions were adopted in the delivery of the child and before the child was born, and during the second stage of labor a  $1\frac{1}{2}$  ampule of pituitrin was administered by the physician by hypodermic. The woman was delivered of a normal girl child who is now living.

Despite the doctor's repeated and long-continued efforts to expel the placenta by means of Crede's method, he was not successful. The temperature and pulse of the patient continued normal. On the second and third days after the birth of the child, the placenta not having been removed, the doctor again resorted to Crede's method, without success. During this period hot stupes were administered. On the fifth day after the birth of the child the placenta had been expelled from the uterus and lay in the external opening of the vagina, and when found in this position was removed by another doctor who was called in to assist—such removal taking place without the use of any instruments. The woman continued normal for another day, and then her temperature went up. Eight days after the birth of the child the patient died, the cause of death being stated in the death certificate as puerperal septicaemia. The defendant doctor, however, was discharged five days after the birth of the child and did not attend the patient during the last three days of her life.

The theory of the plaintiff's case was that instead of adopting the expectant method, it was the duty of the doctor to have invaded the uterus either by hand or with instruments and to have brought about thereby a manual expulsion of the placenta. Four doctors testified in behalf of the

plaintiff (the husband of the deceased patient), that it was not proper and approved practice to have adopted the expectant method, but that manual intervention should have been employed. Twenty-year-old text-books were cited in support of these opinions. In behalf of the defendant-doctor some four or five physicians were called one of whom was perhaps the leading obstetrician of this State, and the author of many books and articles on the subject of obstetrics. These doctors all testified that the expectant method was the proper procedure and that inasmuch as the lochia, pulse and temperature were normal between the second stage of labor and the final expulsion of the placenta five days after the birth of the child, it not only was not the defendant-doctor's duty to invade the uterus, but that it was his duty not to invade it, that the modern proper and approved practice—a practice which has been definitely recognized during only the last ten or fifteen years, however—is to leave the placenta alone and permit it to be expelled by natural means rather than to attempt manual extraction, provided there was no hemorrhage and all the other conditions of the patient were normal. There was no hemorrhage in this case.

The case attracted wide attention and doctors for many miles distant from the seat of the trial came to the court house in order to hear the evidence. On several days all of the nurses of the local hospital were brought to the court room for the purpose of instruction. In behalf of the defendant's theory numerous textbooks were cited, particularly that of Dr. John Osborn Polak and of Williams on Obstetrics. The case, as will be seen, involved an extremely interesting question of medicine. It emphasized the importance of keeping abreast of the times and at the same time it illustrated the law hazards of medical practice. On the one hand the doctor was condemned for not resorting to a practice which fifteen or twenty years ago unquestionably was the recognized practice, and on the other hand he was commended for not following the old practice, but for adopting the new procedure now thoroughly recognized and approved. The trial lasted for nine days and resulted in a verdict for the defendant doctor.

## ALLEGED FAILURE TO HAVE X-RAY TAKEN AND DIAGNOSE FRACTURE

A woman of advanced years, while crossing the street, was struck by an automobile sustaining an injury to her left arm and shoulder. On August 16th, she consulted a physician with respect to her injuries who, upon examination, found the patient to be extremely nervous and who refused to permit manipulation of the parts to determine the extent of the injury. There was swelling of the arm and shoulder and several abrasions of the skin. Hot boric packs were ordered by the physician. This physician, intending to be absent from the city for several days, requested another physician to visit the patient. The second physician saw the patient on the 17th, 22nd, 23rd and 25th days of August. During all of this time the patient still refused to co-operate with the physician and refused to permit him to make a proper examination to determine the extent of her injury. She also refused the advice of the physician to have X-rays taken. The swelling had partly subsided and the abrasions had healed while under the treatment of the second physician, though the patient still refused to permit the physician to make a proper examination. The first physician returning to the city saw the patient on the 27th of August and the 9th, 17th and 24th days of September. On August 27th, the first physician found that the patient still held her arm rigid and close to her body, the swelling was reduced but the patient still complained of pain. Request for permission to make an extensive examination was refused and the patient also refused to have X-rays taken. During this time the first physician dressed the patient's arm and did whatever was possible in his attempt to heal the patient's injury. He advised the patient that he believed there was a fracture and that in order to determine the same it would be necessary to have an X-ray taken and that the taking of an X-ray was not an operation and was painless. However, the patient refused to have the X-ray taken. After much persuasion the patient finally consented to permit the first physician to take an X-ray and an appointment was made, but the patient failed to keep the appointment, telephoning the physician that she had changed her mind.

On September 24th, a third physician was called in who, in consultation with the first physician, again advised the patient of the necessity of having an X-ray taken, to which the patient finally consented and an X-ray was taken on September 24th. The X-ray disclosed an impacted fracture of the head of the humerus with good apposition and good result.

The patient was last seen by the first physician on the 24th day of September, when she left this

physician and went under the care of another physician.

The patient subsequently instituted an action against the first and second physicians who had attended and treated her, charging them with failure to make a diagnosis of the fracture and having failed to have an X-ray taken and being otherwise generally negligent and careless in their examination, treatment and prescribing for the patient. In her complaint the plaintiff charged that she suffered a subglenoid dislocation and a fracture of the left clavicle at the acromion articulation and a fracture of the scapula, together with a fracture of the upper or rounder end of the humerus where it enters the glenoid cavity, together with other injuries in or about the shoulder joint. She claimed that by reason of the carelessness of the defendants in failing to discover the fracture, the same did not properly knit and there was an impairment of function in her arm and shoulder, and that she was required to expend moneys for medical, nursing and hospital care and attention.

On behalf of the defendants a motion was made requiring the plaintiff to serve separate complaints as against each of the defendants, on the ground that there was a misjoinder of the parties defendant in that each of the physicians attended and treated the plaintiff independent of one another and that they were independent contractors and if liable at all were liable only for their own individual negligence and not for the negligence or carelessness of one another. This motion was granted by the court. The granting of the same was of advantage to the defendants as it required separate trials for each of them and in each of which trials there could only be introduced evidence of what the particular physician did. One of the actions came on for trial, the plaintiff testifying in her own behalf and also introducing medical testimony that what the particular defendant did was not in accordance with the proper and approved practice and that the failure to have an X-ray taken to discover the fracture sustained by the plaintiff resulted in an impairment of the plaintiff's arm. The defendant testified in his own behalf as to his treatment and advice to the plaintiff and the numerous attempts made to have the plaintiff consent to the taking of an X-ray. He also introduced expert medical testimony approving of the treatment and advice given to the plaintiff. At the close of all the evidence the case was submitted to the jury which rendered a verdict in favor of the defendant. After the successful termination of this action, the action against the other physician was discontinued by the plaintiff.





# LEGISLATION



By JAMES N VANDER VEER, M.D.  
*Chairman, Committee on Legislation*

## IN SENATE

Senate Int No 11—A bill introduced in the Senate by Senator Seabury C Mastick of Westchester County, concurrent Assembly Int No 64, introduced in the Assembly by Assemblyman Herbert R. Shonk, of Westchester County, would amend sections 172, 181, Labor Law, by prohibiting employment of females over 16 years of age more than 48 hours a week in factories and mercantile establishments, except that for

not exceeding eight weeks in any year, divided into not more than two periods, females may be employed not more than six days or 54 hours a week, or nine hours a day, provided notice of such extension of working hours be sent to Industrial Commissioner at least three days before

Referred to Labor and Industries Committee of both Houses

*Comment* No progress as yet

## THE NARCOTIC BILL

Senate Int No 115—A bill introduced in the Senate by Senator Morton J Kennedy of New York, concurrent Assembly Int No 215, introduced in the Assembly by Assemblyman Morris Weinfield, of New York, would add new article 22, and amend section 4-b, Public Health Law, and repeals section 1746, Penal Law, relative to habit forming drugs

Referred to Public Health Committee of both Houses

*Comment* No progress as yet

Senate Int No 116—A bill introduced in the Senate by Senator Morton J Kennedy of New York, concurrent Assembly Int No 216, introduced in the Assembly by Assemblyman Morris Weinfield, of New York, would add new section 177, Insanity Law, requiring the licensing of private institutions for treatment of narcotic drug addiction

Referred to General Laws Committee of both Houses

*Comment* No progress as yet

## MEDICAL PRACTICE ACT

A bill introduced in the Senate by Senator John L. Karle, of Queens County, concurrent Assembly Int No 307, introduced by Assemblyman Russell Dunmore, of Oneida County, would amend sections 164, 169, 170, 173, 174, and repeal section 171, Public Health Law, relative to practice of medicine, by providing among other things for the registration and licensing of physicians. Referred to Public Health Committee

Int 211      January 20, 1925  
AN ACT

Introduced by Mr. Karle, read twice and ordered printed  
—and when printed referred to the Committee on Public Health

To amend the public health law, in relation to the practice of medicine

*The People of the State of New York, represented in Senate and Assembly, do enact as follows:*

Section 1 Section one hundred and sixty-four of chapter forty-nine of the laws of nineteen hundred and nine, entitled, "An act in relation to the public health, constituting chapter forty-five

of the consolidated laws," is hereby amended to read as follows

§ 164 *Expenses* The fees derived from the operation of this article, *except as otherwise provided in section one hundred and seventy-three, subdivision five*, shall be paid into the state treasury, and the Legislature shall annually appropriate therefrom for the Education Department an amount sufficient to pay all proper expenses incurred pursuant to this article

Section 2 Section one hundred and sixty-nine is hereby amended to read as follows

§ 169 *Licenses* On receiving from the state board an official report that an applicant has successfully passed the examinations and is recommended for license, the regents shall issue to him a license to practice according to the qualifications of the applicant. Every license shall be issued by the university under seal and shall be signed by the president and secretary of the board and by the officer of the university who approved the credential which admitted the candidate to

examination, and shall state that the licensee has given satisfactory evidence of fitness as to age, character, preliminary and medical education and all other matters required by law, and that after full examination he has been found properly qualified to practice. Applicants examined and licensed in accordance with the provisions of this act, who, when admitted to the licensing examination, were citizens of a foreign country, and who had declared intention of becoming citizens of the United States, shall, upon passing the examination, be issued a license valid for six years from the date of such declaration of intention and upon failure of such licensee to furnish evidence of his having actually become a citizen his license shall become invalid and automatically become revoked and his registration shall be annulled. Applicants examined and licensed by other state examining boards registered by the regents as maintaining standards not lower than those provided by this article and applicants who matriculated in a New York State medical school before June fifth, eighteen hundred and ninety, and who received the degree of doctor of medicine from a registered medical school before August first, eighteen hundred and ninety-five, may without further examination, on payment of twenty-five dollars to the regents and on submitting such evidence as they may require, receive from them an indorsement of their licenses or diplomas conferring all rights and privileges of a regents' license issued after examination. The commissioner of education may in his discretion on the approval of the board of regents indorse a license or diploma of a physician from another state, provided the applicant has met all the preliminary and professional qualifications required for earning a license on examination in this state, has been in reputable practice for a period of ten years, and has reached a position of conceded eminence and authority in his profession. Any physician, who was actually engaged in the practice of medicine in this state prior to September first, eighteen hundred and ninety-one, and who failed to register, although eligible to do so at the time, or any physician, whose registration is not legal because of some error, misunderstanding or unintentional omission, may on the unanimous recommendation of the state board of medical examiners that he has submitted satisfactory proof of having complied with all the requirements prescribed by law at the time of his failure to register, or his incomplete registration, receive from the regents under seal a certificate of the facts which may be registered *in accordance with this act*, [by any county clerk and shall make valid his registration] Before any license is issued it shall be numbered and recorded in a book kept in the regents' office, and its number shall be noted in the license, and a photograph of the licensee filed with the records. This rec-

ord shall be open to public inspection, and in all legal proceedings shall have the same weight as evidence that is given to a record of conveyance of land.

Section 3 Section one hundred and seventy of such chapter is hereby amended to read as follows

§ 170 *Registration* [Registry, revocation of license, annulment of registry. Every license to practice medicine shall, before the licensee begins practice thereunder, be registered in a book kept in the clerk's office of the county where such practice is to be carried on, with name, residence, place and date of birth, and source, number and date of his license to practice. Before registering, each licensee shall file, to be kept in a bound volume in a county clerk's office, an affidavit of the above facts, and also that he is the person named in such license, and had, before receiving the same, complied, with all requirements as to attendance, terms and amount of study and examinations required by law and the rules of the university as preliminary to the conferment thereof, that no money was paid for such license, except the regular fees paid by all applicants therefor, that no fraud, misrepresentation or mistake in any material regard was employed by any one or occurred in order that such license should be conferred. Every license, or if lost a copy thereof legally certified so as to be admissible as evidence, or a duly attested transcript of the record of its conferment, shall before registering, be exhibited to the county clerk, who, only in case it was issued or indorsed as a license under seal by the regents, shall indorse or stamp on it the date and has name preceded by the words "registered as authority to practice medicine in the clerk's office of

county." The clerk shall thereupon give to every physician so registered a transcript of the entries in the register with a certificate, under seal that he has filed the prescribed affidavit. The licensee shall pay to the county clerk a total fee of one dollar for registration, affidavit and certificate. The regents shall have power at any and all times to inquire into the identity of any person claiming to be a licensed or registered physician and after due service of notice in writing, require him to make reasonable proof, satisfactory to them, that he is the person licensed to practice medicine under the license by virtue of which he claims the privilege of this article. When the regents find that a person claiming to be a physician, licensed under this article, is not in fact the person to whom the license was issued, they shall reduce their findings to writing and file them in the office of the clerk of the county in which said person resides or practices medicine. Said certificate shall be prima facie evidence that the person mentioned therein is falsely impersonating a practitioner or a former practitioner of a like or different name

The regents may revoke the license of a practitioner of medicine, or annul his registration, or do both, in any of the following cases

(a) A practitioner of medicine who is guilty of any fraud or deceit in his practice, or who is guilty of a crime or misdemeanor, or who is guilty of any fraud or deceit by which he was admitted to practice, or

(b) Is an habitual drunkard or habitually addicted to the use of morphine, opium, cocaine, or other drugs having a similar effect, or

(c) Who undertakes or engages in any manner or by any ways or means whatsoever, to procure or perform any criminal abortion as the same is defined by section eighty of the penal law, or

(d) Who offers or undertakes by any manner or means to violate any of the provisions of section eleven hundred and forty-two of the penal law

Proceedings for revocation of a license or the annulment of registration shall be begun by filing a written charge or charges against the accused. These charges may be preferred by any person or corporation, or the regents may on their own motion direct the executive officer of the board of regents to prefer said charges. Said charges shall be filed with the executive officer of the board of regents, and a copy thereof filed with the secretary of the board of medical examiners. The board of medical examiners, when charges are preferred, shall designate three of their number as a committee to hear and determine said charges. A time and place for the hearing of said charges shall be fixed by said committee as soon as convenient, and a copy of the charges, together with a notice of the time and place when they will be heard and determined, shall be served upon the accused or his counsel, at least ten days before the date actually fixed for said hearing. Where personal service or service upon counsel can not be effected, and such fact is certified on oath by any person duly authorized to make legal service, the regents shall cause to be published for at least seven times, for at least twenty days prior to the hearing, in two daily papers in the county in which the physician was last known to practice, a notice to the effect that at a definite time and place a hearing will be had for the purpose of hearing charges against the physician upon an application to revoke his license. At said hearing the accused shall have the right to cross-examine the witnesses against him and produce witnesses in his defense, and to appear personally or by counsel. The said committee shall make a written report of its findings and recommendations, to be signed by all its members, and the same shall be forthwith transmitted to the executive officer of the board of regents. If the said committee shall unanimously find that said charges, or any of them are sustained, and shall unanimously recom-

mend that the license of the accused be revoked or his registration be annulled, the regents may thereupon in their discretion, revoke said license or annul said registration, or do both. If the regents shall annul such registration, they shall forthwith transmit to the clerk of the county or counties in which said accused is registered as a physician, a certificate under their seal certifying that such registration has been annulled, and said clerk, shall, upon receipt of said certificate, file the name and forthwith mark said registration "annulled". Any person who shall practice medicine after his registration has been marked "annulled" shall be deemed to have practiced medicine without registration. Where the license of any person has been revoked, or his registration has been annulled as herein provided, the regents may, after the expiration of one year, entertain an application for a new license in like manner as original application for licenses are entertained, and upon such new application they may in their discretion, exempt the applicant from the necessity of undergoing any examination.]

1 Every person now lawfully engaged in the practice of medicine within the state and every person hereafter duly authorized to practice medicine, shall, on or before January first of each year, apply to the secretary of the board of medical examiners for a certificate of registration with the regents of the university upon a blank form which shall be furnished by said secretary and shall pay at such time to said secretary a fee of two dollars, provided that any physician who has registered for five consecutive years hereunder shall register annually without the payment of fee and be so registered during the time he shall thereafter continuously practice medicine in this state

2 A physician in making his first registration hereunder shall write or cause to be written upon the application blank so furnished by said secretary, his full name, post-office and residence address, the date and number of his license and such other facts for the identification of the applicant as a licensed practitioner of medicine as the regents may deem necessary and shall duly execute and verify the same before an officer empowered to take acknowledgments of deeds and deliver the same to said secretary by mail or in person. Subsequent registrations after the first registration need not be upon a sworn application by the applicant unless in a particular case the regents, for reasons satisfactory to them, may require that the application be under oath, such subsequent registration shall be made with as little inconvenience to duly licensed practitioners of medicine as possible and to that end the secretary of the board may employ and use in obtaining such subsequent registration, the assistance of the secretary of duly incorporated medical societies who shall be empowered as a representa-

five of the secretary of the board to receive and transmit such application blanks from physicians after the physicians' first registration, together with the license fees payable upon such applications

3 The secretary of the board, on or before October first of each year, after the first registration, shall mail or cause to be mailed to every physician registered in his office, a blank form of application for registration addressed to the last known post-office address of such physician or may cause such blank form of application to be sent to such physician through the secretary of any duly incorporated medical society. The form of application shall be such as to contain proper spaces for the insertion by the applicant of the information required under paragraph 2 of this section

4 The secretary of the board shall issue to any duly licensed physician in this state, upon his application therefor, in accordance with the provisions hereof, a certificate of registration under the seal of the University for the year ensuing and ending December thirty-first

Upon the first of March in each year, or within ten days thereafter, the secretary of the board shall publish and cause to be mailed to each physician registered hereunder in this state, a printed list of the duly registered physicians in this state and each such published list shall contain at the beginning thereof these words

"Each registered physician receiving this list is requested to report to the secretary of the board and to the secretary of any duly incorporated county medical society existing in the county of his residence or to the secretary of any incorporated state medical society in which said county medical society is represented, the name and address of any person known to be practicing medicine whose name does not appear in this registry. The names of persons giving such information will not be divulged"

The names of physicians which shall in any year be added to said list after the same shall have been so printed and distributed as aforesaid, shall be reported quarterly to the secretary of any duly incorporated state medical society of which county medical societies are components

5 Any licensed physician who having failed or neglected to register by January first of any year as required by the provisions of this section shall be required to pay upon registration, in addition to the fee of two dollars, a further fee of one dollar for each thirty days or part thereof, that he is in default, and any licensed physician who engaged in practice and wilfully refuses or omits to register hereunder, shall be subject to a civil penalty of one dollar for each day that such wilful refusal or omission shall continue, provided that if the same continues for more than thirty days the penalty thereafter shall be five dollars per day so long as the said wilful

refusal or omission shall continue, said penalty shall be recoverable in an action by the attorney-general of the state maintained in the name of the people of the State of New York

6 The penalties provided in this section for failure, neglect or omission of a duly licensed physician to register under this article shall be the only penalties that may be imposed therefor, and the legality of his license shall not be affected thereby, and such penalties may for good cause shown, in the discretion of the regents, upon the recommendation of the board of medical examiners, be remitted or compromised

7 Each licensed physician shall conspicuously display his proper registration certificate in his office at all times

Section 4 Section one hundred and seventy-one of such chapter amended by chapter fifty-three of the laws of nineteen hundred and fifteen, is hereby repealed

Section 5 Section one hundred and seventy-two of such chapter is hereby renumbered section one hundred and seventy-one

Section 6 Section one hundred and seventy-three of such chapter as amended by chapter two hundred and eighty-two of the laws of nineteen hundred and twenty-four is hereby renumbered section one hundred and seventy-two and amended to read as follows

[173] 172 *Construction of this article*  
[This article shall not be construed to affect commissioned medical officers serving in the United States army, navy or marine hospital service, while so commissioned, or any one while actually serving on the resident medical staff of any legally incorporated hospital, or any one while actually serving as an interne in a state hospital or other state institution in which medical service is provided, or any legally registered dentist exclusively engaged in practicing dentistry, or any person or manufacturer who mechanically fits or sells lenses, artificial eyes, limbs, or other apparatus or appliances, or is engaged in the mechanical examination of eyes, for the purpose of constructing or adjusting spectacles, eye-glasses and lenses, or any lawfully qualified physician in other states or countries meeting legally registered physicians in this state in consultation, or any physician residing on a border of a neighboring state and duly licensed under the laws thereof to practice medicine therein whose practice extends into this state and who does not open an office or appoint a place to meet patients or receive calls within this state, or any physician duly registered in one county called to attend isolated cases in another county, but not residing or habitually practicing therein, or the furnishing of medical assistance in case of emergency, or the domestic administration of family remedies, or the practice of chiropody, or the practice of the religious tenets of any church. This article shall be construed to repeal all acts

or parts of acts authorizing conferment of any degree in medicine *causa honoris* or *ad eundem* or otherwise than on students duly graduated after satisfactory completion of a preliminary medical course not less than that required by this article as a condition of license ]

1 *This article shall not be construed so as to prevent the following* (1) *The practice of medicine in this state in obedience with the requirements of the laws of the United States, of any commissioned medical officer serving in the United States army, navy or public health service while engaged in the performance of the actual duties prescribed for him under the United States statutes, or* (2) *the practice of medicine in a duly incorporated hospital operating pursuant to the state charities law, of a duly appointed member of the resident medical staff or of an interne, or* (3) *the practice of medicine by any physician duly licensed to practice medicine in a bordering state, who resides on a border of such neighboring state, whose practice extends into this state and who does not open an office or appoint a place to meet patients or receive calls within this state, or* (4) *any lawfully qualified physician in other states or countries meeting legally registered physicians in this state in consultation, or* (5) *the furnishing of medical assistance in case of emergency, or* (6) *the domestic administration of family remedies, or* (7) *the practice of chiropody, dentistry or veterinary medicine, provided those practicing are legally authorized and licensed under the laws of this state so to do, or* (8) *the practice of the religious tenets of any church, or* (9) *the fitting or selling of lenses, artificial eyes, limbs or other apparatus or appliances by any person or manufacturer of the same or the engaging in the mechanical examination of eyes for the purpose of constructing or adjusting spectacles, eyeglasses and lenses*

II *This article shall be construed to repeal all acts or parts of acts authorizing conferment of any degree in medicine causa honoris or ad eundem or otherwise than on students duly graduated after satisfactory completion of a preliminary medical course not less than that required by this article as a condition of license*

It is further provided that any person who shall be actively engaged in the practice of osteopathy in the State of New York on the thirteenth day of May, nineteen hundred and seven, and who shall present to the board of regents satisfactory evidence that he is a graduate in good standing of a regularly conducted school or college of osteopathy within the United States which at the time of his or her graduation required a course of study of two years or longer, including the subjects of anatomy, physiology, pathology, hygiene, chemistry, obstetrics, diagnosis and the theory and practice of osteopathy, with actual attendance of not less than twenty months, which

facts shall be shown by his or her diploma and affidavit, shall upon application and payment of ten dollars be granted, without examination, a license to practice osteopathy, provided application for such license be made within six months after the thirteenth day of May, nineteen hundred and seven. A license to practice osteopathy shall not permit the holder thereof to administer drugs or perform surgery with the use of instruments. Licenses to practice osteopathy shall be registered in accordance with the provisions of this article, and the word osteopath be included in such registration, and such license shall entitle the holder thereof to the use of the degree D O, or doctor of osteopathy.

Section 7 Section one hundred and seventy-four of such chapter is hereby renumbered section one hundred and seventy-three and amended to read as follows

[174 Penalties and their collection] 173 Penalties [Any person who, not being then lawfully authorized to practice medicine within this state and so registered according to law, shall practice within this state without lawful registration or in violation of any provisions of this article, and any person who shall buy, sell or fraudulently obtain any medical diploma, license, record or registration, or who shall aid or abet such buying, selling or fraudulently obtaining, or who shall practice medicine under cover of any medical diploma, license, record or registration illegally obtained, or signed or issued unlawfully or under fraudulent representations or mistake of fact in a material regard, or who, after conviction of a felony, shall attempt to practice medicine, or shall so practice, and any person who shall in connection with his name use any designation tending to imply or designate him as a practitioner of medicine within the meaning of this article without having registered in accordance therewith, or any person who shall practice medicine or advertise to practice medicine under a name other than his own, or any person not a registered physician who shall advertise to practice medicine, shall be guilty of a misdemeanor. Any person who shall practice medicine under a false or assumed name, or who shall falsely personate another practitioner or former practitioner of a like or different name, shall be guilty of a felony. When any prosecution under this article, or under section eleven hundred and forty-seven of the penal law, and any amendments thereto, is made on the complaint of any incorporated medical society of the state, or any county medical society entitled to representation in a state society, any fines collected shall be paid to the society making the complaint, and any excess of the amount of fines so paid over the expense incurred by the said society in enforcing the medical laws of this state, shall be paid at the end of the year to the county treasurer.]

1 *Any person who shall,*

(a) Sell or fraudulently obtain or furnish any medical or osteopathic diploma, license, record or registration, or aid or abet in the same, or

(b) Practice medicine under cover of any diploma, license, record or registration illegally or fraudulently obtained or signed or issued unlawfully or under fraudulent representation or mistake of fact in a material regard, or

(c) Advertise to practice medicine under a name other than his own or under a false or assumed name, and

2 Any person, who, not being then lawfully licensed and authorized to practice medicine within this state and so registered according to law, shall

(a) Practice or advertise to practice medicine

(b) Use in connection with his name any designation tending to imply or designate as a practitioner of medicine

(c) Use the title "doctor" or any abbreviation thereof in connection with his name or with any trade name in the conduct of any occupation or profession involving or pertaining to the public health, unless duly authorized by law to use the same, and

3 Any person, who during the time his license to practice medicine shall be suspended or revoked shall practice medicine, shall be guilty of a misdemeanor and shall also be subjected to the recovery of civil penalties

Such misdemeanor shall be punishable by imprisonment for not more than one year or a fine of not more than five hundred dollars or by both such fine and imprisonment for each separate violation

4 All courts of special sessions within their respective territorial jurisdictions are hereby empowered to hear, try and determine such crimes without indictment and to impose in full the punishments of fines and imprisonments herein prescribed

Such misdemeanors shall be prosecuted upon the private information of any person by the district attorney of the county wherein the same are committed and at any time the attorney-general may, without further authority or direction, supersede the district attorney in the prosecution of such misdemeanors

5 In addition to the criminal punishments of imprisonment and fine as above provided, a civil penalty is hereby prescribed and imposed which shall be one hundred dollars for each such violation, to be recovered by the attorney general in an action against the party or parties guilty of such violation, which action shall be maintained in the name of the People of the State of New York. Such civil penalties shall be cumulative, a separate penalty being recoverable for each separate violation, and each separate day's violation shall constitute a separate violation for which recovery may be had as above provided. The attorney

general, with the consent of the state commissioner of education may compromise claims for such penalties and accept less than the amount claimed or due before or after an action has been begun. No compromise may be made, however, after decision has been made or a verdict rendered, except pursuant to section thirty-four of the State finance law. Notwithstanding the provisions of any other general, local or special law, all fees, fines, penalties and other moneys derived from the operation of this article shall be paid to the regents of the university and shall be available, together with the appropriations made from time to time by the legislature, for the payment of all proper expenses of the regents, for the administration and enforcement of this act only, including the salary of any deputy attorney general assigned for the purpose of enforcing the provisions of this article. The unexpended balance of all such fees, fines, penalties and other moneys derived from the operation of this article remaining on June thirtieth of each year shall be paid to the state treasury.

After this act shall take effect, the regents shall report to the state comptroller on the fifth day of every month the amounts received by them under this article and remaining in their hands, with all expenditures made by them for the preceding month.

6 Judgments for civil penalties recovered under this article may be enforced by execution against the person as provided in the civil practice act. A person taken into custody under such an execution shall not be admitted to the liberties of the jails and shall be confined, Sundays and legal holidays included, for not less than one day and at the rate of one day for each dollar of the amount of the judgment recovered for civil penalties and costs and remaining unpaid. No person shall be imprisoned more than once or for more than six months on the same judgment. The provisions of this article relative to imprisonment for such debts shall be exclusive and the provisions of the debtor and creditor law and of section seventy-two of the civil rights law shall have no application and prosecutions for a crime under this article shall not bar prosecutions for civil penalties.

7 The display of a sign or an advertisement bearing a person's name as a practitioner of medicine in any manner or by implication or containing any other matter forbidden by law shall be presumptive evidence in any prosecution or hearing that the person whose name is so borne is responsible for the display of such sign or advertisement and of a holding out and of the practice of medicine by such person for each separate day such sign or advertisement is anywhere displayed by anyone, but such presumptions are rebuttable by the defense. It shall be necessary to prove in any prosecution or hearing under this article only a single act prohibited by law or a

single holding out or an attempt, without proving a general course of conduct, in order to constitute a violation

8 In any action for damages for personal injuries or death against a person not licensed hereunder for any act or acts constituting the practice of medicine as herein defined, where such injuries or death were contributed to by such act or acts, the fact that such person practiced medicine as herein defined without being duly licensed shall be deemed *prima facie* evidence of negligence

9 All violations of this act when reported to the regents and duly substantiated by affidavits or other satisfactory evidence, shall be investigated and if the report is found to be true and the complaint substantiated, the regents shall report such violation to the attorney-general or district attorney and request prompt prosecution. The regents may appoint such inspectors as are necessary to be paid from the funds received under this act at such salaries as the regents may determine and it shall be the duty of such inspectors under the direction of the regents, to investigate promptly and thoroughly such violations and to procure where possible legal evidence of the same for prosecution of the offenders

Section 8 Article eight of such chapter is hereby amended by adding thereto a new section to be known as section one hundred and seventy-four to read as follows

§174 Revocation of certificates and annulment of registrations

1 Whenever any practitioner of medicine shall be convicted of a felony, there may be presented to the regents a certified or exemplified copy of the judgment of such conviction and thereupon the registration of the person so convicted shall be annulled and his license revoked

Upon reversal of the conviction of such practitioner the regents shall upon receipt of a certified copy of the judgment or order of reversal vacate their order of revocation and annulment of registration but nothing herein contained shall divest the regents of power to proceed against such practitioner under the next subdivision

2 The regents may revoke or suspend the license of a practitioner of medicine and annul his registration or reprimand or discipline as in their discretion they may deem best for the public interest in any of the following cases

Upon finding after due hearing

a That a physician is guilty of fraud or deceit in the practice of medicine or in his admission to the practice of medicine or in his procuring registration, or

b That a physician has been convicted in a court of competent jurisdiction, either within or without this state, of a crime involving moral turpitude, or

c That a physician is a habitual drunkard, or addicted to the use of morphine, cocaine or

other drugs having a similar effect, or has become insane, or

d That a physician is guilty of untrue, fraudulent, misleading or deceptive advertising; or advertising that he can cure diseases which are recognized by the medical profession as incurable, or advertising that he can cure or treat disease by a secret method, procedure, treatment or medicine, or that he can treat, operate or prescribe for any human condition by a method, means or procedure which he refuses to divulge upon demand to the regents, or

e Who undertakes or engages in any manner or by any ways or means whatsoever to procure or perform any criminal abortion as same is defined by the Penal Law

3 Proceedings for revocation of a license, suspension of a practitioner from practice or the annulment of registration under subdivision two of this section shall be begun by filing a written charge or charges against the accused. These charges may be preferred by any person, corporation of public officer, or by the executive officer of the board of regents. Any charges shall be filed with the commissioner of education and a copy thereof filed with the secretary of the board of medical examiners. The president of the board of medical examiners, when charges are preferred, shall designate three of its members as a committee to hear and determine said charges and such committee shall contain at least one member who represents the same school of practice as the physician against whom the charges are preferred. A time and place for the hearing of said charges shall be fixed by said committee as soon as convenient, and a copy of the charges, together with a notice of the time and place when they will be heard and determined, shall be served upon the accused or his counsel at least ten days before the date actually fixed for said hearing. Where personal service or service upon counsel cannot be effected, and such fact is certified on oath by any person duly authorized to make legal service, the secretary of the board of medical examiners shall cause to be published for at least four times, at least thirty days prior to the hearing, a notice of hearing, in a newspaper published in the county in which the physician was last known to practice, and a copy of such notice shall also be mailed to the accused at his last known address. All such notices of charges shall contain a plain and concise statement of the material facts, without unnecessary repetition, but not the evidence by which the charges are to be proven, with a notification that a stenographic record of such proceedings will be kept and that the accused will have opportunity to appear either personally or by counsel at the hearing, with the right to produce witnesses and evidence upon his own behalf, to cross-examine such witnesses, to



examine such evidence as may be produced against him and to have subpoenas issued by the board. The said committee shall make a written report of its findings and recommendations, to be signed by all its members, and the same shall be forthwith transmitted to the board of regents with the entire record and evidence. If the said committee shall unanimously find that said charges, or any of them, are sustained, and shall unanimously recommend that the license of the accused be revoked or the practitioner suspended from practice, and his registration annulled, or that he be otherwise reprimanded or disciplined, the regents may thereupon in their absolute discretion, revoke or suspend said license and annul said registration or otherwise reprimand or discipline as in their absolute discretion they may deem best for the public interest, provided that no greater penalty than that recommended by said committee be imposed. Where the license of any person has been revoked, or his registration has been annulled as herein provided, the regents may, after the expiration of one year, entertain an application for a restoration of license and registration, in like manner as original applications for licenses are entertained, and upon such new application they may in their discretion, exempt the applicant from the necessity of undergoing any examination. The regents may in their discretion restore to good standing any physician who has been suspended from practice.

4 Any licensed practitioner found guilty under the provisions of this section on charges or whose license is otherwise revoked or suspended or registration annulled, or who has been refused registration, or who is otherwise reprimanded or disciplined by the board of regents under this article shall have an order of certiorari for the purpose of reviewing such determination returnable before the appellate division of the

judicial department where the board of regents made the determination complained of, but no such determination of the board of regents shall be stayed or enjoined except upon application to such appellate division, after notice to the state commissioner of education, and upon a showing that the determination of the board of regents was clearly wrong, that the constitutional rights of the applicant have been violated or that the board of regents made its determination without jurisdiction. The board of medical examiners or the board of regents may issue subpoenas and administer oaths pursuant to section sixty-one of the public officers law in connection with any hearing or investigation under this article and it shall be the duty of such boards to issue subpoenas at the request of and upon behalf of the defense.

§ 7 This act shall take effect July first, nineteen hundred and twenty-five

Senate Int No 228—A bill introduced in the Senate by Senator J Griswold Webb, Clinton Corners, N Y, concurrent Assembly Int No 236, introduced by Assemblyman T C Moore, of Westchester County, would add new section 16-a, empowering State Charities Board among other things, to visit and inspect all institutions in which children are received or cared for, and to establish rules therefor.

Referred to General Laws Committee

Comment None as yet

Senate Int No 266—A bill introduced in the Senate by Senator James S Truman, of Owego, N Y, would amend subdivision 9, section 15, Workmen's Compensation Law, by providing for expenses for rehabilitating injured employees, not more than \$10 per week to be spent for maintenance.

Referred to Labor and Industries Committee.

Comment None as yet

## IN ASSEMBLY

Assembly Int No 64—Concurrent Senate Int No 11 See Senate Bill for digest and comment

Comment None as yet

Assembly Int No 120—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would add new section 213, Labor Law, requiring employers to furnish nursing and first aid service in factories, mercantile and other establishments.

(Same as Int No 309 of 1924)

Referred to Labor and Industries Committee.

Comment

Assembly Int No 125—A bill introduced in the Assembly by Assemblyman Joseph Reich, of Kings County, would add new subdivision 10-a, Section 360, Tax Law, by permitting deductions from income for tax purposes of all expenses paid during the year for medical, surgical or dental services. (Same as A. Int 65 of 1924)

Referred to Taxation and Retrenchment Committee.

Comment No progress as yet.

## SCHOOLS BILL

would amend section 10, by providing that b

are necessary to consider this law or a



cation and trustees shall appoint physicians and dentists and may employ nurses for service in schools

Referred to Public Education Committee

*Comment* No progress as yet

Assembly Int No 152—A bill introduced in the Assembly by Assemblyman Morris Weinfeld, of New York, would amend section 13, Workmen's Compensation Law, by striking out provision that claim for medical treatment shall not be valid against employer unless physician within 20 days following first treatment furnish report of injury

(Same as A Int 717 of 1924)

Referred to Labor and Industries Committee

*Comment* No progress as yet

Assembly Int No 184—A bill introduced in the Assembly by Assemblyman F A Miller, of Kings County, would amend section 118, Workmen's Compensation Law, by authorizing physical examinations and practical tests of claimant to determine loss of use and proportionate loss of use of a member, result and test to be part of record

(Same as Senate Int 468 of 1924)

Referred to Labor and Industries Committee

*Comment* No progress as yet

### THE CHIROPRACTIC BILL

Assembly Int No 185—A bill introduced in the Assembly by Assemblyman William M Nicoll of Schenectady, to define and regulate the

practice of chiropractic

Referred to Public Health Committee

*Comment* No progress as yet

### THE NARCOTIC BILL

Assembly Int No 215—Concurrent Senate Int. No 115

See Senate Bill for digest and comment

Assembly Int No 216—See concurrent Senate Bill Int No 116 for digest and comment

Assembly Int No 229—A bill introduced in the Assembly by Assemblyman A Spencer Feld of New York City, would add new section 579-b, Education Law, providing for county supervisors to supervise education of children with retarded mental development

Referred to Public Education Committee

*Comment* Deferred until later

Assembly Int No 233—A bill introduced in the Assembly by Assemblyman Paul Kammerer of New York City, it would amend section 28, Workmen's Compensation Law, by authorizing industrial board to permit claim for compensation to be filed within two years after accident or death

(Same as A Int 48 of 1924)

Referred to Labor and Industries Committee

*Comment* Deferred until later

Assembly Int No 236—Concurrent Senate Int No 228 See Senate Bill for digest and comment

Assembly Int No 237—A bill introduced in the Assembly by Assemblyman T C Moore, of Westchester County, would add new section 16-b, State Charities Law, empowering State Charities Board to visit and inspect places where children, for appearance in court, are held, and to publish rules therefor

Referred to Judiciary Committee

*Comment* Deferred until later

Assembly Int No 301—A bill introduced in the Assembly by Assemblyman C P Miller, of Genesee County, would add new article 4-a, Workmen's Compensation Law, relative to fibroid phthisis (silicosis)

the Assembly by Assemblyman Frank Lattin, of Orleans County, would amend section 13, Workmen's Compensation Law, by permitting injured employees, at employer's expense, to engage medical or other attendance

(Same as A Int No 1508 of 1924)

Referred to Labor and Industries Committee

*Comment* Deferred until later

Assembly Int No 302—A bill introduced in the Assembly by Assemblyman Lewis Stapley of Livingston County, would add new section 151, Labor Law, permitting employment of females at night in any occupation in which it is lawful for males to work at night

(Same as A Int 571 of 1924)

Referred to Labor and Industries Committee

*Comment* None as yet

Assembly Int No 307—Concurrent Senate Int No 211 See Senate Bill for digest and comment

Assembly Int No 384—A bill introduced in the Assembly by Assemblyman Sam Mandlebaum of New York City, would add new section 1097-a, Greater New York Charter, requiring education board to furnish free eye glasses to school children unable to pay therefor

Referred to Cities Committee

*Comment* None as yet

Assembly Int No 396—A bill introduced in the Assembly by Assemblyman C P Miller, of Genesee County, would add new article 4-a, Workmen's Compensation Law, relative to fibroid phthisis (silicosis)

Referred to Labor and Industries Committee

## WORKMEN'S COMPENSATION

IN ASSEMBLY  
AN ACT

January 22, 1925

To amend the workmen's compensation law, in relation to fibroid phthisis (Silicosis)

Section 1 Chapter eight hundred and sixteen of the laws of nineteen hundred and thirteen, entitled "An act in relation to assuring compensation for injuries or death of certain employees in the course of their employment, and repealing certain sections of the labor law relating thereto, constituting chapter sixty-seven of the consolidated laws," as re-enacted by chapter forty-one of the laws of nineteen hundred and fourteen, and further re-enacted and amended by chapter six hundred and fifteen of the laws of nineteen hundred and twenty-two, is hereby amended by the insertion therein of a new article, to be article four-a, to read as follows

## ARTICLE 4-A

*Fibroid Phthisis (Silicosis)*

## Section 60 Definitions

- " 61 Fibroid phthisis (silicosis) treated as accident
- " 62 Limitation of employments
- " 63 Right to compensation
- " 64 Duties of employers
- " 65 Duties of employees
- " 66 Medical examinations
- " 67 Board of Examining Physicians
- " 68 Date of disablement
- " 69 Compensation, how payable
- " 70 Compensation, when not payable
- " 71 Diseases which are accidents

§ 60 Definitions Whenever used in this article

1 "Fibroid phthisis" means an inelastic fibrous condition of the lung tissue caused by the inhalation of particles of free crystalline silica, which shall be referred to as "silicosis"

2 "Ante-primary stage" means that physical signs of damage to the lungs, short of definite physical signs of silicosis, have become evident and that such damage has supervened during and in consequence of employment in any of the employments enumerated herein,

3 "Primary stage" means that definite and specific physical signs of silicosis are or have been present and that capacity for work is or has been impaired by that disease in consequence of employment in any of the employments enumerated herein, though not seriously and permanently,

4 "Secondary stage" means that definite and specific physical signs of silicosis are or have been present and that capacity for work is

seriously and permanently partially impaired by the disease in consequence of employment in any of the employments enumerated herein, but that the employee is not totally permanently disabled and can engage in other employment,

5 "Final stage" means that definite and specific physical signs of silicosis are or have been present and that capacity for work has been totally and permanently impaired by the disease in consequence of employment in any of the employments enumerated herein, and that employee cannot engage in any employment

6 "Suspended" means that an employee, or an applicant for employment, in one of the employments enumerated herein has been examined by a physician and his physical condition has been found to be such that he should not engage in any of the employments enumerated herein, and that such employee has been apprised of his physical condition and advised not to engage in such employments

§ 61 Fibroid phthisis (silicosis) treated as accident The disablement of an employee engaged in any of the employments enumerated in section sixty-two resulting in fibroid phthisis (silicosis) as herein defined shall be treated as the happening of an accident within the meaning of this chapter, and the practice and procedure provided in this chapter shall apply to all proceedings under this article, except where specifically otherwise provided herein

§ 62 Limitation of employments Notwithstanding the provisions of any other section of this chapter, the application of this article shall be limited to the following occupations or employments Miners, quarrymen, and tunnel workers, stone masons' work and granite cutting, pottery workers, and persons employed in the manufacture of refractory silica bricks and flint knapping

§ 63 Right to compensation If an employee is disabled or dies and his disability or death is caused by silicosis as defined herein, and the disease is due to the nature of the employment as herein described, he or his dependants shall be entitled to compensation in accordance with the provisions of this article

§ 64 Duties of employers It shall be the duty of every employer in any of the employments enumerated herein

1 To cause to have made a medical examination of every person in his employ who is exposed to silica dusts, within three months after this article takes effect, to cause to have made a medical examination of every applicant for employment in any process where silica dusts exist, to cause to have made a biennial medical examination of every person in his employ who is

exposed to silica dusts, at such time and in such manner as the commissioner shall determine. If such medical examination shall disclose evidence of silicosis in any stage the employee or the applicant for employment shall be suspended.

2 To refuse employment to any person in any process wherein silica dusts exist if the medical examination discloses (a) that the chest is not of average development with satisfactory expansion, (b) that there is a deformity or obstruction of the upper air passages or elsewhere which interferes with respiration, (c) that there are signs of present or past disease of the lungs or heart, (d) that there are signs of present or past tuberculosis of any region.

3 To use every reasonable means to exhaust or so dispose of silica dusts as to minimize the hazard.

4 Violation of this section shall constitute a misdemeanor punishable for the first offense, by a fine of fifty dollars, for the second offense by a fine of one hundred dollars, and for the third offense by a fine of one thousand dollars or one year in jail, or both.

The industrial board shall prescribe forms or make rules for carrying into effect the provisions of this section.

§ 65 Duties of employees. It shall be the duty of every employee or applicant for employment in any of the employments enumerated herein.

1 To submit himself to medical examination as herein provided,

2 To furnish true information to his employer or prospective employer regarding his past employment in the employments enumerated herein.

The industrial board shall, if necessary, make rules for carrying into effect the provisions of this section.

§ 66 Medical examinations. There shall be a written report for every medical examination made under the provisions of this article, in which the physician shall definitely certify to what degree, if any, the general physical capacity of the employee or the applicant for employment is impaired by silicosis. The employer or the employee, as a matter of right, may demand and shall receive a re-examination and a further report from the Board of Examining Physicians. All medical examinations and reports shall be made in accordance with rules prescribed by the industrial board.

§ 67 Board of Examining Physicians. The industrial board shall name a board of examining physicians, to consist of three physicians, graduates of a recognized medical college and with at least five years actual practice, who shall specialize in the diagnosis and treatment of silicosis, and to whom shall be referred only cases involving controversies in relation to the medical aspects of claims arising under this article, unless otherwise herein provided. The industrial board shall fix the fees of members of the Board of

Examining Physicians and shall prescribe their duties within the limitations of this section.

§ 68 Date of disablement. For the purposes of this article the date of disablement shall be such date as the industrial board may determine on the hearing on the claim.

§ 69 Compensation, how payable. Compensation shall be payable under this article either in a lump sum or in weekly payments as the industrial board shall determine in accordance with the following schedule.

1 For an employee whose disability has been diagnosed as the ante-primary stage of silicosis, twenty-six weeks compensation,

2 For an employee whose disability has been diagnosed as the primary stage of silicosis, fifty-two weeks compensation,

3 For an employee whose disability has been diagnosed as the secondary stage of silicosis, one hundred and four weeks compensation,

4 For an employee whose disability has been diagnosed as the final stage of silicosis, five hundred and twenty weeks compensation.

§ 70 Compensation, when not payable. No compensation shall be paid for the death or disablement of any employee who re-engages in any of the employments enumerated herein after he has been suspended, nor to any applicant for employment whose application has been refused but who engages in any of the employments enumerated herein.

Neither the employee nor his dependents shall be entitled to compensation for death or disability resulting from silicosis unless the disease is due to the nature of the employment and unless he shall have been employed continuously for five years in any of the employments enumerated in this article.

It being the policy and intent of this article to debar from employment in any of the employments enumerated herein for the protection of their health and the conservation of their capacity for work, any persons found to be physically unfit, an award of compensation hereunder shall be deemed to be final and no claim for compensation for death or disability from silicosis thereafter shall be valid and no further compensation shall be paid, provided, however, that nothing herein stated shall affect the rights of an employee to recover compensation in respect to an accidental injury or death arising out of and in the course of his employment in any other occupation than those enumerated in this article.

§ 71 Diseases which are accidents. Nothing in this article shall affect the rights of an employee to recover compensation in respect to a disease to which this article does not apply if the disease is an accidental personal injury within the meaning of subdivision seven of section two of this chapter.

§ 2 This act shall take effect January 1, 1926.



# State Department of Health



## SALE OF TETRAETHYL LEAD RESTRICTED

At a meeting of the Public Health Council of the State, held on January 20th, Chapter VII of the Sanitary Code was amended by adding thereto a new regulation to be known as Regulation 16, to take effect March 1st, 1925, and to read as follows

"The sale or distribution of tetraethyl lead in concentrated form, except in refineries, bulk stations or filling stations, is hereby prohibited. Such sale or distribution shall be made in safe, sealed containers

"Nothing herein contained shall be construed to prevent the sale or distribution of tetraethyl lead in concentrated form for experimental and research purposes or for use under special circumstances to persons whose applications therefor have been approved by the Commissioner of Health of the State of New York."

## SOME LOST OPPORTUNITIES

According to a report received recently a surgeon, by advising against a gall-bladder operation on a known typhoid carrier, neglected a splendid opportunity to serve the interests of public health

In the summer of 1924, this carrier, a woman, who had typhoid fever in 1921, suffered a severe attack of gallstone colic, and agreed to have an operation. On her arrival at the hospital she came under the care of the surgeon in question. In spite of the fact that the woman was a known carrier, the surgeon had two fecal specimens from the patient examined at the hospital laboratory. A third specimen was sent to the State Laboratory. All three specimens were reported negative. He failed, however, to elicit the history of typhoid cases following in her wake which was in possession of the local and state health authorities and advised against operation on the basis of the negative laboratory findings. His advice was accepted, and the woman left the hospital.

A month later another fecal specimen was obtained and an examination at the State Laboratory showed that it contained *B typhosus*. In view of the large proportion of cases in which removal of the gall-bladder and appendix results in terminating the carrier condition, it is greatly to be regretted that the operation was not performed on this carrier on the chance of bringing

to an end the path of devastation that she has left. It is hoped that she may again consent to an operation as it is known that since 1921 she has been the cause of eight, possibly nine, cases of typhoid fever, with two deaths.

Among other lost opportunities in connection with this carrier may be mentioned the fact that at least three of the typhoid patients among her relatives had refused to be vaccinated against the disease.

This case is illustrative of the fallacy of concluding that a chronic typhoid carrier is no longer a carrier, even if a number of negative specimens are obtained. It serves further to justify the policy of the State Department of Health in refusing to consider a chronic carrier to be free from infection until the gall-bladder has been removed, and a series of negative specimens subsequently has been obtained.

## PROPHYLAXIS FOR VENEREAL INFECTION

Medical Prophylaxis was the topic most discussed at the recent conference of Venereal Disease Control Officers held at Hot Springs, Arkansas.

While the so-called American plan for venereal disease control has progressed steadily, is practical and has secured public support, most of the officials who attended the meeting apparently believe that earlier treatment and a disinfection of those exposed, in order to limit the number of new infections, should be encouraged. All agreed that there was convincing evidence that early disinfection *under the supervision of a physician* within an hour of exposure will reduce infection to a negligible degree and that promiscuity will not be increased thereby.

Twenty-five states were represented at the conference and amongst the specialists who were present as consultants were Dr William Allen Pussy, President of the American Medical Association, Dr John H Stokes of the University of Pennsylvania, late of the Mayo Institute, Dr George W Walker, Johns Hopkins University, Dr William F Snow, President of the American Social Hygiene Association and Dr Mark J White, representing the Surgeon General of the Public Health Service, who was the permanent Chairman.

# NEWS NOTES

## PERIODIC HEALTH EXAMINATIONS

A radio talk by Orrin Sage Wightman, M.D., Chairman of the Periodic Examination Committee of the Medical Society of the County of New York, broadcasted from Station W.E.A.F. on January 20, 1925

### *Ladies and Gentlemen of the Radio Audience*

In coming before you as the representative of the Committee on Periodic Health Examination of the Medical Society of the County of New York, I feel deeply responsible as the representative of 3,200 physicians who belong to that Society. It is the largest County Society in the State of New York, and contains about one-third of the State membership.

The County Society is a part of the State Society, which in turn is a part of our National organization known as the American Medical Association. We are thus welded by County, State and Nation into a serious-minded profession which is conservative and at the same time takes seriously the responsibility of our civic and professional duty toward City, State and Nation. The present idea of our County Society is to offer our united thought on Periodic Health Examination, and of so organizing this work that it will admit of greater distribution in both State and Nation.

You all know that it is the aim of every municipality and state to conserve the health of the community. We have been enabled through the painstaking work, and the organization of well known foundations and institutions of research, like the Rockefeller, Carnegie, Milbank, New York Tuberculosis and others, to make a careful study of the causes of disease. An immense amount of money has been invested by our great philanthropists in this way—and I would say well invested, as countless lives have been saved as a result. As its personal contribution to this task, the Medical Profession has given unselfish devotion, and even life itself, in an attempt to discover the causes of disease. But a few short years ago, one of our number, by allowing himself to be bitten by a mosquito infected with yellow fever, told humanity how others could escape the plague of this dread disease. Both here and abroad medical men have been willing to devote their lives for a comparatively small monetary return, in their enthusiastic desire to discover the cause of a baffling disorder.

How is it possible to compute the value of typhoid vaccine as a prophylactic measure, in the prevention of this disease? Do you know that in the Spanish-American War, more men died of typhoid than under fire? And yet in the recent World War, where proper prophylactic measures were taken, there is little or no mention of this

terrible scourge, in spite of the millions of men who were mobilized all over the world.

This is a simple instance of the possibilities of preventive medicine.

We all know that fresh air and sunlight, and proper living quarters make for happiness and longer life. The Department of Health in this great city of ours, under an able leadership, has for years by constant watchfulness been a bulwark of strength in combating the destructive forces of ill health. It is constantly awake to the dangers of the water and milk supplies. It has all food inspected most rigidly, sends its agents and inspectors at the slightest suspicion or alarm, and in the event of an epidemic, is soon master of the situation.

Again, this is preventative medicine.

Whenever a new cure is brought to the attention of the community, everyone becomes interested. Here in particular the medical profession is true to its trust. They are often criticized severely when they will not accept many indigestible frauds which charlatans deal out to a gullible following. They are accused of prejudice, ignorance, jealousy and personal gain—but in spite of cults, quacks and frauds of every type, they pursue the even tenor of their way, knowing the life of the faddist is short, and all of the people cannot be fooled all of the time.

How gladly would all of us welcome an easy and sure cure for tuberculosis! How anxiously are we awaiting the time when we can definitely state the cause of cancer, its curtailment and positive cure, and in the same way one might go through many diseases which at present are not clearly understood, and state that the ambition of every physician is to leave something behind him which would really help his fellow-man to live longer, and save him needless suffering and misery.

I question whether the public at large knows how seriously medical men consider the science of medicine rather than its income. You often hear people complain of fees or charges made by physicians, not realizing that those same men have devoted the best years of early manhood to education and training so that they could better understand the diagnosis and treatment of human ailments. It is commonly reported that it costs about \$20,000 to train a good salesman in a large wholesale house. Now it is well to consider that a physician reaches twenty-eight or thirty years

of age before he is able to secure the collegiate, medical and hospital training which is considered necessary to make him a suitable candidate for the degree of M D

His college course is four years, his medical course is four years, with one or two years in a hospital, making ten years in all. This is preliminary training before a physician is presumed to have a modern education which is adequate and accepted by the Regents of the State of New York as a legal requirement in the practice of medicine. By careful adjustment of college and medical work this may be accomplished in eight years. After all, this is a long while. I state these facts frankly because the public treats too lightly what should be a proper return on the investment of a medical education.

The Periodic Health Examination has meant a very marked step in the advance of the practice of medicine. We previously were content to diagnose disease and attempt its treatment and cure. This meant that symptoms of more serious intent had many minor phases before reaching a dangerous stage, and the patient usually delayed taking himself to the doctor. For this reason our public hospitals are full of really sick people. Under these conditions modern medicine is beginning to realize that it is important for the patient to know and be guarded through pre-clinical signs, and not wait until a disease is well developed before attempting its cure. How much better for us if we could anticipate and prepare for a contingency, if we had any indication that it was threatening us. This in brief is pre-clinical medicine.

Our desire is to bring the family physician not only in closer touch with his patient, but to prepare him so that when his patient comes for more definite physical findings, the physician will be in a position to feel his responsibility toward his patient and thus insure his future usefulness to himself and the community.

There is nobody so close to the family as its physician. He knows, through years of intimate contact, the peculiarities common to the family, he knows in some instances what the parents and grandparents died of, he knows the mental idiosyncrasies as well as the physical shortcomings, and he is in a most strategic position to warn his health client of the pitfalls which may be waiting for him if he goes along without due consideration of his health. The family physician is particularly well equipped to make the necessary physical examinations. He has the background of a careful medical education.

The Medical Society of the County of New York is starting a periodic health program for physicians, which includes the necessary lectures and opportunities for special talks to physicians who are interested in this work. It offers courses of a post-graduate nature. It further offers a large list of bibliography from which the physician can find out what has been written and done

and thought by other physicians in the same field. And more than that, it offers the big idea of the pre-clinical finding of disease before it has fastened itself too firmly upon the individual.

There is no desire on the part of the medical profession to make this a mercenary procedure. The physician is worthy of his hire just as every other professional man is. It cannot be done for nothing. People are apt to make every provision for their future along other lines and totally disregard the possibility of ill-health. The fact that they feel well at the time carries unconsciously the idea that good health will continue forever, and that little time need be given to its future consideration.

We would ask everybody to seriously consider whether they are as healthy as they are entitled to be, and whether some slight correction would not be for their betterment and comfort. Do they realize whether they are underweight or overweight, or whether they are harboring circulatory diseases peculiar to their family, or possibly some weakness of the lungs, or some other hereditary or family peculiarity which at the present time could be easily remedied, or at least corrected, and save them much future worry and annoyance, possibly life itself?

Our intent is not to frighten anyone into an imaginary sickness. We merely urge stock-taking, and to be truly effective, this should occur once a year or once every two or three years.

It is a strange fact that we are willing to watch everything but our health. We spend hours over the consideration of an investment, look most exhaustively into the value of a stock, choose the schools and the homes for our wives and children, are most anxious about the friends our families make, the theatres they attend and the movies they go to see. And yet, when it comes to a matter of health, we choose to be entirely oblivious as to our future and seem to have a terrifying sense that we might discover some hidden ailment, and hence prefer to be left in ignorance.

The Chinese have a habit of hiding the afflicted member when it is disabled under the bedclothes, feeling that if it is out of sight it will cause a disappearance of the disease. Modern methods have required that if we want to live longer and be healthier, we should have this rating made at definite intervals. Most of the time you will find there is nothing wrong with you. Statistics have proven that it is really worth while, that the saving of human life, the saving of future misery and discomfort is incalculable.

We trust that all who may be within hearing will not be frightened or fear that they have anything to worry about by a simple taking of stock. If you have nothing the matter with you, it will show itself very promptly. If you have something the matter with you, you ought to know about it. The majority of people will come through with a clean bill of health. And when through any of our public utterances, through

broadcasting or in the public press the subject of Periodic Health Examination is mentioned, think of your own particular case and decide to have your family doctor look you over carefully, scientifically, and with no desire to either hide or terrify, but with a good, honest statement as to

your physical assets. This will be an hour well spent, not only for its effect upon you, but for the effect it may have upon your family and friends. Your family physician is a safe and sound person to whom you may entrust your health and physical welfare.

## THE NOSE, THROAT AND EAR IN PRE-CLINICAL SIGNS OF DISEASE

By DANIEL DOUGHERTY, M.D.,  
NEW YORK.

Abstract of the Tenth Lecture in the Symposium on the Pre-clinical Signs of Disease conducted by the Medical Society of the County of New York, given January 20, 1925

It is well known that abnormal conditions of the upper respiratory tract often affect the health of the whole body. Let us briefly consider those local conditions which should influence us in the expression of an opinion regarding the present and future health of those examined. Every physician is aware of the signs of diseased tonsils, and of their effects on general health. An examination of the tonsils is usually made by every examiner. Physicians are generally aware of the signs of and effects of chronic disease of the nasal sinuses. We will dwell today on some of the more obscure signs of local conditions which affect general health.

### COUGH

Cough is the most frequent and the most deceiving symptom with which an examiner has to deal. It is caused by a stimulation conducted by the vagus nerve. Since branches of this nerve are widely distributed and are in close connection with nerves from the ear, nose, throat, chest, stomach and the sympathetic nervous system, reflex irritation of widely separated organs may produce a cough.

A physician who is examining a coughing patient will of course look over the lungs carefully. He will next consider the larynx where he will need to keep in mind a variety of irritating conditions of inflammation, ulceration, foreign bodies, neoplasms and neuroses. Each of these conditions has its suggestive signs which will lead the skillful specialist to make a careful examination of the larynx. But whether the physician is a specialist or a general practitioner, he must remember that signs and symptoms which seem to point to a localization of a disorder in the larynx may be only a local manifestation of a general condition. There is for example a so-called nervous cough with apparently laryngeal irritation associated with neurasthenia and hysteria, and there is a dry cough associated with laryngeal chorea.

The pharynx can be readily inspected by the general practitioner, and chronic inflammations, and ulcerations can easily be seen and recognized. A paralysis of the pharyngeal muscles may produce a cough from food irritation. Tonsils

which are hypertrophied may press upon the phrenic and recurrent nerves and be a sufficient cause of troublesome cough. The lingual tonsil and the uvula may also cause a cough. A cough may be caused by almost any abnormal nasal condition as would be expected from the nerve supply of the nose. A general examination will include an inspection of the nose, and if an abnormal condition is found, it may be necessary to refer the patient to a specialist who has the equipment and facilities for making a thorough examination of the turbinates and sinuses.

It must also be remembered that the vagus nerve is distributed to the abdominal organs, and that a cough may be one of the symptoms of gallstones, tapeworm, nephritis or genito-urinary irritation. Cough may mean the presence of an aneurism or cardiac disease, it may be caused by irritation of the auditory branch of the vagus, as by impacted wax in the external ear. Cough may be caused by basilar meningitis, or cranial abscess, or a tumor of the cerebellum.

Since cough is a sign which is evident and annoying to the person examined, the examiner will need to have in mind the numerous conditions which produce the symptom in order to give an intelligent opinion regarding it.

### HOARSENESS

Under hoarseness we may consider all changes in the natural voice from a slight vocal weakness to complete loss of voice. A change in the voice is suggestive of disorders in other organs besides the larynx. Vocal resonance is derived from the nose, the sinuses and the pharynx and any diseased condition in them will often be indicated by a change in the voice.

In all cases of hoarseness, the influence of climate, occupation and habit are to be considered. Irritation from unaccustomed air, dust, vapor, excessive smoking or drinking, all may affect the voice. Hoarseness is present with many general diseases, such as tuberculosis, rheumatic condition, heart lesions and nephritis. The usual cause of hoarseness in these conditions is oedema from venous stasis.

Hoarseness is usually a clinical rather than a

pre-clinical sign of disease. However, hoarseness may be a very early sign of disease. A change in the voice is frequently the first noticeable symptom in tuberculosis, especially in pregnant women, in whom their condition is likely to light up a quiescent tuberculous lesion.

Hoarseness may be caused by nerve conditions due to post-diphtheritic paralysis, which is a rather common condition.

Hoarseness may be a sign of a partial paralysis of the laryngeal nerves as the result of growths on the neck, esophagus or mediastinum, or of goiter or a gumma or an aneurism of the aorta.

The voice may be affected by lesions of the central nervous system.

A general practitioner who is making a health examination must bear the voice in mind and investigate the causes of its abnormalities.

#### NOSE BLEED

Every case of nose bleed demands an investigation into its cause. Nose bleed may indicate a disturbance of the circulation, either cardiac failure or high blood pressure or arteriosclerosis. It may also be due to cirrhosis of the liver or nephritis or chronic alcoholism. Other conditions to be considered are plethora, scorbutus, purpura hemorrhagica, pernicious anemia and hemophilia.

Nose bleed in the aged, seemingly without cause, may be an indication of incipient arterio-

sclerosis, a fact with an important bearing in the treatment of aged patients.

Nose bleed in children may be caused by a foreign body or diphtheritic infection.

Nasal hemorrhage is the most common form of vicarious menstruation and may attend other forms of sexual irritation. It is also a common symptom in hysterical women.

#### CHRONIC SUPPURATIVE OTITIS MEDIA

A running ear is a potential source of danger and a physician making an examination will make careful note of the condition and urge its treatment. It is well known that it may lead to meningitis and abscesses of the brain, and also to general septicemia and pyemia. The liability that the inflammation may be tuberculous is also to be remembered. Bacterial examinations of ear discharges are always to be made, and, when possible, the responsibility of the case is to be shared with the aural surgeon.

In conclusion we wish to emphasize the importance of special symptoms referable to the nose, throat and ear in their relation to general diseases. It is also important for the general practitioner to remember that since the conditions are referred first to him, upon him rests the responsibility for serious results that may develop through his failure to recognize them early and to give intelligent advice regarding their treatment.

### SECOND DISTRICT BRANCH

The annual meeting of the Second District Branch of the Medical Society of the State of New York was held on the evening of January 9, 1925, in the Assembly Room of the Medical Society of Kings, 1313 Bedford Avenue, Brooklyn, with the President, Dr. Frank H. Lasher, in the chair, and sixty members present. The following officers were elected for two years, beginning at the close of the annual meeting of the State Society:

President, Dr. Joseph S. Thomas, Flushing; First Vice-President, Dr. Guy H. Turrell, Smithtown Branch; Second Vice-President, Dr. Charles A. Gordon, Brooklyn; Secretary-Treasurer, Dr. R. F. Seidensticker, Brooklyn.

Dr. Owen E. Jones, President of the Medical Society of the State of New York, spoke on the increasingly cordial relations between the State Medical Society and its constituent county societies. He recognized the original work that is being done by the Medical Society of the County of Kings, especially along the lines of the prosecution of illegal practitioners of medicine, the organization of extensive courses in post-graduate medical education, and the evolution of a practical scheme for periodic medical examinations that was

being copied throughout New York State and the entire nation.

Dr. John E. Jennings, President-elect of the Medical Society of the County of Kings, described the work of post-graduate medical education which is being conducted by the society. One feature of this work is a series of lectures on Friday afternoons at five o'clock, in the Assembly Room of the Medical Society of the County of Kings. These lectures have been exceedingly popular and valuable, and the Assembly Room, seating four hundred, has been crowded at every lecture. The series of 1923-1924 consisted of twenty-five lectures given in a form which was practical to the average general physician. The subjects of the first three lectures are typical of the whole series, and were as follows:

"The Surgical Abdomen," by Dr. Joseph A. Blake.

"The Signs of Incipient Tuberculosis," by Dr. H. A. Bray.

"The Treatment of Pneumonia," by Dr. Harlow Brooks.

These lectures have been collected and published in book form.



Another form of post-graduate education is an extensive series of clinical courses under the joint auspices of the Medical Society and the Medical College. The courses are given in the hospitals at times which are convenient to those who form the classes.

The scientific part of the program consisted of a symposium on the relation of focal infections, and general medicine, as follows:

"Heart and Kidney Disease," Dr. Luther F. Warren

"Gastro-Intestinal Disease," Dr. A. F. R. Andressen

"The Genito-Urinary Tract," Dr. N. P. Rathbun

"Ear, Nose and Throat," Dr. Claude G. Crane

"The Teeth," M. B. Parker, M.D., D.D.S.

The field of the Second District Branch is identical with that of the Associated Physicians of Long Island, which has a thousand members, holds three meetings annually, and publishes its own monthly Journal, The Long Island Medical Journal. There is a cordial spirit of friendliness between the two organizations, and the members of the Associated Physicians show entire loyalty to the Medical Society of the State of New York.

### CADUCEUS POST, AMERICAN LEGION

Caduceus Post, No. 818, American Legion, held its annual meeting and dinner on Wednesday evening, January 21, 1925, in the Yale Club, New York City. Eighty-eight members were present. All the former officers were re-elected as follows: Commander, Graeme M. Hammond, M.D.; First Vice-Commander, Jay D. Whitham, M.D.; Second Vice-Commander, Herbert L. Wheeler, M.D.; Third Vice-Commander, Col. F. F. Reynolds, Adjutant and Treasurer, Mr. Robert R. Gerstner.

The after-dinner speaking was opened by Col. Peter Traub, who commanded a brigade in France, and is now Commander of the 77th Division of the Organized Reserves. He spoke of the high value of the work of the Medical Department warfare, and the need that a considerable number of younger physicians should be commissioned. While it is the policy of the Government to reward those who saw service in the World War, yet that plan has filled the upper grades of service and left the lower positions unfilled. Col. Traub appealed to the members of the Post to join the Reserves and also to influence their friends to seek commissions in the Army.

Rear Admiral Bradley A. Fiske spoke of modern national feelings and aspirations which call for full preparedness as as the best insurance of a continuance of peace.

Col. Charles R. Reynolds, Commander of the Medical Field Service School of the U. S. Army at Carlisle, Pennsylvania, described the courses which were given at the School. This address was of special interest to the members of the Post, for at least seven of the members present had attended the summer course in 1923, and many more are now taking correspondence courses which are under the supervision of the officers of the School. A large

number of reserve officers throughout the State have also taken the courses.

The Carlisle School is housed in the buildings formerly used as the Indian School. The courses are designed to instruct medical men in their peculiar duties in the field. No attempt is made, for example, to teach a surgeon how to treat patients in a ward of a field hospital, but it does teach him how to erect a tent hospital, and how to transport it and its equipment. Other courses give instructions in the work of an ambulance company and the transportation of the sick and wounded. The school also teaches the establishment of first-aid stations in the battle line, and the treatment of the wounded and their transportation back to a field hospital. All this is done by means of an entire outfit of service equipment which requires several hundred men to handle.

Courses for officers of the Regular Army are given throughout the year, but a two weeks' course is given for officers of the Organized Reserves, and for the Medical Students organized in the Reserve Officers Training Camps. Once a week during the summer course a demonstration of battlefield work was given, in which soldiers marked with wounds were stationed in the fields five miles away from the Post along a hypothetical line of battle, and the students went out and established aid stations, found and treated the men, and transported them back to the Post, where a Field Hospital was in operation. The demonstration occupied the entire day, and those who participated in it got a vivid mental picture of the actual equipment in operation.

Caduceus Post is composed of medical men, many of whom held high positions in the World War. It is representative of New York City's best thought in medical preparedness for any possible outbreak of trouble with another nation.

F. O.



# DEATHS



- ALLEN, ANDREW HARRISON, Watertown, Long Island College Hospital, 1879, Fellow American Medical Association, Member State Society Died December 4, 1924
- ALSEVER, WILLIAM DEWEY, Syracuse, Syracuse University, 1900, Fellow American Medical Association, American Climatological Association, Syracuse Academy of Medicine, Member State Society, Physician University Hospital Died December 23, 1924
- ARGUE, HENRY A., Corning, New York University, 1881, Fellow American Medical Association, Member State Society Died December 25, 1924
- GLOVER, JOHN J., Stockport, New York University, 1857, Member State Society Died January 1, 1925
- GRAVES, GEORGE, Herkimer, University of Buffalo, 1870, Member State Society, for many years Treasurer of the Medical Society of the County of Herkimer Died January 24, 1925
- GREEN, ARTHUR RANDOLPH, Mount Kisco, Cornell Medical College, 1903, Fellow American Medical Association, American Public Health Association, Member State Society, Attending Physician North Westchester Hospital Died January 17, 1925
- HARRISON, STEPHEN DECATUR Elmira, College of Physicians and Surgeons of New York, 1879, Fellow American Medical Association, Elmira Academy of Medicine, Member State Society, Alumni Association City Hospital, New York City Died November 21, 1924
- HUNTER, DWIGHT WILLIAMS, New York City, College of Physicians and Surgeons of New York, 1879, Fellow American Medical Association, American Ophthalmological Society, New York Ophthalmological Society, Member State Society Died December 22, 1924
- KENNEDY, JAMES CHARLES, Brooklyn, Bellevue Medical College, 1882, Fellow American Medical Association, Fellow American College of Surgeons, Member State Society, Brooklyn Pathological Society, Brooklyn Surgical Society, Visiting Surgeon St. Mary's and St. Catherine's Hospitals Died January 11, 1925
- LEGGETT, NOEL BLEECKER, New York City, College of Physicians and Surgeons of New York, 1904, Member State Society Died November 9, 1924
- LINDRIDGE, EDWIN F., Brooklyn, Bellevue Medical College, 1875, Member State Society Died January 12, 1925
- LOEWE, JACQUES Brooklyn, Long Island College Hospital, 1897, Fellow American Medical Association, Member State Society, Attending Physician Beth Moses Hospital Died January, 1925
- LOEWENTHAL, PHILIP, New York City, New York University, 1895, Fellow American Medical Association, Member State Society Died December 29, 1924
- McKAY, WILLIAM, New York City, Toronto University, 1878, Bellevue Medical College, 1887, Member State Society, Fellow New York Academy of Medicine Died January 7, 1925
- McMASTER, PORTER REYNOLDS, Greenwich, College of Physicians and Surgeons of New York, 1892, Fellow American Medical Association, Member State Society Died December 21, 1924
- MANGAN, DANIEL CLARENCE, Brooklyn, New York University, 1891, Fellow American Medical Association, Member State Society Died January 6, 1925
- MERRILL, GEORGE VAN RENSSELAER, Elmira, College of Physicians and Surgeons of New York, 1863, Member State Society, Elmira Academy of Medicine Died November, 1924
- NELLIS, WILLIAM JACOB, Albany, Albany Medical College, 1879, Fellow American Medical Association, Member State Society Died December 9, 1924
- ROGERS, BENJAMIN FRANKLIN, Buffalo, University of Buffalo, 1879, Fellow American Medical Association, Member State Society, Buffalo Academy of Medicine Died January 1, 1925
- SKINNER, CHARLES N., Port Jervis, New York University, 1892, Fellow American Medical Association, Fellow American College of Surgeons, Member State Society, Visiting Surgeon St. Francis Hospital Died December 5, 1924
- SLOAT, HORACE MARTIN, Brooklyn, Long Island College Hospital, 1887, Member State Society Died January 13, 1925
- TEPLITZ, ISIDOR, Brooklyn, University and Bellevue Medical College, 1906, Member State Society, Attending Obstetrician Bushwick Hospital Died January 8, 1925
- VEDIN, ALMA, New York City, Woman's Medical College New York Infirmary, 1899, Fellow American Medical Association, American Association of Anesthetists, New York Association of Anesthetists, Member State Society, Anesthetist New York Hospital, Consulting Anesthetist New York Infirmary for Women and Children. Died November 14, 1924
- WILKLOW, GEORGE F., Ellenville, Fellow American Medical Association, Member State Society, Surgeon Benedictine Hospital. Died January 11, 1925



# THE DAILY PRESS



Last week we commented on the reports of outbreaks of para-typhoid fever in patients who had eaten cream puffs from clean bakeries. The articles ascribed the outbreaks to contamination of the food by mice or rats that had one form of paratyphoid fever. The New York American for Sunday, January 11th, had a full page illustrated description of the detective work done by the epidemiologists of the Department of Health in discovering the method of infection and proving every step of the process. The description was clearly written and well adapted to instruct the people regarding the danger from mice and rats, and the methods by which they may infect food, even in apparently clean bakeries and stores. We are printing extracts from the article as an example of an excellent bit of popular medical educational writing done in a way that is both interesting and effective.

"The inspectors paired off and went to each house where the illness had appeared.

"The first thing that they found out was that the symptoms of all the patients were exactly the same. There was high fever, intestinal pains, alarming physical weakness and nervous collapse. Such symptoms might belong to several diseases—ptomaine poisoning or typhoid among them. While the doctors took blood and other specimens for tests, the inspectors went minutely over everything that the families had eaten during the past two or three days.

"And when these lists were compared it was found that there was only one thing of which each and every one of the fifty-eight sufferers had partaken.

"That one thing was cream puffs.

"It was reasonable to suppose, then, that it was the cream puffs which had poisoned each of them, and this supposition was strengthened when it was found that all the cream puffs had come from one bakery.

"By this time the doctors had diagnosed the illness. Everyone of the ailing fifty-eight had para-typhoid fever, which is a milder mannered cousin of typhoid itself.

"The last link of evidence against the cream puffs was forged when remnants of them under chemical analysis, proved to be infected with the para-typhoid bacilli. But how had they been poisoned? And why? Had some one deliberately and wickedly infected the pastries? Or, was there some unclean person who had handled the cream mixture which had filled the puffs?

"When the little army of inspectors, doctors, and chemists trooped into the bakery from which the pastry had come and told the proprietor what

they had discovered, he was both genuinely alarmed and distressed—quite naturally, for he saw his business at stake, and he was as anxious as any one to find out how on earth those cream puffs could have gotten filled with disease germs. So they all went over the place minutely. Every article of food was tested. No contamination was found in any. Every employe was examined for para-typhoid—and not one of them showed a trace. Furthermore, the bakery was immaculately clean to all appearances, and the methods of mixing, cooking and handling the various doughs and fillings were hygienically correct.

"All the human inhabitants of the bakery showed a clean bill of health—but how about other inhabitants? The first possible ones that occurred to the inspectors were rats and mice. Traps were set in the neighborhood and a number of both were captured. They were killed and their viscera examined. And, sure enough, there, in most of them, were thriving colonies of the para-typhoid germ.

"There still remained the main question, however, of how in a hygienically carried-on establishment the rats could have contaminated the cream that went into the puffs? It seemed as though the answer to this would be easy, and back to the bakery went the inspectors to question further the proprietor.

"And here they came up against a closed wall for not only were there no rats in the bakery, but there had not been any for two weeks before the outbreak of the poisoning. And the cream was made fresh every day."

After describing the process of the manufacture of the crust and of the filling, both of which were subject to a cooking heat which would kill the disease germs, the account continues.

"One of the inspectors ordered the pail with the filling in it placed exactly where the other had been before it had been taken back to the kitchen for the filling of the puffs and there he sat minute after minute trying to puzzle out how possibly the germs could have gotten into it.

"He saw that there were shelves high up around the basement but for the moment that conveyed no idea to him. Then, as he sat there, he heard a plaintive 'meow' and something brushed against his leg. He looked down. It was one of the three tabbies who had chased away the rats, making friends with him.

"Suddenly she jumped upon a bench and by gymnastics that only cats know leaped from it and scrambled up on one of the shelves.

"A little pinch of dust came floating down,

dislodged from the shelf by her advent. In it were a few heavier specks of debris.

"And as suddenly as the cat had leaped a great light dawned upon the waiting inspector. He reached up to the shelf and scraped away a little dust that had gathered on the surface. Within it were more of those little dark particles. He took a part of this and scooping out of the cream-filled container some of its substance he threw the dust into it and stirred it. He then took this mixture and another sample of the dust to the Health Board chemist.

"And lo, and behold, when both had been analyzed, within them were found thriving colonies of the para-typhoid germs."

"It was now perfectly clear how the rats had poisoned the cream puffs.

"But the case shows the necessity of bakeries and other establishments for food preparation being kept free from dust. It is not enough that floors and receptacles be kept scrupulously clean and that the handlers of the food be spick and span. Dust is one of the most dangerous carriers of germs, and there should be frequent cleaning of shelves and all places where dust could collect."

In all the article we found only one error. The account says:

"Now the rat is a carrier of many deadly germs which affect it not at all—just as the mosquito carries the malaria germ but never has malaria. Rats and mice act as hosts for the para-typhoid bacilli, but don't suffer from it. But when the rat-carried germ gets by some way or other into a human being, it proceeds to wake up and do its wicked work."

The fact is that rats and mice are often made sick by the para-typhoid germs, and that one form of rat poison that is sold to kill rats consists of living cultures of the germs which are deadly to rats. It is also true that those which survive the attack may be carriers of the germs. The use of the rat virus is dangerous to human beings, and its sale is forbidden by some health authorities.

---

The New York Times of December 3rd, tries to uphold the claims for the chlorine treatment.

Its issue of December 3rd says "Negative Evidence is Indecisive."

"A rather elaborate report was given out by the municipal authorities, and it was to the effect that in their two clinics somewhat prolonged trials had failed to find any virtue whatever in the gas as a therapeutic agent. Statements more or less like this came at the same time from the hospitals, or some of them, where like tests had been made.

"That would have come near to being conclusive had it not been for the fact that the clinic first established—that at the Edgewood Arsenal in Maryland, are continuing with success to do exactly the work that here was called impossible, and in several other places, including the General Electric Company's plant in Schenectady, similar merits in the gas treatment have been demonstrated.

"The judgment, therefore, is confronted by both positive and negative evidence, and in all such cases the rule is that the positive evidence outweighs the negative. One almost is compelled to assume that the failures here were due, not to the worthlessness of the gas, but neglect to use it in strict accord with what has been proved the right way. The probability of this conclusion is the greater because the correct administration of the gas is not an easy or simple matter. When present in the air breathed in greater proportion than 0.15 milligram to the liter it is irritating and harmful, while in less than 0.12 it has no efficacy at all.

"Is Dr. Harris sure that in the tests that failed his apparatus worked within this narrow limit?"

The New York Times makes much ado over an alleged controversy between the Army physicians in Washington and the physicians of the New York City Department of Health over the chlorine treatment. The controversy seems to be over the fact that the Army doctors claim 70 per cent cures of colds, while the City Department succeeded in curing only 7 per cent of its patients.

Any physician knows that in some epidemics the patients recover in a few hours or days, and that in others, recovery takes weeks. The truth seems to be that the chlorine treatment does neither good nor harm.

F O



# BOOKS RECEIVED



Acknowledgment of all books received will be made in this column and this will be deemed by us a full equivalent to those sending them. A selection from these columns will be made for review, as dictated by their merits, or in the interest of our readers.

- PHYSIO-THERAPY IN GENERAL PRACTICE, AND FOR THE USE OF MASSEUSES** By E. BELLIS CLAYTON, M.B., B.Ch. (Cantab) Director Physio-Therapeutic Department, Kings College Hospital, London. William Wood and Co., New York, 1924. Price, \$3.50
- GUY PATIN, AND THE MEDICAL PROFESSION IN PARIS IN THE XVIIth CENTURY** By FRANCIS R. PACKARD, M.D., Author of *Life and Times of Ambrose Pare*. Seventeen illustrations, nine full page plates. Paul Hoeber, Inc., New York, 1924. Price, \$4.00
- PRINCIPLES OF GENERAL PHYSIOLOGY** By SIR WILLIAM MADDOCK BAYLISS, M.A., S.Sc., F.R.S., etc. Late Professor of General Physiology in University College, London. Fourth Edition, 261 Illustrations. Longmans, Green and Co., New York, 1924
- PHYSICAL DIAGNOSIS** By W. D. ROSE, M.D., Lecturer Physical Diagnosis and Associate Professor Medicine, University of Arkansas. Fourth Edition. Three hundred and nineteen illustrations. C. V. Mosby Co., St. Louis, 1924. Price \$8.50
- THE ERRORS OF ACCOMMODATION AND REFRACTION OF THE EYE AND THEIR TREATMENT, A Handbook for Students** By ERNEST CLARKE, M.D., F.R.C.S., Consulting Surgeon Central London Ophthalmic Hospital. Fifth Edition. William Wood and Co., New York, 1924. Price \$3.50
- FUNDAMENTAL PRINCIPLES IN TREATMENT** By HARRY CAMPBELL, M.D., B.S., F.R.C.P., Lond., Senior Physician West End Hospital for Nervous Diseases. William Wood & Co., New York, 1924. Price \$4.00
- AIDS TO PSYCHIATRY** By W. S. DAWSON, M.A., M.D., Oxon., M.R.C.P., Lond., D.P.M., Senior Assistant Medical Officer, Maudsley Hospital, Nervous Diseases. William Wood and Co., New York, 1924. Price \$1.50
- GYNECOLOGY, MEDICAL AND SURGICAL** By P. BROOKE BLAND, M.D. Assistant Professor Gynecology, Jefferson Medical College. 644 Illustrations, 43 colored text figures, 12 insert plates. F. A. Davis Co., Phila., 1924. Students' Edition, \$11.00 net, Library edition, two volumes, \$14.00 net.
- PRECIS DE CLINIQUE SEMIOLOGIQUE (Diagnosis, Prognosis et Traitements)** GASTON LYON, Ancien Chef de Clinique Medicale de la Faculte. Masson et Cie, Editeurs, 120 Boulevard Saint-Germain, Paris. 1924
- THE PRACTICAL MEDICINE SERIES** Eight volumes on the year's progress in Medicine and Surgery. Under the General Editorial Charge of CHARLES L. MITCHELL, A.M., M.D.
- VOLUME I GENERAL MEDICINE** Edited by GEORGE H. WEAVER, M.D., LAWRENCE BROWN, M.D., ROBERT B. PREPPE, A.M., M.D., BERTRAM W. SIPPY, M.D., RALPH C. BROWN, B.S., M.D.
- VOLUME II GENERAL SURGERY** Edited by ALBERT J. OCHSNER, M.D.
- VOLUME III, THE EYE, EAR, NOSE AND THROAT** Edited by CASEY A. WOOD, M.D., CHARLES P. SMALL, M.D., ALBERT H. ANDREWS, GEORGE E. SHAMBAUGH, M.D. Series of 1924. The Year Book Publishers, Chicago. Price \$3 per volume. Price of Series of eight volumes \$15
- REPORT OF THE SCIENTIFIC RESEARCHES OF THE VENEREAL DISEASES** United States Interdepartmental Social Hygiene Board, The American Social Hygiene Association. 1924
- LIPPINCOTT'S NURSING MANUALS. BACTERIA IN RELATION TO MAN, A STUDYTEXT IN GENERAL MICROBIOLOGY** By JEAN BROADHURST, Ph.D., Associate Professor Biology, Teachers College, Columbia University. 147 Illustrations. J. B. Lippincott Co., Philadelphia, 1924
- LOCAL ANESTHESIA SIMPLIFIED** By JOHN JACOB POSNER, D.D.S., New York Chief Dental Department Harlem Dispensary. Fifty-five illustrations. The C. V. Mosby Co., St. Louis, Mo. 1924. Price \$3.50
- INTERNATIONAL CLINICS** By leading members of the Medical Profession throughout the world. Vol. IV, Thirty-fourth Series, 1924. J. B. Lippincott Co., Philadelphia.
- LORD LISTER** By SIR RICHMAN JOHN GODLEE, Bt K.C.V.O., M.S., F.R.C.S. Third Edition, Revised. Oxford University Press, American Branch, New York, 1924. Price \$7.00
- CLINICAL STUDIES IN EPILEPSY** composed of clinical notes on some epilepsies as bearing on the pathogenesis of idiopathic epilepsy. By DONALD FRASER, M.D., F.R.F.P. & S. (Glas.) William Wood & Co., New York, 1924. Price \$2.50
- SAFEGUARDING CHILDREN'S NERVES** A Handbook of Mental Hygiene. By JAMES J. WALSH, M.D., Ph.D., Sc.D., and JOHN A. FOOTE, M.D. Foreword by Honorable HERBERT HOOVER. J. B. Lippincott Co., Philadelphia and London. Price \$2.00
- A TEXTBOOK OF MATERIA MEDICA FOR NURSES** By A. L. MUIRHEAD, M.D., and EDITH P. BRODIE, A.B., R.N. Second Edition. C. V. Mosby Co., St. Louis, 1924. Price \$2.00
- A TEXTBOOK OF PHYSIOLOGY** By H. E. ROAF, M.D., D.Sc., M.R.C.S., L.R.C.P. Illustrated. Longmans, Green & Co., New York, 1924. Price \$8.50 net
- THE CURE OF OBESITY** By Doctor JEAN FRUMUSAN, Translated from the French by ELAINE A. WOOD. William Wood & Co. New York, 1924. \$2.50
- AIDS TO SURGERY** By JOSEPH CUNNINGHAM, M.B., B.S., F.R.C.S., Eng., and CECIL A. JOLL, M.S., Lond., F.R.C.S. Eng. Fifth Edition. William Wood & Co., New York, 1924. Price \$1.50
- FACIAL SURGERY** By H. P. PICKERILL, C.B.E., M.D., M.S. Introduction by Sir W. ARBUTHNOT LANE, Bart., C.B., M.S. William Wood and Co., New York, 1924. Price \$6.50
- RHEUMATIC HEART DISEASE** By CAREY F. COOMBS, M.D., F.R.C.P., London. Introduction by F. J. POYN-TON, M.D., F.R.C.P. London. Numerous original plates and illustrations. William Wood and Co., N. Y., 1924. Price \$4.50
- PRACTICAL LECTURES** Delivered under the auspices of The Medical Society of the County of Kings Brooklyn N. Y., 1923-24 series. One hundred and thirty-two illustrations, three color plates. Paul B. Hoeber, Inc., New York, 1925. Price \$5.50

# BOOK REVIEWS

**EMERGENCY OPERATIONS FOR GENERAL PRACTITIONERS ON LAND AND SEA, AN ILLUSTRATED MANUAL OF PROCEDURE AND TECHNIQUE.** By H. C. ORRIN, O.B.E., F.R.C.S., Ed., Surgeon, Ministry of Pensions Orthopedic Hospital, Newcastle-on-Tyne, late Civil Surgeon to the Third London General Hospital. William Wood and Company, New York, 1924. Price, \$2.75

This book is written for general practitioners, recent graduates, and ships' doctors, who may be suddenly confronted with situations in which they may find it difficult to extricate themselves unless some knowledge of just how to meet the emergencies is at hand. The book contains sixteen chapters in which are described the urgent major and minor operations of surgery. There is no discussion of diagnosis or alternative methods of treatment. The topics covered are anaesthetics, technique, operations upon the abdomen including those for appendicitis, hemorrhage from gastric or duodenal ulcers, strangulated hernia, rupture and gunshot wounds of the intestines and intestinal obstruction. He sets forth the technique of trephining, and operations upon the ear and nose. He tells how to remove foreign bodies from the air passage and the food passage. He discusses the emergency treatment of wounds in general, compound fractures and severed tendons and nerves, as well as cellulitis and infections in tendon sheaths. Emergency operations receive their due share of attention. Another chapter is devoted to the arrest of hemorrhage and the treatment of shock. Of the emergency operations upon the chest, the author describes treatment of mammary abscess, the technique of paracentesis and empyema. Among the urgent conditions in the genito-urinary system which may require emergency surgery, he describes aspiration of the bladder, suprapubic cystotomy, and an operation for hydrocele. He describes ovariotomy, operations for ruptured tubal pregnancy and pyosalpinx.

While a little knowledge is a dangerous thing to have at one's disposal, a small manual of this kind is a great asset to those who may be called upon to meet the emergencies described herein. For doctors are frequently called upon to do that which they have not been trained to do and do not wish to do, but which from their inability to delegate to others, must be done by them. The performance of these operations often under unfavorable and unkindly circumstances has frequently given the patient a fighting chance.

R. H. F.

the volume presents special features for study. In the Dardanelles Campaign, organized evacuation of sick and wounded by sea, and the problems of sanitation on a very restricted and overcrowded area under hostile fire, were the all-important considerations. In Macedonia, the dominant feature was warfare in mountainous country or in river valleys and ravines, the hot-beds of malaria. These required the organization of special ambulance transport for sick and wounded over mountain tracks, and extensive measures for combating a disease that threatened to repeat, in the history of the campaign, the disaster of the Walcheren Expedition in 1809. In Mesopotamia, the effects of extremes of heat and cold, the organization of river and desert transport, the problems of disease prevention generally and a variety of administrative difficulties were prominent features. East Africa was typical of a campaign in a tropical and bush country with troops operating in columns over a vast area against an elusive and mobile enemy, and exposed to all kinds of tropical diseases. North Russia on the other hand, was of exceptional interest, as there the medical services had the unusual experience of working for a great part of the year in an Arctic region over trackless, snow-clad and ice-bound regions. All these campaigns, therefore, are deserving of study by the student of military medical history." In addition to the above campaigns, this volume presents a most complete description and set of illustrations of the various methods of transportation of wounded that has yet been published. In appendix C are given the citations of the awards to medical men of the Victoria Cross, the Albert Medal, the Distinguished Service Order and other awards for bravery.

The editor and his co-workers are to be commended for having so quickly and so efficiently and so thoroughly presented to the world, this complete presentation of the Medical History of the War. The lesson which should be learned from these volumes, especially the last one, is the real importance and necessity of the medical branch of the Army. Too frequently the other arms of the Service have belittled the medical service and ignored it until some great emergency has arisen, and then the blame has been placed on failure of the medical branch, when the failure has been because of lack of consideration in plans. All through this volume, G. H. Q. overlooked the medical service in general plans to the detriment of the wounded.

H. M. Moses

**HISTORY OF THE GREAT WAR BASED ON OFFICIAL DOCUMENTS—MEDICAL SERVICES GENERAL HISTORY Vol IV** By MAJOR-GENERAL SIR W. G. MACPHERSON, K.C.M.G., C.B., LL.D., and MAJOR T. J. MITCHELL, D.S.O. Octavo of 711 pages, illustrations, maps and charts. London, His Majesty's Stationery Office, Imperial House, Kingsway, W.C. 2, 1924. Cloth, 25 shillings net.

This fourth and final volume of the Medical Services of the British during the World War covers the records of the Army in various parts of the World. It includes the operations of the Gallipoli Peninsula, in Macedonia, in Mesopotamia and Northwest Persia, in East Africa, in the Aden Protectorate and in North Russia. The editor truly states in the preface "The history of the Medical Services in each of the campaigns recorded in

**DISEASES OF THE CHEST AND THE PRINCIPLES OF PHYSICAL DIAGNOSIS** By GEORGE W. NORRIS, M.D., and HENRY R. M. LANDIS, M.D. Third Edition, revised. Octavo, 907 pages, 433 illustrations. Phila. and London, W. B. Saunders Co., 1924. Cloth, \$9.50.

By universal acknowledgment, "Norris and Landis" has become a standard textbook in the field it covers. The issuing of a new edition is naturally looked upon by students of internal medicine with considerable interest. In this, the third edition, the highest expectations are realized. All that is basic is retained in its full and well rounded presentation, but much has been added in the light of more recent well founded research. The book stands forth today most complete, a model of its kind.

FOSTER MURRAY, M.D.

**THE PRINCIPLES AND TECHNIQUE OF ORAL SURGERY** By ADOLPH BERGER, D.D.S., Assistant Professor of Oral Surgery, School of Dental and Oral Surgery, Columbia University, 355 Engravings, from original drawings, radiographs and photographs Dental Items of Interest Publishing Co., Brooklyn, 1923

This book is a record of the author's "personal experience gathered from fifteen years of active clinic work and private practice." In a very concise and comprehensive manner he gives a complete, remarkably well-illustrated story of every phase of Oral Surgery in only 444 pages

Some illustrations depict so clearly and in sequence the operations that the text is almost superfluous. The chapters are short and almost independent, but do full justice to the topic under consideration, conveying to the reader the most modern ideas and methods on the subject

Great skill and simplicity are shown in his operations on the maxillary sinus with the least mutilation to the neighboring dental organs and post-operative complications that are often the result of the so-called classical operations on the maxillary sinus

With courage and authority based on practical clinical experience for many years he opposes the view of many, that are against the performance of operations on the maxillary sinus through the mouth. He also shows thorough knowledge of modern dentistry and uses sound reasoning by advising conservative methods in dealing with diseased dental organs

This book is a valuable contribution and aid to everyone doing Oral Surgery. With the exception of the last few chapters on Ankylosis and Neoplasms that belong to major surgery, one can easily follow the author in every procedure, due to the clearness of presentation and wonderful illustrations

VICTOR STOLL

**MIND AND MEDICINE** By THOMAS W. SALMON, M.D., Professor Psychiatry, Columbia University Columbia University Press, New York 1924

This is an address delivered at the opening session of the College of Physicians and Surgeons, Columbia University, September 26, 1923, by the distinguished psychiatrist, Professor Thomas W. Salmon.

The modern physician can no longer justify a cold, aloof attitude toward the patient with mental symptoms. Fear for example, may cause death just as surely as carcinoma, it may demoralize and disable just as inevitably as empyema. Fear is as much of an example of a medical fact as hemorrhage.

The physician of the future will be trained to deal with the *total reactions* of human beings—mental and physical and social

The general hospital of the future will have suitable wards for the mentally ill

The psychoneuroses (the well known "nervousness" of the laity) were long ignored by the profession because of the absence of demonstrable organic changes. Hence the jazz cults came to the rescue

We have known the names of the common forms of insanity less well than we have known those of rare tropical diseases

Popular medical compromises have been to deny the genuineness of mental phenomena or to transform them into uterine displacements, impacted molars and endocrine disorders

Suppose that Michelangelo had steadfastly ignored one of the principal pigments. That is just what we, claiming to practice an art, have stupidly been doing in medicine

A lot of good would result if those who are engrossed by the more physical of the biologic processes were to read this little book.

A. C. JACOBSON

**ALLGEMEINE UND EXPERIMENTELLE PATHOLOGIE, NACH VORLESUNGEN FÜR STUDIERENDE UND ARZTE, VON DR. HERMANN PFEIFFER**, o.o. Professor und Vorstand der Lehrkanzel für allgemeine und experimentelle Pathologie an der Universität Graz, Mit 50 Abbildungen im Text und 8 teils mehrfarbigen Tafeln Urban & Schwarzenberg, Berlin und Wien 1924

This work embodies the consideration of only certain, selected fields in the domain of pathologic physiology. These subjects are dealt with in great detail, and afford valuable and interesting study. It is always of exceptional interest to read the views of a master, especially when he attempts to explain the mechanism by means of which disturbance of structure and function is brought about. Of particular note are his chapters on inflammation, the disturbances of the circulation, metabolism and of the internal secretions. The book is well worth reading, and is a desirable candidate for membership in the pathologist's library

MAX LEDERER

**HANDBOOK OF MODERN TREATMENT AND MEDICAL FORMULARY** A condensed and comprehensive manual of practical formulas and general remedial measures Compiled by W. B. CAMPBELL, M.D. Seventh Revised Enlarged Edition by John C. Rommel, M.D., and C. E. Hoffman, Ph.M. F. A. Davis Co., Phila., 1924 Price \$5.00 net

This book, now in its seventh revision, is greatly enlarged and contains much new material. To those who are not familiar with the art of prescription writing, it offers an exceptional opportunity to become acquainted with the manner in which drugs are combined and their application to diseases, which are alphabetically arranged. The formulae, if not used as presented, suggest possible ideas that the prescriber may utilize in making his own prescriptions. The metric and apothecaries' systems are both given for convenience. Recent graduates will find it a great help in meeting the difficulties that occur when at a loss in knowing, when, how, and what to write for

F. S.

**DYSPEPSIA AND ITS SELF-TREATMENT** By JADU NATH GANGULI, B.A., M.B. Formerly Senior Scholar, Calcutta University M. B. Nath, Biswanath Printing Works, Benares City 1924

This is a small book for the laymen, written by an old Hindu practitioner, who himself was for many years a sufferer from "dyspepsia" and who cured himself by the methods he outlines. The descriptive matter reads like the pages of the old almanacs, with difference that the treatment of all the diseases described is based on various obsolete theories, combined with a mixture of auto-suggestion and Hindu philosophy. The book makes interesting reading for the physician, and probably in India, where it is published, fills a need among the laity.

A.

**INTERNATIONAL MEDICAL ANNUAL. A Year Book of Treatment and Practitioner's Index.** Forty-second year, 1924. Octavo of 536 pages with 54 plates and 99 illustrations. William Wood and Company, New York

This publication is an encyclopedia of medical and surgical facts and procedures. This year is the forty-second of this annual and the editors have incorporated in one volume a wonderful amount of information which is modern in both medicine and surgery. Beginning with 4 important advances are recorded in various diseases through the alphabet to a discussion on Yellow Fever. As a handy reference book of progress, by British practitioners chiefly, this volume will be useful as it is concise, modern and accurate.

H. M. MOSES



# PRUNES



## The Easy Mark

My night bell rang It was about two a.m. It awakened me out of a sound sleep Wrapping my bathrobe around me I descended the stairs to the front door A young girl about 15 or 16 years of age stood there.

Her salutation was "May I use your telephone, Doctor?" Before I could answer she had made her way to the phone which was attached to the wall near the staircase. She turned the crank and "central" finally answered To my surprise and astonishment she called out the number of one of my neighboring fellow practitioners For the longest while the operator tried to obtain an answer Finally the little girl said, "Don't answer Well, that is funny I tried his front door bell a short time ago and there was no answer either"

Brushing past me in the hall while I held the door open, she explained "My sister's little baby is awfully sick and Dr F is the family physician I could not get him to answer his front door bell, so thought that I would try his phone number I knew you would not mind Much obliged. Good night."

After ascending the stairs and about to return to bed my better half murmured "A night call. May I do anything for you?" After pondering a moment my reply was "I think I should like you to knock me on the head"

ROBERT E COUGHLIN, M D

## Man Worth 98 Cents

"Marked down to 98 cents" would be a queer and insulting tag to put on a man. Yet that is what a man amounts to, considered in terms of his chemical contents, writes "The Toronto Globe." The analysis has been made by some technical sharp, and this is the astounding report

The ingredients of man plus water are as follows  
 Fat enough for seven bars of soap  
 Iron enough for a medium sized nail  
 Sugar enough to fill a shaker  
 Lime enough to whitewash a chicken coop  
 Phosphorus enough to make twenty-two hundred match tips  
 Magnesium enough to make a dose of magnesia.  
 Potassium enough to explode a toy cannon  
 Sulphur enough to rid a dose of fleas  
 This whole collection is worth 98 cents and that when things are three times as high as they used to be—*Tribune*

## A Charming Thought

It was after dinner and the talk had turned to psychology This disturbing question had just been put "When does old age really begin?"

To establish a formula was proving rather difficult, when one lady, who did not look her years, found the following

"To me, old age is always fifteen years older than I am"—*Cyrano (Paris)*

"Of all the things that that specialist ordered you to give up, what do you miss the most?"  
 The twenty-five dollars he charged me"

## One Bathtub a Season Is Enough

"Rafael Sabatini says 'A \$25 stenographer today is better off than a seventeenth century queen' So she is The queen had more dresses but no bathtub The \$25 stenographer has a bathtub and uses it"—*Arthur Brisbane*

Uhuh! but we'd like to be present when the parent of a stenographer tried to reason with her along this line

"Look here, Pansy You can't have no more new clothes this season You've got to turn your money over to mommer and me so we can put in a new bathtub"

Rouge of two thousand five hundred years ago has been discovered near Odessa Were there never any good old times?—*Punch*

"The slow thinkers live longest," says a prominent psychologist Not if they cross the street.—*Detroit Free Press*

## A Rumor

There is no truth in the recently published rumor to the effect that chiropractors, if and when consigned to Sing Sing, are forced to break big stones up into little ones with their bare hands, kneading and thumping the stubborn quartz into dispassionate and unresisting gravel

They are permitted to use regular sledges, exactly like those furnished to their fellow inmates And a friend of ours who is in the hardware business, wholesale, says that all of the great penal institutions are placing large advance orders for 12 pound rock-crushing mallets—*Medical Pocket Quarterly*

## More Than Possible

Hi A young lady (librarian) tells me your friend Ima Dodo asked her today for a book by Shakespear called "Veins and Adenoids"—Mervin L Lane, *Sun*

## Job's Comforter

Sick Man I feel as though I've been through hell!  
 Friend (at bedside) Now, Bill, you musn't go crossin' yer bridges before you come ter them—*Bulletin (Sydney)*

## A Losing Combination

As the M D rose to depart he cautioned the negro

"For your chills you are to take a pill at seven o'clock, and if you shake again take the other pill at eleven o'clock."

"Oh, Lawd, doctah," wailed the ducky, "ah kin see mah finish!"

"What do you mean?"

"Whenebber ah shakes to sebben come lebber ah loses out ebbery time!"



# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 4

NEW YORK, N Y

FEBRUARY 6, 1925

## HOW CAN WE BEST TREAT PERNICIOUS ANEMIA? \*

By LOUIS M WARFIELD, A B, M.D

ANN ARBOR, MICH

IN 1849 Addison read his original paper before the South London Medical Society. He called the disease idiopathic anemia and laid stress upon the bad prognosis. It was not until twenty-three years later that Biermer published his cases. He gave to the disease the name it usually bears, pernicious anemia. The English call it Addison's anemia, the Germans call it Biermer's anemia. If it bears anyone's name it should be Addison's. Wm Hunter, (1) who maintains that sore mouth is always present, would call it glossitic anemia. He thinks if this term were in general use that more cases would be seen early and more cases could be cured. In regard to the use of the adjective "pernicious" he expresses himself as follows: "The name pernicious is false, misleading, hurtful, and harmful, it is mischievous, prejudicial, disadvantageous, disserviceable, it is unlucky, sinister, obnoxious, oppressive, burdensome, it is inauspicious, destructive, and venomous, it is bad, as bad can be, ill-contrived, ill-conditioned, grievous, deplorable, lamentable, and pitiable, it is wrong, shocking, hateful, detestable, and confounded, it is inadvisable, unprofitable, inexpedient, useless, unskillful, and hopeless." It is easy to see that he feels strongly on the subject.

In a discussion on Addison's anemia at Guy's Hospital A F Hurst (2) began his remarks with this sentence, "It is now generally agreed that Addison's anemia is caused by a hæmolytic toxin produced by some infection in the alimentary canal." It seems to me that that is too dogmatic a statement in view of the paucity of proof which can be brought forward to substantiate it. Wm Hunter since 1900 has held that oral sepsis plays a large part in the causation of the disease. However, his views are not accepted by the majority of those most competent to pass judgment. He groups the

anemias which most resemble each other into four classes (3)

(A) Addisonian anemia (seasonal, *glossitic*, hæmolytic, hyperplastic)

(B) "Septic anemia," Hunter 1900-3 (*non-glossitic*, non-hæmolytic, aplastic)

(C) Cancer of stomach (*non-glossitic*, non-hæmolytic, aplastic)

(D) Bothriocephalus latus anemia (*non-glossitic*, hæmolytic)

Addison's anemia, according to him, is a disease characterized by sore tongue (100% of 200 cases), absence of HCl in stomach contents, and associated with periodontitis, pyorrhea alveolaris in which streptococci are found. The oral sepsis may be a separate cause of anemia, so-called septic anemia, and complicates the picture of Addison's anemia. Removal of the teeth, every one, allows absorption to cease and patients recover up to a certain point. He feels that if more attention were paid to the symptom of sore tongue it would not be one and a half to two years before the patient was seen by someone who understood the disease. Even if one does not agree altogether with Hunter's ideas he has done a service in consistently insisting upon early diagnosis and clean mouths.

There is one clinical sign without which practically all are agreed the diagnosis of Addison's anemia cannot be made. That is absence of free HCl in the stomach contents, often an achylia gastrica. This is a point of great importance and cannot be too strongly emphasized (Levine and Ladd, and others). (4) Some insist that even if all the evidence points to Addison's anemia the presence or HCl renders the diagnosis extremely doubtful. Achlorhydria has been found several years before the development of anemia, in one instance 12 years (Hurst). Hurst (5) mentions congenital achlorhydria and speculates on its effect in rendering people more susceptible to poisons.

\*Read at the Annual Meeting of the Medical Society of the State of New York, at Rochester April 23, 1924.

swallowed. He also says, "It seems to me that a full recognition of the fundamental part played by achlorhydria in the production of Addison's anemia will more than anything else lead to the realization that the disease is no more pernicious than any other form of secondary anemia."

A tendency seen in some of the more recent articles is to relegate into the background the examination of the blood. Hunter, for example, thinks that the combination of sore-mouth, achlorhydria, age over 40, the seasonal character (onset and relapses occurring in the months from July to September) slight fever, lemon-yellow color is sufficient for diagnosis. They are not always present by any means. Cases of undoubted Addison's anemia are seen with normal blood counts and the color index is not invariably 1 or 1 plus. The difference between 8 and 1 may well be due to a faulty instrument used in estimating the hemoglobin or to the variation in the human element in reading the instrument, so that too much reliance cannot be placed on the color index. When the other signs and symptoms are present the diagnosis is certain in spite of the blood count. This should not be interpreted to mean that the blood examination is of no particular value and therefore need not be made, it only shows how important the other signs are in the diagnosis.

Giffin and Bowler (6) in an analysis of 628 cases of pernicious anemia found other diseases present in 108. In 10 cases the diagnosis of gall-bladder disease was substantiated clinically. No one was operated. They say that removal of foci of infection may improve the patient's condition, but they have no evidence that this has any direct effect upon the disease. They conclude that "while other diseases may produce a blood picture typical of pernicious anemia, the clinical and remaining laboratory features are absent to such a degree that it is doubtful whether the complete pernicious anemia syndrome is ever seen as a result of other disease."

Rinker (7) urges a more intensive study of the so-called primary anemias for foci of infection. Should these foci prove to have a relationship to the anemia, the anemia would then be no longer primary. This is the goal for which all are striving. Idiopathic or primary anemia is a term which confesses on its face total ignorance of the cause of the anemia. This anemia must have a cause, when that is found it is no longer primary but secondary anemia. The answer to the question "How can we best treat pernicious anemia?" is found in the discovery of the cause of the anemia. Up to the present time the cause has escaped detection, although from time to time

a case here and there is, by intensive study, taken out of the category of pernicious primary and put into the class of secondary anemia.

I confess that I cannot agree with those who look for the cause in alimentary tract poisoning. That there is production of poison which apparently has selective action on the bone-marrow, especially the red cell-forming part, is credible, and experimentally certain toxins as abrin and ricin have been shown to produce changes in bone-marrow like those due to pernicious anemia, yet the fact that at post mortem the marrow is often red and hyperplastic before exhaustion sets in argues more for an increased destruction of red cells than for an under-production of red cells. It may well be that the hyperplasia is an aberrant hyperplasia, resulting from the tremendous effort on the part of the marrow in response to toxic stimuli, and that the cells so produced by a poisoned marrow are rendered more easily phagocytizable by the so-called reticuloendothelial system. The fact remains that hemolysis outruns production. Since it is the property of the phagocytes to take up cells no longer of any use or changed in some way chemically so that they are capable of being phagocytosed, it does not seem logical to predicate an increased power of phagocytosis. This, however, may be present. However, as the body is filled with such cells ready to seize upon particulate matter of various kinds, an especial toxic stimulus to this so-called system seems a superfluous hypothesis. Peabody (8) and his associates are now studying phagocytosis from a new angle, and have already found unusual phagocytosis in the bone-marrow, the site of red cell production. The phagocytic cells are large mononuclear elements similar to those found elsewhere in the body with the greatest concentration in the spleen.

The achlorhydria does not seem to me to be a sufficient factor in the production of the anemia. We see many cases with achlorhydria who do not have pernicious anemia. Also the achlorhydria may be present for years before the anemia supervenes. The foulest mouths I have ever seen have not had pernicious anemia. It comes hard for me to believe that the swallowing of streptococci into a stomach unprotected by free HCl in the absence of any intestinal ulceration can produce toxins sufficient to produce pernicious anemia. There is no proof of the change in intestinal flora when the feces of cases of pernicious anemia are examined. In an intact intestine when the movements are daily or oftener how can there be absorption sufficient to damage the bone-marrow? If the intestinal glands at autopsy showed evidences of infection, such as is found in tuberculosis, for example, one might

assume that bacteria passed through the intact intestinal mucous membrane as the tubercle bacillus is said to pass. But the glands do not show infection, they are hemolymph glands, as Warthin has shown. Chronic foci of infection at the roots of teeth, in sinuses around the face, in gall-bladder, appendix, etc., discharge poison directly into the blood stream. It is understandable how such foci may, every second of a person's life, be injuring bone-marrow until the time comes when the symptoms and signs of pernicious anemia appear. I am of the opinion that achlorhydria is not a cause of pernicious anemia, but a result of the cause which produces the whole disease. The neurological symptoms and the combined lesions of the cord are not produced by even profound anemia of secondary type except in rare cases. We are yet far from a knowledge of the cause or causes of this baffling disease, with its remarkable remissions and relapses which last for variable periods. Stockton (9) has reported a remission of twenty years. Frequent blood examinations showed no striking peculiarities but there was absence of free HCl in the stomach contents throughout all the years. The patient died of pernicious anemia. How are we to explain this? It is just this remarkable variability of the length of remissions of this disease which renders it almost impossible to evaluate any given method of treatment. The tendency to remission shown at times by cases apparently on the verge of death makes it natural to attribute the remission which sets in to some special method.

It is our habit to study our cases of pernicious anemia as intensively as possible. We call in all the specialist help in our search for possible foci of infection. We examine the stools and culture the duodenal contents. We have a complete gastro-intestinal examination made by the X-ray department. Absence of HCl in the stomach contents makes us feel that we are dealing with a true Addison's anemia, and we may not find any focus of infection. The presence of HCl only spurs us on to greater and more intensive search.

Let me cite an illustrative case.

CASE I, H. K.—White, male married American, taxi driver, 42 years of age.

Entered hospital 3-28-22 complaining of weakness, shortness of breath and occasional epigastric pain.

The family and personal history are not important.

The present illness began in the fall of 1920 about 1½ years preceding entrance to the hospital. At that time he noticed a gradually increasing weakness which incapacitated him for work. He considered that he was becoming

ing pale, and his friends told him he looked yellow. He also experienced occasional severe epigastric pain, brought on by exertion, and not related to meals. He was nauseated at such times but did not vomit. His physician gave him some medicine, and after about six months he apparently recovered and was able to resume work. He remained well until the winter of 1921, when he again became gradually weak and unable to work, and the attacks of pain recurred. Treatment at this time, similar to that given before, was ineffective. He became progressively worse up to the time of entrance to the hospital, at which time he was almost bedfast.

He had no soreness of the mouth, no sensations of numbness or tingling in the extremities. During the course of his illness he lost about 15 pounds in weight.

*Examination* at the time of entrance revealed extensive pyorrhea alveolaris, marked pallor together with a definite yellow color of the skin, and a palpable liver and spleen. Otherwise, there were no significant signs. There was no abdominal tenderness. The blood Wassermann was negative, as were the urine and stool examinations. Blood pressure was 110 systolic and 70 diastolic. The blood showed 20% hemoglobin, 1,000,000 red cells, and 3,000 white cells. The stained smear showed a relative lymphocytosis of 40%, together with great variation in the size and shape of the reds. No nucleated red cells were seen. The reticulated or young red cells constituted 2% of the total number. It was impossible to do a gastric analysis, because the patient could not swallow the tube, but the vomitus which was obtained every time an attempt was made to pass the tube showed complete absence of free hydrochloric acid and very little combined acid, without any bile. Gastro-intestinal X-ray revealed nothing except a slight hypermotility of the intestine.

*Clinical Course* During a prolonged stay in the hospital, interrupted by occasional visits home as his condition improved, the patient showed a very slight and occasional rise in temperature up to 100°. He was transfused repeatedly with 500 to 600 cc of whole blood at a time, and each time his weakness and shortness of breath improved temporarily, but only so long as the added blood remained in his circulation, which was about ten days. He had none of the attacks of epigastric pain while under observation. Finally, after a lapse of five months under intermittent hospital treatment, from which no permanent benefit resulted, the abdomen was surgically explored. A thickened gall-bladder containing many stones was found. This was evacuated and drained, complete removal not being at-

tempted because of the patient's poor general condition. Recovery from the operation was prompt, and two weeks later the patient stated that he felt better than he had at any time during the preceding two years. Within four weeks the hemoglobin had increased to 60%. In two months he stated that he considered himself a well man, and letters from him at intervals since that time have regularly confirmed this. A blood examination two months after operation showed 85% hemoglobin, 4,200,000 reds and 6,500 whites, with no significant abnormality in the stained smear.

Here was a case with no sore mouth but with oral sepsis and absence of free HCl. Except for the last finding Hunter would probably class this as septic anemia. He probably would have lost all his teeth by extraction. He had a palpable liver and spleen, lemon-yellow color, blood findings not incompatible with those of pernicious anemia. Several blood transfusions were of no great benefit. Finally, on suspicion that he might have chronic gall-bladder disease, the abdomen was explored. This, then, was not a case of idiopathic pernicious anemia in spite of the achlorhydria, but might well have passed for one and, in fact, for a while did pass for one. We have learned our lesson, however.

CASE II, H S—64 years old, retired railroad engineer. He was in the Out-Patient Department on July 5th, 1923, at which time he was complaining of burning in the epigastrium and was diagnosed chronic gall-bladder disease. This was confirmed by X-ray examination of the gastro-intestinal tract. He returned and entered the hospital November 8th, 1923, with the complaint of numbness and tingling in his legs, palpitation of the heart, and pallor, which began about the latter part of July.

*Examination* showed general arteriosclerosis, with some myocardial insufficiency and chronic gall-bladder disease, without splenic enlargement.

The hemoglobin, on entrance, was 30%, reds 980,000, whites, 3,500, with 61% of lymphocytes, some nucleated reds, poikilocytosis, anisocytosis, 5% reticulated reds, normal fragility. Stool negative.

In spite of all our pleadings with him he refused to be operated upon.

Another case had some rather unusual features and is cited here on account of the post mortem finding of hyperplastic bone-marrow.

CASE III, M S—55 years old, admitted February 1, 1921, complaining of aching pain across the abdomen especially on the left side. For past 30 years he has had attacks of pain in the right upper quadrant, with jaundice at

times. There were chronic constipation and dyspepsia.

The *present illness* began 6 months before admission, with distress in the upper left abdomen, bad taste in the mouth, eructations of gas. There were slight numbness and tingling in the hands and feet. The mouth was never sore.

*Examination*. The patient was jaundiced, spleen was large and tender. There was irregular fever with attacks of pain and tenderness over the spleen.

Blood. Hemoglobin, 30%, reds, 1,370,000, whites, 7,000, Polys, 82%, L L, 4%, S L, 10%, M, 4%, nucleated reds, anisocytosis, poikilocytosis. After transfusion of 350 cc of whole blood the hemoglobin was 33%, reds, 1,750,000, whites, 7,300. Later the white blood cells were 11,000.

The stools were negative. There is no note of HCl. Streptococci were grown from a duodenal culture.

Cholecystotomy was performed with removal of stones and drainage of the gall-bladder. The patient did not long survive the operation.

At autopsy there were found chronic septicopyemia, embolic infarcts in spleen and kidneys, and hyperplasia of bone-marrow.

In spite of the infection the leucocytes were only 7,000, but there was a relative polymorphonucleosis of 82%. This man had a pernicious anemia blood picture. It is the blood picture which most physicians rely upon to make a diagnosis of pernicious anemia. These three cases show how frail a reed this is upon which to hang a diagnosis.

Then, how can we best treat our cases? First and foremost, study them intensively. Do not pay so much attention to the blood picture. It is only one part of the picture and may be very misleading. I fear the term "pernicious" has so saturated the minds of the profession that when they find a typical blood picture they give up the fight. Since it is known that certain chronic focal infections can closely simulate the picture of primary pernicious anemia, all such should be intelligently cared for. I speak advisedly, for too often with insufficient evidence foci have been blindly attacked. If after the most painstaking study there is evidence pointing to some organ, as the gall bladder, then preliminary transfusions and later laparotomy are surely justifiable. In a disease such as Addison's anemia, when prognosis is usually so grave, I believe we are justified in accepting a gambler's chance provided that the patient is not harmed thereby. Last year we removed the gall-bladder from a woman who had all the symptoms and signs

of Addison's anemia. We found only a slightly thickened gall-bladder which revealed under the microscope mild chronic inflammatory changes. The patient rapidly recovered from the operation, for a while became much better, gaining weight and both hemoglobin and red cells. After six months a relapse started and inside of four months she died. There was no evidence that the cholecystectomy had helped or harmed her.

Shall we transfuse? I can find no reliable statistics which show that transfusions have ever cured a case. There is an impression abroad that while the remission is at times accelerated, the relapse is earlier and the eventual outcome is the same as if there had been no transfusions. This is my experience. Bloomfield, in an analysis of a group of cases relative to the value of transfusion as an emergency measure, found that there was no evidence that it was of value or that the immediate mortality was decreased by the procedure. Transfusion in his series of 58 cases neither increased the length of remission or the duration of life.

Some give arsenic in various ways. Kulcke (10), in a review of all cases in the City Hospital at Dresden, comes to the conclusion that we have not made much progress in treatment in the past ten years. He thinks the best drug is arsenic and the parenteral administration has no advantages over the oral. I cannot see that neoarsphenamin, cacodylate of sodium or other arsenical preparations given intravenously or subcutaneously have any advantage over Fowler's solution given by mouth.

Splenectomy has its advocates and seems on the whole a logical procedure. Bloomfield (11) did not find that splenectomy showed any improvement over other measures. The best results are claimed to follow when the spleen is removed when remission sets in. Giffin and Szlapka (12) summarize the results of splenectomy on fifty patients as follows:

- 1 This review concerns fifty patients with pernicious anemia for whom splenectomy was performed. All were operated on more than three years ago.

- 2 The operative mortality was 6 per cent.

- 3 Ten patients (21.3% of those who recovered from operation) have survived splenectomy three years or longer.

- 4 Five patients (10.6% of those who recovered from operation) have survived splenectomy more than four and one-half years, and are still living. The total length of history of these five patients averages almost six years.

- 5 It may be stated with reasonable accuracy that, in addition to the immediate remission which occurred constantly following splenec-

tomy, splenectomy prolonged life in at least 20% of our cases.

6 We cannot satisfy ourselves that any particular pre-operative characteristics of the disease are indicative of favorable results following splenectomy. However, in the type of case in which there is evidence of active hemolysis, the patient shows a more marked immediate improvement.

7 Splenectomy may be recommended in pernicious anemia when, in view of all the circumstances, personal as well as medical, the possibility of the prolongation of life appeals to the family and to the patient. Occasionally the operation may be performed in order to bring about an immediate remission. We may, therefore, look upon splenectomy as a method of treatment in certain cases bearing in mind that the results are only fair and that there is still a small percentage of operative mortality.

Krumbhaar (13) has published a statistical study of the results of splenectomy collected from the literature. He tabulates 208 cases of pernicious anemia upon whom splenectomy was performed with the following results: post-operative death (within 1 month) 35 cases, post-operative mortality 16.8 per cent, record of subsequent death, 79, unimproved, 26, improved, 144.

Krumbhaar thinks that the pendulum has swung too far against splenectomy. In certain cases of "relatively recent onset, with a fair blood picture, signs of an enlarged spleen and increased hemolysis, splenectomy is usually advisable."

With this opinion I find myself in agreement and I feel that all who give the matter careful consideration will also agree.

Walterhoefer and Schramm (14) have scraped the bone-marrow from one tibia and have reported improvement in the cases. Just how such a procedure could be of therapeutic use is difficult to understand. It is very doubtful if this will be taken up as a method of treatment. Iron, as Stieglitz has shown, is found in the kidney tubules of cases of pernicious anemia and interferes with kidney function. It has long been considered that iron was of no value in this anemia. Now it would appear that the administration of iron actually may do harm by interfering with normal kidney function. Iron, then, had better be withheld from cases of pernicious anemia.

In view of the constant absence of HCl in the stomach contents it seems logical to administer dilute HCl. This should be given in dram doses (4 cc) in a glass of water with essence of pepsin, lemon and a little sugar in order to make it more palatable. This should be sipped throughout the meal. This should

not be stopped during the remission, as the achlorhydria is permanent and atrophy of the gastric mucosa is a constant pathological finding. Passey (15), however, presented before the Guy's Hospital Society a section of stomach removed at operation from a case of Addison's anemia. He called attention to (1) the presence of oxyntic cells though in apparently smaller numbers than normal, (2) evidence of inflammation, the openings of the secreting ducts being choked with leucocytes, (3) very little atrophy. There had been no free HCl in the test meal. The section did not appear very different from one removed from a case of chronic appendicitis, in which for a time there was absence of free HCl, but later free HCl appeared in the test meal. This only goes to show that the achlorhydria in certain cases is probably functional and is not dependent upon the complete atrophy of the gastric mucosa. There was no note of the reason for the abdominal operation.

In conclusion, I would make an urgent plea for the more intensive study of cases with a blood picture quite similar to that of idiopathic primary anemia. Should there be any free HCl in the stomach contents after a test meal, it is more than probable (Levine and Ladd) that the case is not a primary but a secondary septic anemia. Some of the attention which has been lavished upon the teeth, tonsils and accessory nasal sinuses should be directed to the study of the chronic infections of the gall-bladder. The infection in that situation is not always readily demonstrable. If there be evidence, though slight, that the gall-

bladder is not normal, I feel that in view of the gravity of the anemia, it is justifiable to lay before the patient and his family the question of operation. In the hands of a competent surgeon and a skilled anesthetist the risk of operation is not great. I believe we are justified in advising operation under the circumstances. It is by weighing all the evidence carefully and proceeding boldly, yet honestly, that we can hope in the present state of our ignorance to rescue a further small number of victims.

#### REFERENCES

- 1 Hunter, Wm, *Brit. Med. Journ.* I, 421, Mar 18, 1922
- 2 Hurst, A. F, *Guy's Hosp. Reports*, 72 154, 1922
- 3 *Loc. cit.*
- 4 Levine, S. A. and Ladd, U. S., *Bull. Johns Hopkins Hosp.*, 32.254, 1921
- 5 *Loc. cit.*
- 6 Griffin, H. Z. and Bowler, *Minn. Med.*, 6 13, Jan., 1923
- 7 Rinker, F. C., *Virg. Med. Monthly*, 57 417, July, 1920
- 8 Peabody, F. W. and Brown, G. O., *J. A. M. A.*, 82 963, Mar 22, 1924
- 9 Stockton, C. G., *Amer. Jour. Med. Sc.*, 158 471, 1919
- 10 Kulcke, E., *Muench. Med. Wch.*, 70 803, 1923 (June 22)
- 11 Bloomfield, A., *Bull. Johns Hopkins Hosp.*, 29 101, 1918
- 12 Griffin, H. Z. and Szlapka, T. L., *J. A. M. A.*, 76 290, 1921 (Jan. 29)
- 13 Krumbhaar, E. B., *Amer. J. Med. Sc.*, 166 329, Sept., 1923
- 14 Walterhoefer and Schramm, *Archiv f. Klin. Chirurgie*, 118 794, 1921
- 15 Passey, B. A., *Guy's Hosp. Reports*, 72 154, 1922.

### FACTORS INVOLVED IN THE ACIDITY OF THE STOOLS OF INFANTS\*

By ALAN BROWN, M.B. (Tor) and FREDERICK F. TISDALL, M.D. (Tor)

From the Wards and Nutritional Research Laboratories of the Hospital for Sick Children and the Department of Pediatrics, University of Toronto

THE number of investigations of the exact acidity, that is, the hydrogen ion concentration, of infants' stools, reported in the literature are comparatively few. When the possible importance is considered of the relation of the acidity of the stools to the general condition of the infant, the rate of growth, the presence of fermentative diarrhoea, parenteral infections, and many other conditions, it is rather surprising that so few determinations have been reported. The only results which the authors have been able to find have been recorded in the German literature.

#### MEANING OF THE TERM PH

A great deal of work has been done by investi-

gators who have taken a measured portion of the infant's stool and titrated this with an alkali to the point of neutrality. This, however, determines not only the amount of free acid present, but also a portion of the acid which has already combined with certain bases. At first glance it would appear that if the acid were combined with a base it would be neutral and thus not enter into this titration, but it must be remembered that all salts are not neutral in reaction. One example of this is acid sodium phosphate. It is thus obvious that these titrations have not the same significance or value as the determination of the exact degree of acidity present in the stool.

The question arises as to what constitutes the degree of acidity of a solution. The degree of acidity of a solution depends on one thing and

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester April 23, 1924.  
Published in part in *American Journal of Diseases of Children*, April, 1924.

that is the number of free hydrogen ions present. When a substance such as ordinary salt is placed in solution it is present in two forms, first as molecular or undissociated NaCl, which is chemically inert, and secondly as dissociated (ionized) or chemically active sodium and chlorine ions. Similarly acids in solution are present in two forms, the molecular or inactive and the dissociated or active forms. All acids, however, on dissociation must give free hydrogen ions ( $H^+$ ) regardless of the type of acid. Some acids are stronger than others, which simply means that they are more completely dissociated or ionized than the others. Hydrochloric acid is an example of a strong acid as it is practically entirely dissociated into its hydrogen and chlorine ions. Acetic acid is a weak acid because it is only slightly dissociated, (about 2 per cent), by far the greater part being in the molecular or inactive form.

If the degree of acidity of a solution depends on the number of free hydrogen ions, then the acidity may be measured by determination of the amount of hydrogen ions present in the solution. This is exactly what is done when the acidity is measured. The concentration of the hydrogen ions, and consequently the degree of acidity, is expressed in terms of a fraction of a gram of hydrogen ions per litre of solution. Thus a solution may have an acidity of one-tenth of a gram of hydrogen ions per litre or one ten-millionth of a gram, or any other amount. It is obvious, however, that this is a very cumbersome method of expressing the acidity of a solution, so the logarithmic notation first suggested by Sorensen is used. Thus, a solution containing one-tenth of a gram of hydrogen ions per litre is expressed as  $10^{-1}$ , or  $\frac{1}{10^1}$ , one one-

hundredth of a gram as  $10^{-2}$ , or  $\frac{1}{10^2}$ , or one one-

thousandth of a gram as  $10^{-3}$ , or  $\frac{1}{10^3}$ , and so on.

Even this, however, is a little cumbersome, so the figures 1, 2, 3, etc., are used in place of  $10^{-1}$ ,  $10^{-2}$ ,  $10^{-3}$ , etc., preceded by the symbol pH. Consequently pH 1, pH 2, pH 3 as the case may be, simply mean a definite amount by weight of hydrogen ions per litre of solution.

A solution with a pH 1, (or one-tenth of a gram of hydrogen ions per litre) is strongly acid, a solution with an acidity of pH 7, (or one ten-millionth of a gram of hydrogen ions per litre) is neutral and if the concentration is less than one ten-millionth as expressed by pH 8, pH 9, pH 10, etc., it is alkaline. It is beyond the scope of this paper to enter into a discussion of the means by which the amount of hydrogen ions are directly determined, other than to state that this is accomplished by expensive electrometric apparatus. The authors, however, in the present investigation have utilized a simple and well known procedure

by means of which colorimetric determinations have been made with rapidity and accuracy. In 1915 Levy, Rowntree and Marriott<sup>(1)</sup> suggested the use of the Collodion sacs for the determination of the pH of blood. The blood was dropped into collodion sacs and dialyzed for five minutes. The dialysate was found to be free from proteins and coloring matter but contained the blood salts, and was well adapted for use with indicators. In 1920 Kramer and Greene<sup>(2)</sup> utilized collodion sacs for the colorimetric determination of the pH of milk and obtained results which were found to be quite accurate when checked by electrometric determinations. It is obvious that the same principle can be used for the determination of the acidity of stools. One of us (Tisdall) devised a method which was employed in this study, the technique of this method is described in detail in *American Jour Dis Children*, April, 1924.

#### OBSERVATIONS

During the past summer over 1,300 determinations were made of the pH of infants' stools. The object of the investigation was not to study the effect on the pH of the stools of carefully prepared variations in the diet, but rather to determine the acidity as a routine procedure over a considerable period of time. Although it was quite evident at the beginning of this work that a number of the results would be of little use, still it was hoped that valuable information might be obtained where possibly least expected. In the opinion of the authors the results obtained have justified the procedure.

With the exception of a few stools from newborn, breast-fed infants all the specimens were obtained from artificially fed babies. They varied in consistency and appearance from that of loose green diarrhoeal stools to that of hard brown constipated stools. It was soon found that the presence of mucus produced an alkaline reaction. As a result of this, many diarrhoeal stools which contained mucus gave an alkaline reaction when it was quite evident that the underlying condition was an increased acidity of the intestinal contents. (Chart I.) This is probably the explanation of some of the conflicting statements made by older writers that diarrhoeal stools, under fermentative conditions, may have an alkaline reaction. It was also found that the brown, formed, constipated stool was frequently not nearly so alkaline as the pasty stool, and in other cases it was observed that reactions as alkaline as pH 8.3 were obtained with stools of a fluid to semi-fluid consistency. This simply demonstrates that the firmness of a stool may give little indication of the degree of acidity present. Most of the stools with a reaction more acid than pH 6.6, with the exception of diarrhoeal watery stools, were of a curdy consistency and had an acid odor. Values were obtained from the stools of artificially fed

babies, which varied from pH 4.6 to slightly more alkaline than pH 8.3. As stools were rarely encountered with an alkalinity of more than pH 8.3 the standards were not extended beyond this value.

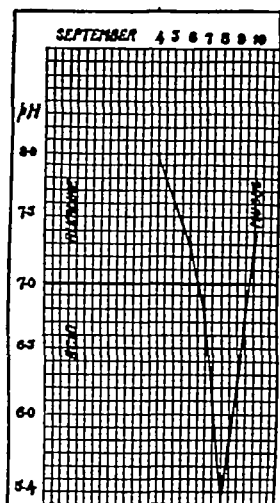


Chart I Case J F illustrating that the presence of mucus produces an alkaline reaction. On September 6th, the stool was brown, pasty, September 7th, yellow, pasty, September 8th, yellow, curdy, and September 10th, yellow, fluid with mucus.

Only a few determinations, twelve in number, were made of the acidity of stools from breast-fed infants. As practically no infants were admitted to the hospital during the past summer who received breast milk exclusively, specimens were obtained from the Burnside new-born clinic. All the infants were under two weeks of age. The pH was found to be singularly constant. It varied only from pH 4.7 to 5.1 in the twelve specimens examined.

In a general way it was found that the degree of acidity of the stools was largely dependent on the type of food used. The stools from normal breast-fed infants as mentioned above had an acidity of about pH 5.0. Infants fed on butter-soup<sup>(3)</sup> generally had stools with a pH of about 5.8 to 6.2, while the stools from infants fed on protein milk, cows' milk dilutions with added carbohydrate, or whole soured milk with added carbohydrates were generally more alkaline than pH 7.0. It has usually been considered that protein milk with its low sugar content would produce an alkaline stool, while a feeding with a high carbohydrate content would produce an acid stool. In this respect some very surprising results were obtained. In certain instances it was found that infants fed on protein milk or soured milk, had acid stools which remained acid until carbohydrates were added to the diet. (Charts II and III.) Also it was found that the most alkaline stools were obtained from infants fed on whole soured milk with a total carbohydrate content as

high as twenty per cent. No consistent difference was found in the acidity whether the carbohydrate was added in the form of corn syrup, dextrin, maltose or cane sugar. The values obtained with one baby (Baby W B) serve as an example.

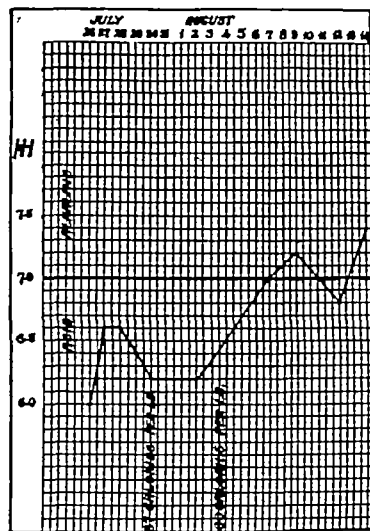


Chart II Case G L, age 2 months, weight 8 lbs, illustrating that the addition of carbohydrate to protein milk may change the reaction of the stools from acid to alkaline. The diet on July 27th was protein milk (powdered preparation) 2/3 strength 30 ounces. On July 30th 2/3 ounce of casein was added, and on Aug 4th 1 ounce of corn syrup was added.

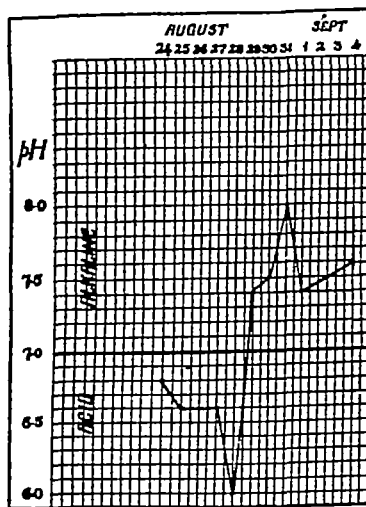


Chart III Case R N Age 12 months Weight 17 lbs illustrating that the addition of carbohydrate to soured milk may change the reaction of the stools from acid to alkaline. Until the afternoon of August 27 this infant was on 2% soured milk 40 ounces and 1 ounce of dextrin maltose. The stools which were yellowish green in color contained a lot of fat curds. They would not be characterized as good stools. On the afternoon of August 27th the feeding was changed to 4 per cent soured milk 25 ounces, and granulated sugar 3 1/2 ounces. By August 30th the stools were of a yellow-grey pasty appearance. It is to be noted that the total amount of fat given was practically unchanged.



This infant was studied over a period of three and a half months. The diet consisted of whole soured milk with added carbohydrate up to a total content of twelve per cent for the first two and a half months, then to just under twenty per cent for the following month. During this period the acidity of the stools was determined sixty-three times. Of these sixty-three determinations only four were more acid than pH 7.6. The values generally ranged from pH 7.6 to 8.3. The stools were large, brownish, grey and soapy and when the inner part was exposed had a greasy appearance.

The effect of the addition of calcium carbonate to the food was determined in a few instances. It was found in certain cases that the addition of fairly large quantities (23 gm per day) of the salt to buttersoup feeding made the stool more alkaline (Chart IV). On the other hand in diarrhoeal conditions it produced practically no change. Although not sufficient cases were studied to draw authoritative conclusions, still, it appears that while the addition of calcium carbonate to the food in normal cases makes the stool more alkaline, in diarrhoeal conditions it has little effect.

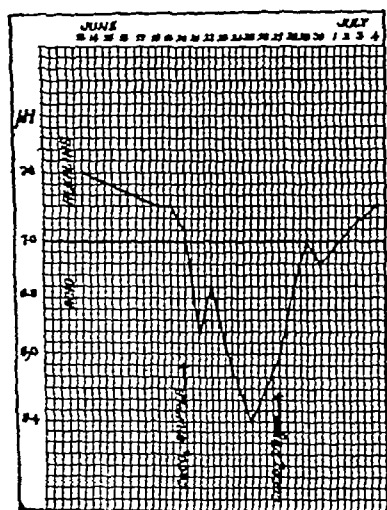


Chart IV—Case J D, illustrating the effect produced on the acidity of the stools by the addition of calcium carbonate to a diet containing a small amount of calcium salts. This infant was fed buttersoup 14 ounces, whole milk 7 ounces and 23 grams calcium carbonate. The calcium carbonate was omitted and then replaced with the above result.

Observations were made on the effect of parenteral infections in a large number of cases. In the majority of instances the acidity of the stools increased and their consistency changed from smooth, pasty, to slightly loose and curdy (Chart V). In other infants the presence of parenteral infections seemed to have no effect either on the pH of the stools or on their consistency (Chart VI). In one infant rather unusual results were

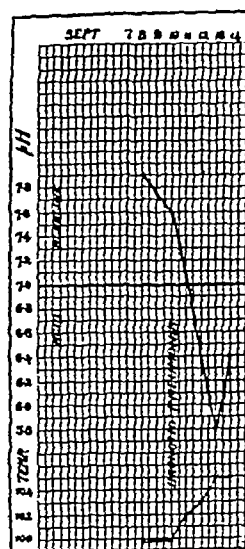


Chart V—Case R S, illustrating the change in the acidity of the stool in the presence of a parenteral infection.

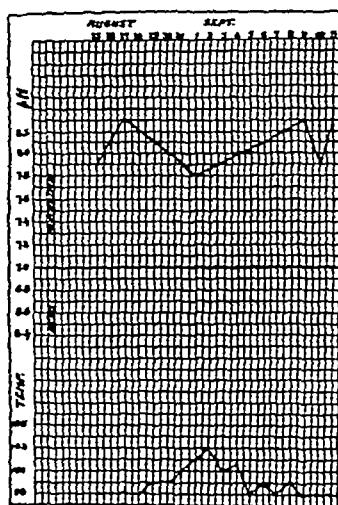


Chart VI—Case W B, illustrating that in some cases the acidity of the stool is practically unaltered in the presence of a parenteral infection. The consistency of the stools in this case did not change during the infection.

obtained. This baby (Chart VII) developed a pyelitis and the stool, observed daily, showed the following changes: Aug 30th, brown, semi-formed, Aug 31st, loose, greyish, curdy, Sept 1st, brown fluid with mucus, Sept 2nd, very watery with a few green curds and mucus. Yet in this case the pH never became more acid than 7.1. It is probable that the early production of mucus more than neutralized the effects of any acids present. It is of interest to note that shortly after this, the infant showed evidences of a prolapse of the rectum, which condition may have been a factor in the early production of mucus. From the forego-

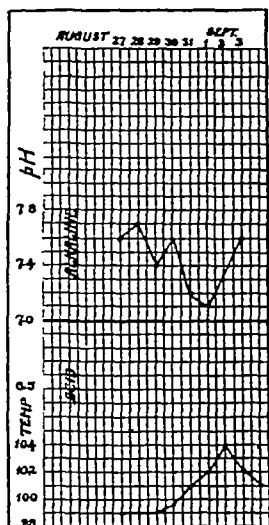


Chart VII Case K S This infant in the presence of a parenteral infection developed loose watery stools with a few green curds and mucus. The stools did not show the preliminary acid reaction before the presence of mucus was noted.

ing observations it appears that parenteral infections generally cause an increased acidity of the stool, although there are many exceptions to this rule.

The question arises whether the acidity of the stool has any connection with the rate of growth of the infant. The answer may be both in the negative and the affirmative. It is well known that infants gain well on foods which normally produce acid stools, such as breast milk, buttersoup and malt soup. It is also obvious that they may gain just as well on foods which normally

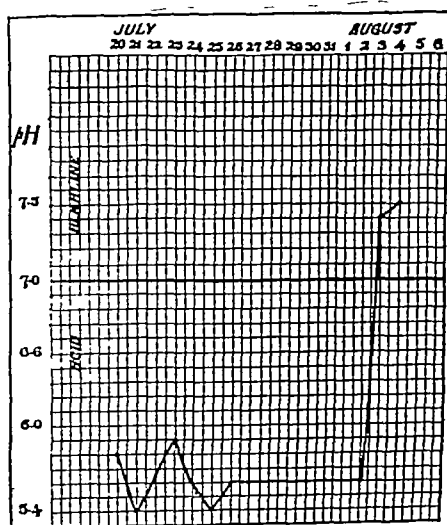


Chart VIII Case B J, illustrating the rapid change in the acidity of the stools with a change in the food. On August 2nd the food was changed from buttersoup to a whole cows' milk dilution with added carbohydrate.

produce alkaline stools such as whole milk dilutions or whole soured milk, with added carbohydrates. It was found, however, that if the acidity was greater than that which is normally found with the particular type of food given, the infant did not do well.

Some further observations made during the course of the present investigation are of interest. When the food was changed from buttersoup to either whole milk dilutions or whole soured milk, with added carbohydrates, the pH of the stool changed with surprising rapidity. If the change in the food was made at 2 o'clock in the afternoon, the stools obtained the following morning at 9 o'clock were of a different consistency and of a much more alkaline reaction. (Chart VIII)

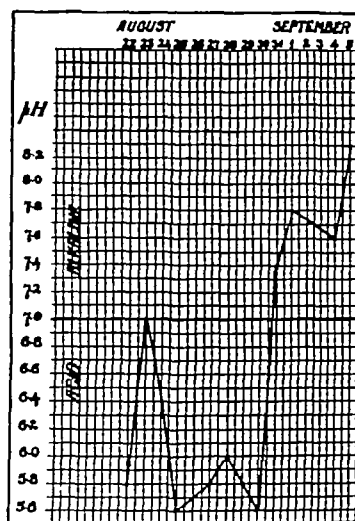


Chart IX. Case M K. On August 22nd the food in this case was changed from 2 per cent soured milk 20 ounces and  $\frac{1}{2}$  ounce of corn syrup to 4 per cent soured milk 20 ounces and 3 ounces of dextrin maltose. A marked change in the acidity of the stool did not occur until August 30th, eight days later. No reason was found for this delayed action.

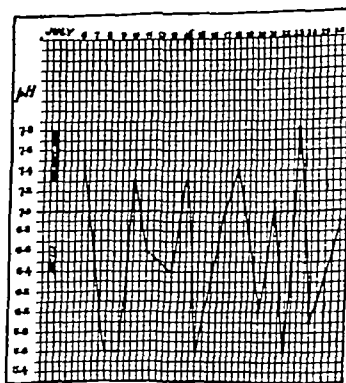


Chart X Case H S. His chart shows the wide daily variations in the acidity of the stool which was encountered only occasionally. No apparent cause was found for these variations.

Another point of interest observed was that in occasional cases when an infant was given a food which would normally produce an alkaline stool the reaction would be acid for some days, then for no apparent reason the stool would suddenly change in consistency and become alkaline (Chart IX). A third observation of interest was that in certain infants the acidity of the stools showed wide daily variations. No apparent cause for this was found (Chart X).

### DISCUSSION

It is now well recognized that of the three main organic constituents of infants' food, that is, the fats, the carbohydrates and the proteins, it is chiefly the carbohydrates that are concerned with the production of acid. This production of acid is the result of the fermentative action of micro-organisms which break down the carbohydrates into lactic, acetic, formic, butyric and succinic acids. Lactic acid is the acid that is produced in the largest quantities, although occasionally a considerable amount of acetic acid may be present. Only traces of the other acids are found (<sup>4</sup>).

Fats are normally broken down by some of the intestinal secretions into the higher fatty acids and glycerine. These higher fatty acids, however, are non-irritating, or at most only slightly so. It has not been conclusively demonstrated that bacteria can split fat or break down the non-irritating higher fatty acids into the irritating lower fatty acids (<sup>5</sup>). At the same time the presence of fat and the higher fatty acids may have a stimulating effect on the growth of bacteria and thus indirectly increase the acidity.

The proteins are affected by many micro-organisms and various products are found such as indol, skatol, certain amin bases and ammonia. From our standpoint we are chiefly interested in the ammonia production on account of its alkaline reaction. Certain acids may be formed in small quantities but their effect is greatly overbalanced by that of the ammonia produced. It is thus evident that bacterial action on proteins with the resultant liberation of ammonia tends to produce an alkaline reaction.

From the foregoing statements it would appear that the reaction of a stool depends largely on the ratio of the carbohydrates to the protein in the food. Although this is true, nevertheless there are a number of other factors which greatly influence the reaction of the faeces. These will be discussed briefly.

It is known that normally, bacterial growth in the intestinal canal is almost entirely limited to the lower part of the ileum and the large intestine. As the production of acid from carbohydrates is accomplished by the action of micro-organisms it is obvious that this production of acid must occur in the lower ileum and the large intestine, the

so-called zone of fermentation. If normally no fermentation occurs in the upper part of the small intestine and sugars can be absorbed by this part of the intestine it is clear that one of the important factors in the production of acid is not the amount of sugar in the food but the amount of sugar which reaches and remains in the zone of fermentation. This point has been strongly emphasized by Bessau (<sup>6</sup>). Freudenberg and Heller (<sup>7</sup>) have demonstrated most clearly that the rate of absorption of a sugar has a definite effect on the acidity of the stool. Utilizing the fact that caramel is poorly absorbed by the intestinal mucosa, (<sup>8</sup>) Freudenberg and Heller fed an infant a whole cows' milk dilution containing 80 gms of caramelized cane sugar. The caramelization was accomplished by heating the cane sugar in an open pan until it was of a dark brown color. The pH of the stool was found to vary from 4.7 to 5.0. The cane sugar was then added without being caramelized and the stool promptly became alkaline with a pH of 6.7 to 7.4. It is obvious, therefore, that the rate of absorption of the carbohydrate by the intestine is an important factor in the production of acid.

As the production of acid from carbohydrates is the result of bacterial action different bacteria may produce different degrees of acidity. That this is so has been clearly demonstrated. Some observers (<sup>9, 10, 11</sup>) have found that the colon bacillus will not produce an acidity greater than pH 5.0 and that when the acidity is greater than this (pH 4.6) the colon bacillus is killed. *Streptococcus lacticus* produces an acidity of pH 4.2 to 4.6 while the *bifidus* produces an acidity as great as pH 3.7 (<sup>12</sup>). It is well known that in alkaline stools the bacterial flora is largely gram negative while in acid stools the flora is preponderantly gram positive (*Bifidus*, *lacticus*, *acidophilus*, etc.). The question at once arises, is the acidity of the stools the result of an infection and subsequent growth of an acid producing organism, or is the presence of these organisms secondary to other factors? It would appear most reasonable to assume that acid stools are the result of an infection and the resultant preponderant growth of the acid producing gram positive organisms. This question has been investigated at some length by many bacteriological workers. Their results will not be discussed here. However, a series of experiments from the chemical standpoint have been reported by Scheer (<sup>13</sup>), which are most interesting. He inoculated various milk media with stools from infants fed on breast milk and also from infants fed on protein milk. In three days' time the acidity of the media had reached pH 3.7 regardless of the type of stool with which it had been inoculated. It is evident that acid producing organisms were present in both types of stools but that in the protein milk stool the conditions were not favorable for their

proliferation, with the resultant production of acid. It therefore seems probable that the acidity of the stool is not the result of an infection by any particular type of organism but rather the result of conditions which allow one or another definite type or organism to grow.

The reaction of the stool can be altered by the addition of certain inorganic substances to the diet. This has been demonstrated by Scheer and Muller<sup>(13)</sup> who added alkaline sodium phosphate to breast milk and changed the reaction of the stool from pH 5.0 to pH 7.1. In the present work, it has been shown that the addition of a large amount of calcium carbonate may change the reaction of the stool (Chart IV). The explanation of the change is that the acids present react with these bases and produce salts which have only a slight degree of acidity (Buffer influence).

As already mentioned the presence of proteins tends to produce an alkaline reaction on account of the production of ammonia by bacterial action. From the discussion so far it would appear that the reaction of the stool depends on the ratio of the amount of carbohydrate present in the zone of fermentation on one hand, to the amount of protein bases on the other hand. It has been shown that the type of carbohydrate may influence the acidity of the stool by being poorly absorbed in the upper part of the small intestine and thus reaching the zone of fermentation in fairly large quantities. Also if the condition of the cells in the intestinal wall is such that they absorb the carbohydrate poorly, regardless of the type of carbohydrate in the food, then the amount of sugar available for fermentation would be increased, with a resultant increase in the acidity of the stool. In the opinion of the authors this is probably one of the most important factors in the production of acid in the intestinal canal.

There are at least two other factors which may be of considerable importance in determining the acidity of the stools. The first is the amount of intestinal secretion, which may have a marked effect on account of its alkaline reaction. The second is that in many pathological conditions it is probable that the zone of fermentation extends further up the intestinal canal than is normally the case.

It has been shown by Scheer<sup>(12)</sup> that there is enough carbohydrate present in protein milk to allow the production of an acidity of pH 3.7 when inoculated with infants' stools. Consequently if protein milk is fed to an infant enough carbohydrate is being given, to produce an acidity of pH 3.7 if it is not absorbed before it reaches the zone of fermentation. It has been stated by Finkelstein<sup>(14)</sup> that at least three per cent carbohydrate, and frequently more than this amount, should be present in the food in order to enable the metabolism of the body to proceed in the normal man-

ner. Then if in an effort to correct an intestinal acidity an infant is fed protein milk with its low sugar and high protein and base content, for a sufficient period to allow the low sugar to interfere with the nutrition of the intestinal cells, it is possible for the sugar to reach the zone of fermentation with the resultant production of acid. The addition of sugar to the diet might then stimulate the intestinal cells, so that there would be an increased absorption of the sugar and a resultant decrease in the acidity of the stool. Also stimulation of the intestinal cells from the increased sugar content in the food might influence the amount of alkaline intestinal secretions and also the length of the zone of fermentation.

It is of interest to note the results obtained in the present investigation in the light of the above remarks. In Chart II we see that an infant fed on protein milk had stools with an acid reaction. The addition of sugar to the diet changed the reaction of the stool to the alkaline side of neutrality. A similar result is shown in Chart III. This infant was on a diet containing 6.5 per cent carbohydrate and the reaction of the stools was quite acid. The carbohydrate was increased to 18% and the stools promptly became more formed and had an alkaline reaction. Numerous other infants were fed whole soured milk with added carbohydrate up to a total content of 20 per cent and in the majority of cases the stools were smooth and pasty with a strong alkaline reaction. A possible explanation for this surprising result is that the high carbohydrate so stimulated the intestinal cells that the absorption of sugar occurred very rapidly and thus lessened the opportunity for fermentation. The possibility must also be considered that the stimulated intestinal cells diminished the extent of the zone of fermentation and also produced a larger quantity of alkaline secretions. A further explanation might be found in the work of Wolff<sup>(15)</sup> who showed that when the concentration of the sugar was greater than 10 per cent fermentation was hindered.

The production of an acid stool by a parenteral infection may be explained on the ground that the vitality of the intestinal cells is diminished by the infection. This results in a lessened absorption of carbohydrate and consequently an increase in the amount available for fermentation with the resultant production of acid. No doubt the zone of fermentation is also increased.

From the foregoing remarks it might be assumed that the authors are advocating the use of high sugar diets in combination with whole soured milk to combat diarrhoeal conditions. While it is beyond the scope of this paper to enter into any discussion of this aspect of the problem, the authors simply draw attention to the fact that in certain diarrhoeal conditions the use of a concen-

trated high carbohydrate food will produce constipated alkaline stools. Similar results have been reported by Davidsohn and Rosenstein<sup>(10)</sup>. In many other cases the use of this type of feeding will be followed by strongly acid watery stools and disastrous results.

### SUMMARY

- 1 In the present investigation over 1,300 determinations of the pH of infants' stools have been made.
- 2 The pH of stools from normal new-born, breast-fed infants was found to be singularly constant, varying from 4.7 to 5.1.
- 3 The acidity of stools from artificially fed infants was found to vary from pH 4.6 to somewhat more alkaline than pH 8.3.
- 4 An acidity as great as pH 4.6 was encountered in artificially fed infants only in severe diarrhoeal conditions. Infants fed on buttersoup generally had stools with an acidity of about pH 6.0. Infants fed on protein milk, cows' milk dilutions with added carbohydrates, and whole soured milk with added carbohydrates generally had stools more alkaline than pH 7.0.
- 5 Whole soured milk with added carbohydrates up to a total content of 20 per cent generally produced strongly alkaline stools.
- 6 No difference was consistently observed in the acidity of the stool whether the added carbohydrate was in the form of corn syrup, dextrin maltose or cane sugar. In the present investigation the effect produced by other sugars was not determined.
- 7 The degree of acidity of the stools was generally increased in the presence of parenteral infections.
- 8 Based on the present work and the work of others the factors which influence the acidity of the stools have been discussed. From the chemical standpoint the acidity apparently depends on the ratio, in the intestinal zone of fermentation, of the carbohydrate on one hand to the protein and base on the other. The amount of carbo-

hydrate in the zone of fermentation, apparently is influenced, by the extent of the zone of fermentation, by the type of carbohydrate and by the state of health of the intestinal cells.

The authors are indebted to Miss A. M. Courtney, B. A., Director of Nutritional Research Laboratories of this hospital, for her many suggestions in the carrying out of this work, and to Dr. L. M. Murray, of the Resident Staff, for the preparation of the charts.

### REFERENCES

- 1 Levy, R. L., Rowntree, L. G., and Marriott, W. McK. *Arch Inter Med*, 16, 389, 1915.
- 2 Kramer, B., and Greene, C. H. *Proc Soc Biol Chem*, Dec. 1920 XXXVIII.
- 3 Brown, A., Courtney, A. M., and MacLachlan, I. F. *Am J Dis Child*, 24, 368, 1922.
- 4 Tobler, L. and Bessau, G. *Allgemeine Pathologische Physiologie der Ernährung und des Stoffwechsels im Kindersalter*, J. F. Bergmann, Wiesbaden, 1914, 183.
- 5 Schiff, E., and Kochmann, R. *Jahrb f Kinderheilk*, 99, 181, 1922.
- 6 Bessau, G. *Jahrb f Kinderheilk*, 92, 14, 1920.
- 7 Freudenberg, E., und Heller, O. *Jahrb f Kinderheilk*, 96, 49, 1921.
- 8 Grafe *Munchen Med Wchschr*, 1914, quoted by Freudenberg, E., und Heller, O., *Jahrb f Kinderheilk*, 96, 49, 1921.
- 9 Michaels, D., and Marcora, F. *Ztschr f Immunitätsforsch*, 14, 170, 1912.
- 10 Clark, W. M. *J Biol Chem*, 22, 87, 1915.
- 11 Scheer, K. *Biochem Ztschr*, 130, 545, 1922.
- 12 Scheer, K. *Ztschr f Kinderheilk*, 29, 253, 1921.
- 13 Scheer, K., under Muller, F. *Jahrb f Kinderheilk*, 101, 143, 1923.
- 14 Finkelstein, H. *Lehrbuch der Sauglings krankheiten*, Julius Springer, Berlin, 1921, 291.
- 15 Wolff, E. *Ztschr f Kinderheilk* 31, 226, 1922.
- 16 Davidsohn, H., und Rosenstein, S. *Ztschr f Kinderheilk*, 35, 207, 1923.

## RELATIONSHIP OF THE COUNTY MEDICAL SOCIETY TO THE COMMUNITY\*

By SAMUEL J. KOPETZKY, M.D.

NEW YORK CITY

IT is a momentous occasion for any man to be called to the leadership of the affairs of his fellows. The deep sense of gratitude he feels for the honor bestowed on him begets an even greater consciousness of responsibility. For the incoming President of the Medical Society of the County of New York, this latter feeling is enhanced by the high standards set for him by his predecessors. To equal the accomplishments of the administrations ending with Dr. Eugene H. Pool's will be no easy task.

One year ago, when Dr. Pool entered upon the office he has brought to such a successful conclusion, he spoke to you about the future development of the practice of medicine, and the physician considered as an individual was his topic. I am going to talk to you of the relationship of physicians as an organized group to Society. From the days when the oath of Hippocrates formulated what were even then the

standards which governed the practice of healing, the physician as an individual has enjoyed a privileged place in public esteem. He has been respected for his skill, loved for his charities and trusted for the self-evident unselfishness of his purpose. He was not only the healer when sickness made his care a necessity, but he was friend and counsellor in many intimate matters not directly connected with the healing art. He won this enviable position in the family circle because the family recognized his expert knowledge in matters concerning health and the high personal character which made him an impartial and competent adviser.

It is a somewhat astonishing anomaly that medical organization, which, after all, but represents these same physicians banded together, has not received the same confidence. Whereas the advice of the individual doctor is accepted in a spirit of cooperation and good faith, the counsels of physicians as a group—that is, of organized medicine—are too often met with sus-

\* Inaugural Address read before the Medical Society of the County of New York at the New York Academy of Medicine on January 26, 1925.

picion and mistrust. This skepticism has its origin, in all probability, in a general cognizance of the spirit of self-interest which ordinarily motivates the association of those engaged in kindred pursuits. To dispel it, it is necessary that a true estimation of the purpose and responsibilities of the county medical society be made.

The county medical society does not partake of the nature of a trade union or an industrial guild. While it is always vigilant in the defense of its members against external aggression, it has never made its defenses public offenses. It parallels its care for its members by its ever present concern for the public welfare.

The scientific function of the County Society is well understood. It is generally realized that it is a forum for the exchange of scientific ideas, that medical theories are brought here for discussion and scientific standards here set. It is not so commonly known what the communal obligations of the County Medical Society are, and I propose to outline here the conception of the public duties of the Medical Society of the County of New York, which it shall be my endeavor to realize during the coming year. These duties are educational, they are political and they are inter-vocational, insofar as they affect the professions allied to medicine.

Of the many offices of the County Society, probably none are more important than those which fall within the broad classification of educational functions. Scientific healing has passed out of its infancy and childhood and is now adolescent. As with all adolescents, the untrained observer has difficulty in distinguishing the beautiful from the ungainly, the permanent from the ephemeral and the true from the false. It is the part of the County Society, which is medicine's responsible spokesman, to clear up these confusions and keep before the public those facts which tend to make a healthy community. New discoveries in medicine should be reported to the public by the medical organization. Supposed cures should not be allowed to be disseminated, distorted by ignorance and magnified by self-interest, through the avidity of a reporter for news or the greed for publicity of a quack. The Society should furnish the press, the radio and other publicity agencies with bona fide news, and they, on their side, should cooperate to the end that all medical items published shall be authentic and trustworthy. There is a very definite obligation on the part of those who control publicity channels in this regard. Experience has demonstrated that the competent and honest physician does not require advertising to attract patients. Almost invariably the doctor who resorts to this means of self-aggrandizement is the man who has neither the professional nor the personal qualities to succeed in the practice of

medicine otherwise. Similarly, the discoverer of a real medical cure does not rush into special feature writing to gain its acceptance. The tuberculosis theories and the cancer cures of innumerable faddists may furnish sensational reading, but they divert many invalids from the real road to health and exploit the scientific ignorance of the very people whom it is the duty of the press to enlighten. Whatever the latitude that the law allows, it is a moral responsibility of newspaper publishers, broadcasting stations and all others who have access to the public eye and ear to lend their agencies to educational programs for the betterment of community health, and to refuse to spread the pretensions of the advertising quack or the vagaries of self-deluded enthusiasts. To some extent this is already being done, as the very fact that we are able to broadcast this talk through the courtesy of Station WEAf illustrates.

Even more important than the circulation of knowledge along the lines of curative medicine, is the need for the authoritative instruction of the public in the field of prophylaxis, or prevention. Preventive medicine has made, and rightfully, a very strong appeal to the lay imagination, and it is the role of the County Society, as it should be of the publicity media already spoken of, to see that none but the proper seeds fall in the receptive soil of public interest. The Medical Society of the County of New York was one of the pioneer medical organizations to recognize this, and, in conformity with the oriental theory that it is easier and better to stay well than to get well, it has instituted extensive machinery to enable the doctor to perform, and the entire public to receive, a health examination periodically. It is our purpose to make the physician more alert to recognize pre-clinical signs of disease, and to educate the public not to wait until sick, but to look for advice, at regular intervals, on how to remain well. The task of the Society has been made easier by the fact that the community is alive to its share of the obligation in this connection, and much valuable aid is being given to our program by such lay agencies as the New York Tuberculosis Association, the Milbank Foundation and the Committee for Health Service Among Jews.

The educational duties of the County Medical Society embrace still another important item not generally included in this classification. This is the exposure of quackery, both within and without the medical profession. It is a deeply rooted belief on the part of many people that organized medicine opposes irregular medical practice for economic reasons. This observation is exceedingly superficial. Charlatanry does not menace the physician, nor does its presence lessen the number of patients physicians are called upon to treat. Its danger is for the sick and ailing. The victim of the quack eventually reaches the

physician, and when he does, it is usually with a condition which has arrived at the stage of chronicity and requires prolonged treatment for a cure,—if it can be cured at all. Inasmuch, however, as even the intelligent layman is rarely able to detect the falsity of the pseudo-scientific claims made by the various cults, the County Society must expose the fads and "isms" which arise to prey on disease, not by arbitrary denunciation, but by an analysis of the fallacies on which these systems rest. Where, as in physical culture and various dietary fads, there is some element of truth in the cult's theory, it should be defined and its limitations explained. While there are always certain types who have a native preference for charlatanry, many people would be saved from exploitation by quacks if they were made to realize the downright absurdities, frauds and half-truths on which these irregular systems rest.

When we come to the political ramifications of the County Society's activities, we find that they center chiefly about the enactment and enforcement of laws affecting the community health. There is no greater concern of the state than the preservation of the health of its people, and it is a primary obligation of our legislators, regardless of party affiliation, to do what they can to effect this. Where and to whom shall they more properly turn for advice upon measures affecting the practice of medicine and the correlated topics concerning public health than to the organized profession? The County Medical Society has no paid lobby. It does not engage in legislative trading of any kind. But it has, in its Committee on Legislation, a group of vigilant, far sighted doctors who analyze every measure introduced into the Legislature which has any bearing whatsoever upon the practice of healing. Through this Committee, the endorsement of the physicians of the County is given to those bills which preserve the skill and integrity of the medical profession, promote public health and defend the people against the depredations or chicanery. Similarly legislation designed to admit untrained and unqualified men to the care of the sick or to hamper the advancement of medical knowledge is opposed.

The attitude of organized medicine toward the requirements for a medical diploma exemplifies the spirit we bespeak for all legislation affecting the public health. Despite the costliness and duration of the medical course, physicians have consistently supported laws framed to increase their scientific equipment. The medical course is among the most arduous of all professions, and it is the doctors themselves, who, realizing the importance of adequate training, have made it so. Likewise, when a law was proposed at Albany last year to strengthen and enforce the Medical Practice Act, although it entailed a certain irksome and unpopular feature for the

profession, the majority of the organized physicians of the state were prepared to accept it for the general good. This is the spirit which should be carried by the Society into all its efforts to foster or deter legislation. Whether it is an enforcement law to be promoted or an anti-vivisection act which must be opposed because it threatens the very life of medical research, whether it is a measure for hospital construction or the consolidation of existing city institutions to be supported or a strike bill which must be fought to the last ditch lest it empower numberless ignorant and unprepared faddists to treat the sick, the County Society must bring to its intervention in legislative matters the purest scientific spirit of analysis, impartiality and vision.

Hand in hand with law enactment, law enforcement is a problem which must necessarily occupy much of the County Society's attention. The Medical Practice Act, while seemingly fool-proof, is in reality very laxly enforced, and it is only when an extremely sensational instance of the dangers of irregular practice comes to light—as with the Connecticut diploma mill exposure or the death from diphtheria of a child who was treated by chiropractic instead of the administration of anti-toxin—that there is a spasmodic flurry of enforcement. The Medical Society of the County of New York, which exacts the highest scientific standards from its members, has a right to expect the community to demand the prosecution of quacks and unlicensed practitioners of the different cults. Even one life is too dear a price to pay for failure to enforce the medical practice laws. It is the aim of the Medical Society of the County of New York to procure as stringent enforcement of the statutes governing the practice of medicine as the present state of the law permits.

The third broad classification of County Society obligations to which I have referred, comprises the relationship of organized medicine to the allied professions, such as pharmacy, dentistry and nursing. These groups work in such close co-relationship with medicine that anything which lowers the efficiency of their operations is bound to react upon our own efforts, for medicine is the parent trunk from which all other branches for health promotion spring. An instance of the aid that medicine can be to the associated professions may be found in the recent legislative activity against what we have termed the "bootleg" drug stores. Following the closure of the saloons, a number of bartenders transferred their activities to drug stores, which they purchased and ran as a shield for their bootlegging activities. Not only did they sell liquor in violation of the law, but what they sold was frequently an impure and adulterated product. The reputable pharmacists, alarmed at the aspect their profession was given, sought legislative

relief With the help of the medical organizations, this was obtained

With regard to nursing, a very difficult situation has arisen which it is essential that the County Society should attempt to solve The present educational requirements for nursing, which are constantly being intensified and increased, have evolved a type of nurse who, while very valuable in public health work, is becoming more and more unsuited to the bedside tasks which are the essential features of her profession Drawn from the better educated classes, the nurse of today is unwilling to perform the more menial tasks which are assigned to her In fact, when stationed in a home where there is sickness, she frequently requires service and attention which are an additional burden to a family already disrupted by illness Although, superficially, it might seem that an educated, highly trained woman would be better able to essay the nurse's role, in actual practice it is a fact that the best equipment for the nurse, outside of the simple technical and anatomical knowledge which must necessarily be part of her training, is a cheerful desire to serve, a tactful sympathy and the ability and willingness to carry out the doctor's orders implicitly Other attributes fade into insignificance beside these It is true that the intensively trained nurse has a place in public health work, in teaching and in administration, but for the usual clinical care she is wasted unless she possesses the rare quality of being willing to shed her light under a bushel An intermediate nurse, who could perform the usual bedside duties equally well, would have the further advantage of being less expensive and would thereby make nursing care available to a large proportion of our population to whom it is now denied

While on the subject of nurses, there is one more connection in which an obligation rests upon the County Society Several instances have come before us wherein supposedly reliable registries have sent out women who were, personally, totally unfit to assume the responsibilities

which devolve upon a nurse Cases like these, which occur due to the failure of the registries to investigate their applicants for positions, tend to discredit a profession which actually has an exceedingly high personal average We propose to work out an arrangement whereby the County Medical Society could exercise some supervision over the nursing registries analagous to its position in the matter of certified milk and commercial laboratories, so that the public may be spared the danger of irresponsible nurses, and the nursing profession the undeserved reflections which a reprobate few can cast upon the whole

In considering the numerous directions that County Society activities might so profitably take, the question naturally arises as to how these aims may be attained Much can be done, as in the past, through the regular machinery of the Society—through its administrative bodies, through its counsel, and through the *New York Medical Week*, its official organ If the County Society is really to carry through its program to advance the physical well-being of the community, however, co-operation with other organizations is needed The press, the radio, the cinema, all are agencies for public information which the Society can, and is willing to, supplement by its expert knowledge Much that comes from all of these media in the way of medical news is at present incorrect and misleading We offer them a source of dependable information, uncolored by cheap sensationalism or self interest The large, unofficial health organizations are desirable allies and we shall welcome them as such in our common interest

The ship of organized medicine is setting sail on a new year Its flag is service, its port community health We, whom you have chosen to direct its course are grateful for the confidence reposed in us and will endeavor to merit it If we can make the community realize our aims and the sincerity of our purpose, if we can reach common grounds of mutual respect and understanding, our period of service will not have been in vain

## THE VARICOSE DISEASE \*

By ROBERT F BARBER and FUAD I SHATARA

*From the department of surgery of the Long Island College Hospital*

BROOKLYN, N. Y.

IN this paper it is not the intention to enter into a detailed and fatiguing description of the varicose vein and its pathological sequelae such as phlebitis, hemorrhage, eczema, ulcers, etc Those points only will be taken up that seem to have a bearing on the object of this paper That object is an investigation into the

nature of varix Time will not permit of a consideration of the operative treatment

In the lower extremity varicosities occur primarily in the internal saphenous vein and its branches More rarely the external saphenous is the seat of the lesion The appearance of these dilated veins is too well known to require further description

\*Read at the Annual Meeting of The Medical Society of the State of New York, at Rochester, N. Y., April 23, 1924



The literature is replete with descriptions of varicosities of the communicating or perforating veins. At operation we have followed these veins to the deep fascia, split the fascia at the point of perforation, and have noted an immediate change to normal in the calibre of the vessel. We have never seen the dilatation extend deeper than the deep fascia.

As regards the condition of the deep veins, the venae comites, the femoral and their branches, there has been much discussion and no evidence. In view of what has been said of the condition of the perforating veins below the deep fascia when the surface veins are varicose, it seems reasonable to suppose that they are rarely if ever varicose. When by operative interference the blood has been shunted from the diseased superficial veins into new channels of which the deep veins are no small part, the latter have never failed to handle the stream adequately. At least this would seem to indicate that the deep veins were functioning normally.

The venous valves are bicuspid with their cavities directed towards the heart. Veins are enlarged just above the attachment of the cusps so that blood may readily flow behind the latter, force their free margins together, and so occlude the lumen. Valves do not occur in veins less than one millimeter in diameter and are also lacking in many of the larger trunks, such as the venae cavae and the pulmonary and portal veins. The number of valves in any vessel is subject to considerable variation. The number of valves seems to diminish with age. The adult average in the saphenous is eight to ten. Although the point is not always well covered, according to the literature, the valves of the perforating veins allow the blood to flow towards the deep veins only. Within the last year this statement has been questioned. From dissections done by one of us (Dr F I Shatara) at the Long Island College Hospital, the point was established that the valves are so placed that the blood flows from the deep to the superficial system in the perforating veins. This confirmed the work done by others. Our conception of the venous flow between the superficial systems and the deep systems must be reversed. The perforating veins act as a spillway for the deep veins and thus relieve the tension on the deep veins which results from muscular action. The valves are to prevent the back flow of blood. They are called upon to do this only when the muscles are in action. During muscular action the pressure on the venous wall results instantly in an increase in the local venous pressure. As the blood is being delivered at any point in a vein with a certain pressure, this increased local venous pressure may temporarily exceed the pressure being delivered. This will have the effect of not only spurting the blood onward but also backward. In normal veins the valves now come into play

and prevent this reflux. The reflux is not checked in varicose veins and normal circulation is impeded.

Except for these momentary spurts which are checked by valves in normal veins the flow of blood is always in one direction. The conception or better misconception of the flow of blood in varicose veins is almost identical in previous writings on the subject. A reading of any of the standard texts on surgery will give the impression that varicosities are due to the fact that the valves in the internal saphenous have become incompetent and the weight of the entire column of venous blood from the vena cava is placed on the terminal veins, which thus become stretched, elongated, thin walled and tortuous. That high central pressure causes incompetency of the valves. The valves being gone the veins distend, and finally the blood begins to flow in the wrong direction in the saphenous, a "vicious circle" being established.

Because of lack of valves they say that regurgitation is not checked, and the blood flows in the reversed direction. In a normal individual standing erect the blood flows from the toes toward the heart past open valves. The valves are not concerned with this onward flow, and if the valves were not there the flow would continue in the same direction. The "jinx" of the valves has been something that must needs be explained by these writers, and they all fall into the same errors. Enlarge the vein much or little the flow is still in the same direction. The rate may be altered but not the course of the stream. The blood does not flow forward because of the ever present valves. The onward flow is due to one thing only, the vis a tergo received from the capillaries.

If the blood current is reversed in varicose veins we have some other analogous problems to explain. In varicocele the veins become dilated and the valves useless. By the old reasoning the flow should be downward. What happens to the arterial and venous streams when they meet in the testicle. The blood supply is terminal and something in the nature of a trophic disaster should happen. It does not happen. The reason is that the hypothesis of reversed circulation is a fallacy.

It is now opportune to take up a critical consideration of the clinical tests that are used in varicose veins.

*The Trendelenburg Test.* With the patient in the horizontal position the lower extremity is elevated. After the internal saphenous vein has emptied digital compression is made over the saphenous opening. The patient then stands. The pressure is released. If there is an immediate filling of the internal saphenous by a column of blood dropping from above downward, the test is positive. A positive test means that the valves

are incompetent From points higher than the compressing finger the drop of the column of blood is almost instantaneous It is a dramatic test and a *sine qua non* for varicose veins But a dilated internal saphenous vein can be seen with the naked eye No bicuspid venous valve will work in a dilated vein The test is of little value because we know that the valves are useless the instant that we see the big veins

*The Filling Time Test* The technique is the same as for the Trendelenburg test, except that the digital compression is continued in the upright position and the time recorded until the internal saphenous vein is full Authorities arbitrarily state that if the filling time is thirty seconds or less it indicates that either the deep or the perforating veins are varicose If between thirty and sixty seconds then the varicosity is confined to the superficial veins In the former condition operation is supposed to be useless We have operated on patients with a filling time of twenty seconds with good result The filling time is a figure due to a personal equation and very variable It varies with the size number and length of the veins It gives us in seconds a record of the time that the arteries of the extremity take to fill up the visible venous structures The figures are too relative to be of value as a clinical test This statement presupposes that the arteries in a given case are normal

*The Manometer Constriction Test* In our early studies we devised this test as a means of measuring the so-called back pressure in varix The patient lies in the horizontal position The lower extremity is elevated and the saphenous is emptied The cuff of an arterial sphygmomanometer, preferably a Tycos, is applied either above or below the knee, and the pressure in the cuff raised to eighty millimeters of mercury This is sufficient to shut off the hydrostatic drop without shutting off the arterial circulation The patient then stands up and the pressure in the cuff is gradually released When the pressure in the cuff is just slightly lower than the hydrostatic pressure above the cuff the blood is seen to drop rapidly past the cuff and fill the veins below The test should be carried out rapidly before the veins fill from below The readings in forty-three patients averaged about forty millimeters of mercury above the knee and fifty below the knee This test led us at first to the erroneous conclusion that the hydrostatic pressure is greater than the *vis a tergo* This test has given us figures which simply represent the downward pressure of the column of blood, *i e*, the gravity or hydrostatic pressure As circulation is maintained this pressure cannot be as great as the *vis a tergo* As a balance against this hydrostatic pressure there is always an equivalent hydrostatic pressure in the arteries This latter pressure is incorporated in the *vis a tergo* The same figure

could be obtained by measuring the distance from the cuff to the auricle with a rule and multiplying by a constant factor The greater the distance the higher the figure obtained Therefore the test is of no special value

*The Blood Manometer Test* The readings obtained by this test greatly modified our previous views, and upon these readings many of the conclusions are based As far as we know, this method, though simple and with reasonable precautions safe, has never previously been tried out on human beings A glass tube three millimeters in diameter and one hundred and fifty centimeters long is connected with a piece of rubber tubing twenty-five centimeters long The other end of the rubber tube is slipped over the end of an 18 gauge Yale needle, four to six centimeters in length The needle and rubber tube are sterilized It is difficult to sterilize the glass tube on account of its length Therefore care must be taken to prevent any reflux of blood from the tube into the vein of the patient The cuff of a sphygmomanometer is applied just below the knee With the patient recumbent the skin of the leg is rendered sterile and the needle introduced into one of the superficial veins The blood rises in the tube with no pressure in the cuff The level is noted The pressure in the cuff is then raised and the effect on the column of blood is observed and recorded Now the patient stands erect and immediately all pressure is taken out of the cuff The column of blood rises The new level is noted Pressure is again applied to the cuff The column of blood rises The new level is noted The needle is removed and pressure and dressings applied Measurements are also taken from the point of puncture to the episternal notch Speed is essential to prevent clotting

Consider for a moment what the blood manometer test shows The test has undergone changes since it was first devised As our knowledge grew we increased the scope of the test Due to technical difficulties we do not attempt to get all possible readings on every case We do not wish it to be understood that we have reached the end by any means This is a preliminary report and is made with all possible reservations Under ideal conditions four readings are taken two in the horizontal position and two in the upright Taking the observations in their numerical order, an average reading would be as follows

No 1—17 centimeters

No 2—50 centimeters

No 3—90 centimeters

No 4—125 centimeters

The pressure in eight normal individuals and twelve patients was studied by this method The

patients all had marked varicosities. The pressure in varicose veins did not differ from the pressure in normal veins. Venous pressure is a wonderful variable, and is influenced by many factors. The first reading represents the venous pressure in the horizontal position, the physiologist's pressure. The second reading represents the potential venous pressure in the horizontal position. The third reading, the first in the upright position, always gives a figure which is proportionate to the distance to the auricle. At the latter point the blood flows over the dam, so to speak, and any tendency to a greater pressure is dissipated in the increased rate of flow of the blood. The fourth reading represents the potential venous pressure in the upright position. The energy to cause this latter pressure is always there but it is not shown. We check the energy which is being dissipated in rate of flow, dam up the stream in a way, and measure the potential drive.

As a result of this test we are in a position to lay aside certain views which were formerly held. Having done these tests on varicose and normal individuals, and having obtained pressure readings which are identical, we are in a position to state that reversed circulation does not occur. The capillaries deliver a *vis a tergo* which is capable of accounting for circulation in the vein. The calibre of the vein does not alter the drive.

The capillaries of the leg may be compared to the fulcrum of a balance. The weights in either pan are the columns of arterial and venous blood. Although the pans balance the weight and strain are constant on the fulcrum. The strain eventually tells, and in certain individuals the capillaries in the unprotected superficial tissues leak and give rise to ecchymoses and skin discolorations so commonly seen in varicose veins. The absence of valve action from dilatation has nothing to do with this strain, but the added strain on the vessels from back spurring during muscular action in dilated veins with functionless valves, adds insult to the injury already present. The legs are often pigmented with copper markings where no ulcer has been. This we interpret as the scar of chronic capillary leaks with permanent pigmentation resulting. Any somatic cell residing in such a locality is living in an unhealthy state. Slight skin abrasions may readily lead to infection, and an entirely different aspect be given to the picture by the introduction of this new element. The very bones may be involved. The disease may well be said to extend from core to circumference.

Consider for a moment two apparently healthy young individuals, with the same blood pressure, the same occupation, and the same general conditions of life. One develops varix and the other does not. There must be a congenital or inherent

weakness of the walls of the veins and their protecting structures of the one and not the other. In the early stage of the process of dilatation the valves work. The weakness lies not in the valve but the vessel wall. The deep veins are protected by the strong, deep fascia. This fascia acts on the veins in a manner similar to the action of the shoe of the automobile tire on the inner tube. The superficial veins have the skin alone to protect them against internal pressure, and the tendency to dilate. This is apparently not enough in some individuals and the veins begin to stretch both transversely and longitudinally. It is not till this actually happens that the valves go by the board, yet the disease is blamed on the valves. The valve is merely an incident in the story.

Thus it is held that the venous walls and their protecting structures are in a congenital or acquired condition that invites varix. It is to be understood, however, that the arterial blood pressure is normal or above normal. When the blood pressure is reduced locally the veins are much less liable to dilate. In one disease, thromboangitis obliterans, of which we have seen many examples, the local blood pressure is much reduced from arterial block. We have never seen varicose veins in this disease.

This work was begun to add to what had been done by others on the subject of varix. As a result to date it is believed that a new point of view must needs be taken on the nature of the lesion. Although the work is still incomplete the conclusions can already be drawn.

(1) That varicose veins are the pressure results on the least protected veins of the leg.

(2) That the blood flows in these veins in the same direction as always, *ie*, towards the heart.

(3) That the real pressure in the veins that does the damage is the result of *vis a tergo*, and which is of necessity a greater pressure than any hydrostatic pressure could be.

(4) That the teaching of vicious circle is a figment of the imagination and does not exist.

(5) That trophic changes in the legs are part of the penalty of man's upright position. The changes in the deep structures of the legs are probably all due to infection.

### Discussion

Dr FRED I SHATARA. In the five minutes allotted me to discuss this paper I can do no more than attempt to emphasize certain phases of the problem, which, because of lack of time Dr Barber found it impossible to emphasize. It is impossible to report the results of several years work in twenty

minutes When, several years ago, through the courtesy of Dr Barber, I was permitted to assist him in studying this disease, the problem appeared simple, and the ground well covered by previous investigators The more we studied the disease in the clinic, laboratory, operating and dissecting rooms, the more complex it became A start was made by accepting the teachings previously inculcated, but our findings compelled us to modify and abandon some of these teachings The studies have not been concluded, and future findings may modify present views With this reservation the following summary is presented

1 The internal saphenous vein, which is most frequently varicose, is an evolutionary defect Since man assumed the upright posture, the weight of the column of blood between the auricle and the thigh was superimposed upon the long, unsupported column of blood in the lower extremity, constantly subjected to the action of gravity With this structural defect as a pre-causes may start the disease Varicose veins may be a penalty the human being pays for standing upright on his hind legs, but those upon whom the penalty is most frequently imposed are those whose livelihood requires them to spend most of their time on their feet, and who can, therefore, least afford the penalty

2 The circulation in varicose veins is similar to that in normal veins as the vis a tergo, except when the heart is decompensated, is sufficient to overcome the obstacles in the way of the venous current There is no reversed circulation in these veins

3 Venous pressure, like arterial pressure is greatly variable, gravity playing an important role, there is, however, always a pressure gradient maintained with maximum pressure in the aorta and minimum pressure in the afferent vessels that empty into the right auricle

4 Venous valves have only one function, namely, to occlude the lumen when pressure is exerted on the vein wall during muscular contraction, and thus prevent backward regurgitation In varicose veins, the valves are insufficient, and during muscular contraction, the blood is forced not only onwards, but also backwards This backward regurgitation explains some of the pathological changes in varicose veins On the other hand this valvular insufficiency is only a link in the chain, and does not explain the whole pathological picture It must not be forgotten

that the internal saphenous vein is superficial, and therefore not subject to muscular compression Again sections removed from varicose veins have sometimes shown perfectly normal valves but a phlebosclerotic vein wall

5 To the valves in the perforating veins has been assigned a role which they do not play Upon this alleged role the filling time test is based The status of the deep veins, and therefore the operability of a given case is supposed to be determined by this test In dissections carried out at the Long Island College, these valves have been found to open both ways, and in several perforating veins, in individuals with normal veins, these valves are absent In dissections carried on for Dr Elmer D Twyman, by Dr Ranson of Northwestern University, and Dr Cowgill of Kansas University, the valves, contrary to common anatomical teachings were found to open towards the superficial system These findings were reported in the December, 1923, number of the Surgical Clinics of North America

6 In regard to the deep veins it is felt that while they may be the site at times of phlebitis with subsequent thrombosis they are unlike the superficial veins not subject to the varicose process They enjoy a strong fascial support, which is of greater moment than the action of flimsy valves It must not be forgotten that the superficial system of veins is, after all, a tributary of the deep system For both the internal and external saphenous veins ultimately join the femoral and popliteal veins respectively If varicosity, and subsequent downward regurgitation in the deep system were possible, then the blood delivered by the saphenous veins, would not return to the heart, but regurgitate downwards then back to the saphenous veins via the perforating veins, then back again to the deep system Thus a vicious circle which may result in gangrene of the lower extremity may be established Clinically, this condition has not been encountered Again, if varicosities of the deep veins exist, it would be reasonable to expect an accompanying varicosity of the external saphenous vein which empties into the popliteal Clinically, varicosity of the external saphenous is not frequent, has not been noted in cases with filling time of less than thirty seconds, and exists as a result of varicosity of the internal saphenous with which it often communicates



# EDITORIALS



The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

**Editor-in-Chief**—NATHAN B VAN ETEN, M D,  
New York  
**Associate Editor**—ORRIN SAGE WIGHTMAN, M D,  
New York  
**Executive Editor**—FRANK OVERTON, M D Patchogue

### COMMITTEE ON PUBLICATION

E ELIOT HARRIS, M D, *Chairman* New York  
ORRIN SAGE WIGHTMAN, M D New York  
EDWARD LIVINGSTON HUNT, M D New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

**President**—OWEN E JONES, M D Rochester  
**First Vice President**—GEORGE A. LEITVER, M D Piermont  
**Second Vice President**—LUTERNE COVILLE, M D Ithaca  
**Speaker**—E. ELIOT HARRIS, M D New York  
**Vice Speaker**—GEORGE M FISHER, M D Utica  
**Secretary**—EDWARD LIVINGSTON HUNT, M D New York  
**Assistant Secretary**—WILBUR WARD, M D New York  
**Treasurer**—CHARLES GORDON HEYD, M D New York

### CHAIRMAN, STANDING COMMITTEES

**Arrangements**—FREDERICK H. FLAHERTY, M D Syracuse  
**Public Health and Medical Education**  
JOSHUA M VAN COTT, M D, Brooklyn  
**Scientific Work**—ANDREW MACFARLANE, M D Albany  
**Medical Economics**—HENRY LYLE WINTER, M D Cornwall  
**Legislation**—JAMES N VANDER VEER, M D Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex President and the Councilors of the District Branches.

**First District**—EDWARD C RUSHMORE, M D Tuxedo Park  
**Second District**—FRANK H LASHER, M D Brooklyn  
**Third District**—ARTHUR J BEDELL, M D Albany  
**Fourth District**—CHARLES C TREMBLEY, M D Saranac Lake  
**Fifth District**—NELSON O BROOKS, M D Oneida  
**Sixth District**—GEORGE H FOX, M D Binghamton  
**Seventh District**—WILLIAM I DEAN, M D Rochester  
**Eighth District**—HARRY R. TRICE, M D Buffalo

### COUNSEL

GEORGE W WHITESIDE, Esq, 27 William St New York  
Telephone, Broad 1744

### ATTORNEY

ROBERT OLIVER, Esq, 27 William St New York

### EXECUTIVE OFFICER

JOSEPH S LAWRENCE, M D 51 Chapel Street, Albany

### SECTION OFFICERS

**Medicine**  
**Chairman**—ROBERT L. LEVI, M D New York  
**Secretary**—L. WHITTINGTON GORHAM, M D Albany

**Surgery**  
**Chairman**—MARSHALL CLINTON, M D Buffalo  
**Secretary**—EDWARD S VAN DUYN, M D Syracuse

**Obstetrics and Gynecology**  
**Chairman**—HAROLD C. BAILEY, M D New York  
**Secretary**—NATHAN P SEARS, M D Syracuse

**Pediatrics**  
**Chairman**—JOSEPH C PALMER, M D Syracuse  
**Vice-Chairman**—ROGER H. DENNETT, M D New York  
**Secretary**—ARTHUR W BENSON, M D Troy

**Eye Ear Nose and Throat**  
**Chairman**—ARTHUR G BENNETT, M D Buffalo  
**Secretary**—EUGENE E HINMAN, M D Albany

**Public Health, Hygiene and Sanitation**  
**Chairman**—PAUL B. BROOKS, M D Albany  
**Secretary**—ARTHUR D JACQUES, M D Lynbrook

**Neurology and Psychiatry**  
**Chairman**—EUGENE N BOUDREAU, M D Syracuse  
**Secretary**—CLARENCE O CHENEY, M D Utica

## THE ANNUAL MEETING

Monday, Tuesday, Wednesday and Thursday, May 11, 12, 13 and 14, at Syracuse, are only three months away and every member of the Medical Society of the State of New York should immediately mark his calendar and reserve those days for refreshing his medical knowledge, for rest after this hard winter, for recreation with men who speak his language, for renewal of old friendships, and for expression of his individual opinions upon organized medicine

Although the Committee on Arrangements received a severe blow through the untimely death of the Chairman, Dr W Dewey Albever, one of the truly great men of our profession, they have reorganized under the able and experienced leadership of Dr F H Flaherty of Syracuse, and are actively developing what promises to be one of the best State Meetings in our history

The Hotel Syracuse will be the headquarters for the Society and while the accommodations are ample, members will do well to make reservations there as early as possible

The Women's Medical Society of the State usually meets at the same time and place. The State Department of Health may also hold an official conference, and a large number of physicians and their families and friends are expected

Dr Andrew MacFarlane, of Albany, Chairman of the Committee on Scientific Work, announces the near completion of a program even more attractive than that given at the Rochester meeting last year, which was one of the best for a short meeting we have ever attended

And the Commercial Exhibitors are taking spaces that will provide most interesting features

Let us all co-operate in developing a great meeting in Syracuse.

N B V E

## PROGRESS IN PERIODIC HEALTH EXAMINATIONS

The concept of periodic health examinations is undergoing a normal development and growth. It has not sprung fully formed from the brain of the medical profession, as the writings of some of its lay promoters would seem to indicate. Those who have made examinations conscientiously and scientifically have been embarrassed in judging what points to investigate. Even the nomenclature to describe the examinations has had to be developed, and the new word *pre-clinical* is coming into use to describe the mild signs which often precede the more serious symptoms of diseases.

It would seem to be a simple procedure to make a physical examination of an apparently healthy adult, and on its basis to prescribe a course of treatment, diet, or habit-forming which will indicate unerringly the pathway to a long and vigorous life. But the problem is not so simple.

Our practical ideas of what a periodic health examination should be are derived from previous experiences with large groups of persons. There are six principal groups in which periodic physical examinations have been made:

- 1 The United States Army
- 2 Those having life insurance policies
- 3 Workmen in industrial plants
- 4 Children in public schools
- 5 Tuberculosis patients
- 6 Infants and children in milk stations and clinics

Life insurance examinations have been practiced by nearly every physician, and these are the examinations which have given the average physician his idea of what to look for when making a modern periodic health examination. But an insurance examination takes account of only a few gross conditions, and the physician does not advise a patient regarding the meaning or the correction of the defects that are found. What an insurance company wants to know is how many persons out of a thousand of those examined will die during each year, or other given period. It is concerned only with the mass of those insured and not with individuals. It considers that every serious defect found may develop into disease and death, and so it fixes its insurance rates accordingly. It makes no attempt to correct defects. It is concerned with *clinical* signs, as distinguished from the *pre-clinical* signs which are sought in modern periodic health examinations.

Pediatricians in their milk stations and baby clinics have more nearly pointed the way for health examinations of adults. A pediatrician expects to see the babies regularly every week,

or month, to give advice regarding diet and habits of life, and to see that the children do not develop ill health to such a degree that they show clinical signs of disease. The yard-stick by which they measure the success of their work is the normal development of the babies.

A person making a modern periodic examination imitates the pediatrician in a baby clinic, and the yardstick by which he measures his success is the physical vigor of his patient.

Making a physical examination of a healthy adult, and giving advice regarding pre-clinical conditions require an immense amount of thought along lines which have not been intensively considered heretofore. The periodic health examination committee of the Medical Society of the County of New York has recognized the difficulty, and has invited sixteen specialists to present the subject of pre-clinical signs of disease, each in his own specialty. We have reported some of the addresses in this Journal and hope to report the rest. Some of the lecturers have told us about the embarrassment which they have felt because previously they had not given special thought to these examinations. These lectures have been wonderfully clear and simple, and may be readily followed by every general practitioner of medicine.

The lecturers have emphasized the importance of some modern conceptions which were unknown a few years ago, among them being focal infections, endocrines, metabolism, allergy, and immunity, together with the modern ideas of cancer and the interpretation of X-ray pictures.

The point which we wish to make right here is that it takes sixteen lectures to cover the subject of the simple pre-clinical signs of disease which any examiner is likely to meet. If the boiled-down abstracts of these lectures were printed, they would make a pamphlet of over twenty pages on the subject "How to make a periodic examination."

The evident lesson to be drawn from these facts is that a physician must prepare himself to make the examinations. Yet the preparation is not difficult or lengthy. The greatest value of the abstracts which we are printing is that they constitute an index or guide to the various conditions for which an examiner must look. The preparation of a standard index to periodic examinations is something new and is worthy to be classed as an excellent piece of research work.

The entire medical profession is indebted to the lecturers of the Medical Society of the County of New York for their conscientious work in preparing a standard guide for making a periodic health examination.

F O

## MEDICAL PRACTICE ACT

By this time you have had an opportunity to read the Medical Practice Act, which appeared in last week's issue of the Journal. As was stated, this bill has been prepared by the Department of Education and introduced into both houses. This need was commented on by the Governor in his annual message to the Legislature, and the endorser in both houses is a member of the majority party, so it is to be expected that the bill will receive the support it deserves. Several of the important revisions that have been made in the bill are the following:

First—It is provided that annual registration shall continue so long as the physician wishes to practice. The fee of \$2.00 remains the same and also the period of five years during which it shall be paid, is unchanged. The object in extending the period of registration is evident. Unless every physician in the County registers annually, it would be very difficult to determine at any particular time who are licensed to practice. The idea of the Department of Education at present is that annually they will submit to each physician in the State a list of the physicians residing in that County who are licensed to practice. Every physician receiving such list is asked to advise the Department of Education of the name and address of any person living in the same County who is practicing medicine, but whose name does not appear in the list. The Department of Education then—with its inspectors provided by the funds received from the registration fees—will investigate such report and collect evidence against the non-licensed practitioners. This evidence will be given to the District Attorney and if he, for any reason, prefers not to handle the matter, or is too much engaged

to undertake it immediately, he can refer it to a Deputy or the Attorney General's office, who will be detailed to bring early prosecution.

The second revision has to do with the penalties to be imposed upon physicians who fail to register. It will be noted in Section 170, article 6, that under no condition shall the penalties for non-registration affect the legality of the license of the physician to practice and such penalties may, for good cause shown, be remitted or compromised by the Board of Regents.

The third important revision will be noticed in Section 172, beginning "This article shall not be construed so as to prevent the following." These exceptions are now drawn so that it will be more difficult for persons employed in the various ways outlined to engage in the practice of medicine illegally, as numerous instances in the past have shown some of them inclined to do.

The fourth revision is in Section 173 under "Penalties." In Article 5 it will be seen that the monies accumulated from fees and penalties following in the enforcement of this act, shall be paid to the Regents of the University and shall be available for the administration and enforcement of this act only.

These revisions have definitely improved the bill, making it more workable, clarifying certain questions that were hazy in many minds last year, and assuring the physicians the protection they deserve from their State license, as well as guaranteeing to them that they shall not lose it except for such specific offenses as have always been considered sufficient and just cause for depriving a man of his privilege to practice medicine, or to be a member of the Medical Society.

J S L

## MEETINGS OF COUNTY MEDICAL SOCIETIES IN FEBRUARY

The executive officer has a list of the meetings of the sixty County Medical Societies of New York State and keeps it up to date, so far as possible. It is our desire to co-operate with him in every possible way and to give full publicity to the activities of the county societies. We are gratified with the response to our request for news from the County Societies, and we have used every item that has been sent to us, and in addition we have printed whole paragraphs of County Society news which have come to us through other channels. We are glad to publish the following list of County Society meetings to be held during February:

Albany, Second Tuesday	February 10
Bronx, Third Wednesday	February 18
Cayuga, Second Tuesday	February 10
Erie, Third Monday	February 16

Kings, Third Tuesday	February 17
Livingston, Second Tuesday	February 10
Montgomery, Second Tuesday	February 10
Nassau, Last Tuesday	February 24
New York, Fourth Monday	February 23
Onondaga, Second Tuesday	February 10
Orleans, First Tuesday	February 3
Queens, Last Tuesday	February 24
Rensselaer, Second Tuesday	February 10
Richmond, Second Wednesday	February 11
Schenectady, Second Tuesday	February 10
Tompkins, Third Tuesday	February 17
Ulster, First Tuesday	February 3

This list is as complete as the information on hand will permit. We hope that the list for March will be even more perfect.

F O



# LEGAL



By **GEORGE W. WHITESIDE, Esq.**  
Counsel, Medical Society of the State of New York

## DROP A NICOLL BILL IN THE LEGISLATIVE SLOT AND RECEIVE A DOCTOR'S DEGREE

A barber, after years of calling "next" and giving shaves, shampoos and haircuts, passes a few months in a chiropractic school and emerges as a doctor of chiropractic, he is licensed as such without examination, so that his lack of the elements of education are not known. He and two similarly endowed chiroso who have been either plumbers or turkish bath rubbers, are appointed by a judge having chiropractic proclivities to decide upon the sanity of a man charged with first degree murder. They solemnly proceed to examine chiropractically the defendant's spine and report to the court that the defendant has "misaligned and displaced vertebrae" from which they conclude that he is of unsound mind and should be sent to Mattewan Asylum for the criminal insane.

While this may sound like the scenario of a movie comedy, it may happen in actual life in this state if the Nicoll bill, designed to "regulate" chiropractic, is passed by the Legislature. Let us see how such an absurdity can be brought about by a legislative act. The Nicoll bill will, as shown in a previous issue of the Journal in this department, grant without examination, licenses to a thousand or more chiropractors, it will confer upon such untried and untested licensees the right to use the degree D.C., or Doctor of Chiropractic, it will also grant "the civil rights, privileges and immunities \* \* \* granted to all professional persons by the Civil Practice Act and the Judiciary Law." By Section 31 of the Judiciary Law, in criminal cases or habeas corpus proceedings, where the soundness of a person's mind is an issue, the court may have that question inquired into by three disinterested competent physicians. When the osteopaths were licensed under a similar exemption in 1907, without examination, it was not then suspected that they would be deemed physicians, but when the courts were called upon to construe their status, it was held that an osteopath so licensed was deemed a "regularly qualified physician." So, under the Nicoll bill there will

be added as "regularly qualified physicians" this large mushroom crop of chiropractors. So having been licensed without examination, having been given the title of doctor and having been thereby constituted regularly qualified physicians, it is quite clear that such chiropractors would claim the right to be appointed as alienists on such a commission under the Judiciary Law.

This is but one of the many absurdities that would result from the chiropractors' persistent efforts by legislative act to reap the fruits and benefits of study and education without spending the time or making the effort to obtain such education. You cannot make the ignorant, untrained and uneducated chiropractor a finished product of thorough education by legislative act which confers upon him the titles that heretofore have been gained only by an arduous and difficult course of academic education, specialized scientific instruction, and satisfying the regents tests. Whilst if the Nicoll bill should become law, such chiropractor might legally masquerade before the public by virtue of a legislative decree, as educated and trained and pretend to be something that he is not for his own personal pecuniary advantage, such a farcical procedure under the guise of a legislative method to "regulate" the practice of chiropractic cannot help but bring legislative procedure and practice into public disrepute.

From these considerations it can be readily seen that the Nicoll bill proposes to grant as a special privilege to a favored class, without reference to the qualifications of such class, practically all of the honor, titles, privileges and rewards that physicians enjoy only after meeting the highest mental, moral and scientific tests. Your legislators who will consider this bill will know nothing about these phases and patent evils of the bill unless their attention is called specifically to them. Every duly licensed physician in this state can effectively prevent the enactment of the chiropractic license farce by showing up this bill to his legislators.

## REMOVAL OF NASAL HUMP AND RESECTION OF DEVIATED SEPTUM

A case recently tried by your counsel involved an operation on the nose for the reduction of the hump and the straightening of a deflected septum by a surgeon practicing the specialty known as rhino-plastic surgery.

The patient's contention was that too great a part of the nasal bones had been cut away, thereby causing the bridge of the nose to sag, resulting in an unsightly nose. The plaintiff took the stand in his own behalf and was frequently ex-



anned, in the presence of the jury, by various doctors who testified in the case. His appearance was unfortunate and was such as might well have been calculated to inflame the sympathy of the jury in his favor.

The case was interesting from both the medical and legal point of view. Unquestionably the result as it was exhibited to the jury, was not good, and because it was so obvious, it was much more difficult to defend than are those bad results which are not so apparent to the lay eye. Where there is a bad result and the defendant doctor has either caused it or has in anywise participated in causing it, a serious problem is always presented, for the reason that it is difficult to restrain juries from expressing their sympathy for the patient in the form of punitive verdicts against the doctors, irrespective of whether they are responsible under the rules of law.

In this case three doctors testified in behalf of the plaintiff, but only one of them gave an opinion in response to a hypothetical question that the procedure followed by the defendant-doctor was not in accordance with proper and approved practice. Two doctors of unquestioned standing and of very wide reputation testified in behalf of the defendant doctor that the procedure followed by him was in all respects proper. All of the doctors on both sides of the case who had specialized in rhino-plastic surgery testified that in operations of this character the desired result cannot always be achieved in one operation, that it frequently requires several operations to ac-

complish that which is sought to be accomplished. The specialty of rhino-plastic surgery was compared to sculpture and the problems confronting the surgeon practicing this specialty were said to be analogous to those confronting the sculptor, who, as we all know, attains the perfect line and complete symmetry only as a result of long, painstaking and patient effort.

The question in these malpractice cases is not: Was there a bad result? The question is: Did the defendant doctor fail to follow proper and approved practice, and if this is so, did such failure lead to the bad result? That is to say, was it the competent producing cause of the result complained of?

In the case we are discussing the defendant doctor testified that he had told the patient before the first operation that it might take several operations in order to achieve complete success, and that after he was notified by his patient that there was a sagging of the nose he invited the patient to return for a further operation, but the patient declined or failed to come to him for that purpose.

Fortunately, in this case, the jury, while sympathizing with the plaintiff, unquestionably felt that the bad result was not the fault of the doctor sued, that is, that it had not been occasioned through any failure to follow proper and approved practice on his part. Accordingly a verdict was rendered against the patient and in favor of the doctor.

#### REMOVAL OF UVULA IN PERFORMANCE OF TONSILLECTOMY AND ADENECTOMY WITH CLAIMED RESULTANT IMPAIRMENT OF SPEECH

A child of about four years of age was referred by the family physician to a specialist in ear, nose and throat work, the physician having found that the adenoids and tonsils of the child were enlarged and diseased. Arrangements were made for the specialist to remove the adenoids and tonsils at the home of the child. The specialist accompanied by his assistant, were met at the child's home by the family physician, who administered the general anaesthesia to the child, and a tonsillectomy and adenectomy were performed by the specialist. There was no excessive bleeding and the child had come out of the anaesthesia and was in good condition at the time the specialist left. At the time of the operation it was found that the uvula was diseased and it was necessary to remove a part thereof. Nothing further was heard of this patient until some months later when the operating surgeon was served with a summons and complaint on behalf of the child against himself, it being charged that the operation performed by him was negligently and unskillfully done and that in the removal of the tonsils he had cut part of the flesh and organs in the child's throat so that the

child's speech became impaired and she was otherwise seriously injured. It seems that some other physician, subsequent to the operation, upon examining the child, informed the parents that the removal of part of the uvula was unnecessary and that the same would impair the speech of the child and prevent her from becoming a singer.

Upon a physical examination of the child it was found that the removal of the tonsils and adenoids was well done and that part of the uvula had also been removed. The child was found to be very fat and had a peculiar pasty color. She would not talk to the examining physician, so that it was not possible for him to judge of her character or speech. However, to the examining physician, the child appeared to be suffering from a mild form of faulty development due to imperfect function of the ductless glands which retards her progress in speech and changes the character of speech.

The plaintiff's attorneys having failed to bring the action on for trial, a motion was made in behalf of the doctor to dismiss the action for lack of prosecution, which motion was granted, dismissing the complaint in favor of the doctor.



# LEGISLATION



By JAMES N VANDER VEER, MD  
Chairman, Committee on Legislation

## INDEX OF BILLS OF INTEREST TO THE MEDICAL PROFESSION IN SENATE

Senate Int 11—Labor Law, in re hours of employment of females Digest printed in January 23rd Journal

Senate Int 115—Public Health Law, in re habit forming drugs Bill printed in January 23rd Journal

Senate Int 116—Insanity Law, requiring licensing of private institutions for treatment of drug addicts Bill printed in January 23rd Journal

Senate Int 211—Public Health Law, amending Medical Practice Act Bill printed in January 30th Journal

Senate Int 228—State Charities Law, empowering State Charities Board to visit and inspect all institutions in which children are received or cared for Digest of bill printed in January 30th Journal

Senate Int 263—Insanity Law, relative to qualifications of examiners in lunacy Bill printed in February 6th Journal

Senate Int 266—Workmen's Compensation Law, providing for expenses for rehabilitating injured employees Digest printed in February 6th Journal

Senate Int 278—Criminal Code, in re violations of orders of local health boards Bill will be printed in February 13th Journal

Senate Int 282—Public Health Law, empowering local health board to prescribe that a person willfully violating or omitting to comply with any lawful order or regulation prescribed by it or a local health officer, shall be guilty of a misdemeanor Bill will be printed in February 13th Journal

Senate Int 283—County Law, in re providing expenses of public health nurses Bill printed in February 6th Journal Conc Assembly Int 399

Senate Int 302—Education Law, relative to medical inspection and health service in public schools Bill printed in February 6th Journal

Senate Int 308—Workmen's Compensation Law, relative to fibroid phthisis (silicosis) Bill printed in January 30th Journal, under conc. Assembly Int 386

Senate Int 349—Public Health Law, relative to powers and duties of local health boards Bill will be printed in February 13th Journal

Senate Int 351—Public Health Law, permitting physician to use vaccine virus to prevent small-pox, etc Bill will be printed in February 13th Journal

Senate Int 380—Workmen's Compensation Law, in re medical and surgical attendance for injured employees, by providing employee shall select physician, conc Assembly Int 570 Bill printed in February 6th Journal

## IN ASSEMBLY

Assembly Int 64—Labor Law, in re hours of employment of females, concurrent Senate Int 11 Digest printed in January 23rd Journal

Assembly Int 120—Labor Law, in relation to turning nursing and first aid services in factories and mercantile and other establishments Bill printed in January 23rd Journal

Assembly Int 123—Tax Law, permitting deductions from income for tax purposes of all expenses paid during the year for medical, surgical or dental services Bill printed in January 23rd Journal

Assembly Int 127—Education Law, providing that boards of education and trustees shall appoint physicians and dentists and may employ nurses for service in schools Bill printed in January 23rd Journal

Assembly Int 152—Workmen's Compensation Law, striking out provision that claim for medical treatment shall not be valid against employer unless physician within 20 days following first treatment furnish report of injury Digest Printed in January 23rd Journal

Assembly Int 182—Workmen's Compensation Law, providing compensation for disability shall not exceed \$30 per week, instead of \$20 as at present Bill printed in February 6th Journal.

Assembly Int 184—Workmen's Compensation Law authorizing physical examinations and practical tests of claimant to determine loss of use of a member, result and test to be part of record. Digest printed in January 23rd Journal

Assembly Int 185—Defining and regulating the practice of Chiropractic Bill printed in January 23rd Journal

Assembly Int 191—Workmen's Compensation Law, in re enforcing claims Bill printed in February 6th Journal

Assembly Int 201—Workmen's Compensation Law, in re compensation for disabilities or death resulting from poisoning, etc Bill printed in February 6th Journal

Assembly Int 202—Workmen's Compensation Law, in re compensation for poisoning by gasoline or other volatile petroleum products Bill printed in February 6th Journal

Assembly Int 203—Workmen's Compensation Law, providing for compensation in case of infection or inflammation of skin on contact surfaces due to oils, cutting compound, etc Bill printed in February 6th Journal

Assembly Int 204—Workmen's Compensation Law, providing for compensation in case of diseases due to inhaling silica dust Bill printed in February 6th Journal

Assembly Int 214—State Charities Law, authorizing investigations by superintendent or officer designated by him, and authorizing an arrangement for use of laboratory service of hospital Bill printed in February 6th Journal

Assembly Int 215—Public Health Law, in re habit-forming drugs, conc Senate Int 115 Bill printed in January 23rd Journal

Assembly Int 216—Insanity Law, requiring licensing of private institutions for treatment of drug addicts, conc Senate Int 116 Bill printed in January 23rd Journal

Assembly Int 229—Education Law, providing for county supervisors to supervise education of children with retarded mental development Digest printed in January 30th Journal

Assembly Int 233—Workmen's Compensation Law, authorizing industrial board to permit claim for compensation to be filed within two years after accident or death Digest printed in January 30th Journal

Assembly Int 236—State Charities Law, empowering State Charities Board, among other things, to visit and inspect all institutions in which children are received or cared for, and to establish rules therefor, conc Senate 228 Digest printed in January 30th Journal

Assembly Int 237—State Charities Law, empowering State Charities Board to visit and inspect places where children for appearance in court, are held and to establish rules therefor, conc Senate 231 Digest printed in January 30th Journal

Assembly Int 301—Workmen's Compensation Law, permitting injured employees, at employer's expense, to engage medical or other attendance Bill printed in February 6th Journal

Assembly Int 302—Labor Law, permitting employment of females at night in any occupation in which it is lawful for males to work at night Digest printed in January 30th Journal

Assembly Int 307—Public Health Law, amending Medical Practice Act, conc Senate Int 211 Bill printed in January 30th Journal

Assembly Int 384—Greater New York Charter, requiring education board to furnish free eyeglasses to school children unable to pay therefor Digest printed in January 30th Journal

Assembly Int 386—Workmen's Compensation Law, relative to fibroid phthisis (silicosis) Bill printed in January 30th Journal

Assembly Int 399—County Law, in re expenses of public health nurses Bill printed in February 6th Journal

Assembly Int 413—Public Health Law, empowering local health boards to prescribe that a person willtully violating or omitting to comply with lawful order or regulation prescribed by it or a local health officer, shall be guilty of a misdemeanor, conc Senate Int 282 Bill printed in February 6th Journal

Assembly Int 414—Criminal Code, giving Special Sessions Courts jurisdiction in cases of wilful violation to comply with lawful order of local health board or officer, where penalty does not exceed \$50 nor imprisonment six months, conc Senate Int 278 Bill will be printed in February 13th Journal

Assembly Int 422—Civil Practice Act, providing physicians and nurses may disclose professional information as witnesses in action to annul marriage on ground of fraud Bill printed in February 6th Journal

Assembly Int 434—Prison Law, providing for removal to hospitals of prisoners confined either for civil or criminal cause, when they require immediate medical or surgical treatment Bill will be printed in February 13th Journal

Assembly Int 536—Public Health Law, permitting physician to use vaccine virus to prevent small-pox, under certificate of approval issued by Health Commissioner Bill will be printed in February 13th Journal

Assembly Int 570—Workmen's Compensation Law, relative to medical and surgical attendance for injured employees, by providing employee shall select physician, conc. Senate Int 380 Bill will be printed in February 13th Journal

## SUMMARY OF BILLS INTRODUCED IN LEGISLATURE

Senate Int No 11 (conc A Int 64)—A bill introduced in the Senate by Senator Seabury C Mastick of Westchester County, concurrent Assembly Int No 64, introduced in the Assembly by Assemblyman Herbert R Shonk of Westchester County, would amend sections 172, 181, Labor Law, by prohibiting employment of females over 16 years of age more than 48 hours a week in factories and mercantile establishments, except that for not exceeding eight weeks in any year, divided into not more than two periods, females may be employed not more than six days or 54 hours a week or nine hours a day, provided notice of such extension of working hours be sent to Industrial Commissioner at least three days before

Referred to Labor and Industries Committee of both houses

No action on bill as yet

## THE NARCOTIC BILL

Senate Int No 115 (conc A Int 215)—A bill introduced in the Senate by Senator Morton J Kennedy of New York, concurrent Assembly Int No 215, introduced in the Assembly by Assemblyman Morris Weinfeld of New York, would add new article 22, and amend section 4-b, Public Health Law, and repeals section 1746, Penal Law, relative to habit-forming drugs

Referred to Public Health Committee of both houses

No action on bill as yet

Senate Int No 116 (conc A Int. 216)—A bill introduced in the Senate by Senator Morton J Kennedy of New York, concurrent Assembly Int No 216, introduced in the Assembly by Assemblyman Morris Weinfeld of New York, would add new section 177, Insanity Law, requiring the licensing of private institutions for treatment of narcotic drug addiction

Referred to General Laws Committee of Senate, and to Judiciary Committee of Assembly

No action on bill as yet

STATE DEPARTMENT OF EDUCATION BILL  
TO AMEND THE MEDICAL PRACTICE  
ACT

Senate Int No 211 (conc A Int 307)—A bill introduced in the Senate by Senator John L. Karl of Queens County, concurrent Assembly Int No 307, introduced in the Assembly by Assemblyman Russell Dunmore of Oneida County, would amend sections 164, 169, 170, 173, 174 and repeal section 171, Public Health Law relative to practice of medicine, by providing among other things for the registration and licensing of physicians

Referred to Public Health Committees of both houses

No action on bill as yet

Senate Int No 228 (conc A Int 236)—A bill introduced in the Senate by Senator J Griswold Webb, Clinton Corners, N Y, concurrent Assembly Int No 236, introduced in the Assembly by Assemblyman T C Moore of Westchester County, would add new section 16-a, empowering State Charities Board among other things to visit and inspect all institutions in which children are received or cared for, and to establish rules therefor

Referred to General Laws Committee

No action on bill as yet

Senate Int No 263—A bill introduced in the Senate by Senator James A Higgins of Kings County, would amend section 81, Insanity Law, relative to qualifications of examiners in lunacy

Referred to General Laws Committee

No action on bill as yet

No 266

Int 263

IN SENATE,

January 23, 1925

Introduced by Mr Higgins—read twice and ordered printed, and when printed to be committed to the Committee on General Laws

## AN ACT\*

To amend the insanity law, in relation to qualifications of examiners in lunacy

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section eighty-one of chapter thirty-two of the laws of nineteen hundred and nine, entitled "An act in relation to the insane," constituting chapter twenty-seven of the consolidated laws, as last amended by chapter six hundred and seventy-three of the laws of nineteen hundred and twenty-one, is hereby amended to read as follows

§ 81 Medical examiners in lunacy, certificates of lunacy The certificate of lunacy must show that such person is insane and must be made by two reputable physicians who have filed with the commission a certified copy of the certificate of a judge of a court of record showing qualifications in accordance with law The qualifications of medical examiners in lunacy certified after date from which this act shall take effect shall be that he or she must be a reputable physician, graduate of an incorporated medical college, who has been in actual practice of his or her profession at least three years, and shall have at least two years actual experience in the care and treatment of the insane in an institution for the insane | graduates of an incorporated medical college who have been in the actual practice of their profession at least three years, and have filed with the commission a certified copy of the certificate of a judge of a court of record, showing such qualifications

in accordance with forms prescribed by the commission]

Such physicians shall jointly make a final examination of the person alleged to be insane within ten days next before and inclusive of the date of the granting of the order. The date of the certificate of lunacy shall be the date of such joint examination. Such certificate of lunacy shall be in the form prescribed by the commission, and shall contain the facts and circumstances upon which the judgment of the physicians is based and show that the condition of the person examined is such as to require care and treatment in an institution for the care, custody and treatment of the insane.

Neither of such physicians shall be a relative of the person applying for the order, or of the person alleged to be insane, or a manager, superintendent, proprietor, officer, stockholder, or have any pecuniary interest, directly or indirectly, or be an attending physician in the institution, to which it is proposed to commit such person.

§ 2 This act shall take effect immediately

\* Matter in *italics* is new matter in brackets [ ] is old law to be omitted

Senate Int No 266—A bill introduced in the Senate by Senator James S Truman of Owego, N Y, would amend subdivision 9, section 15, Workmen's Compensation Law, by providing for expenses for rehabilitating injured employees, not more than \$10 per week to be spent for maintenance.

Referred to Labor and Industry Committee

No action on bill, as yet

Senate Int No 278 (conc A Int 414)—A bill introduced in the Senate by Senator George L Thompson of Kings Park, N Y, concurrent Assembly Int No 414, introduced in the Assembly by Assemblyman Edwin W Wallace of Nassau County, would amend section 56, Criminal Code, by giving Special Sessions Courts jurisdiction in cases of willful violation to comply with lawful order of local health board or officer, where penalty does not exceed \$50 nor imprisonment six months.

Referred to Codes Committees in both houses

No action on bill, as yet.

Senate Int No 282 (conc A Int 413)—A bill introduced in the Senate by Senator George L Thompson of Kings Park, N Y, concurrent Assembly Int No 413, introduced in the Assembly by Assemblyman Edwin W Wallace of Nassau County, would amend section 21, Public Health Law, by empowering local health board to prescribe that a person willfully violating or omitting to comply with any lawful order or

regulation prescribed by it or a local health officer shall be guilty of a misdemeanor.

Referred to Public Health Committees of both houses

No action on bill, as yet

Senate Int No 283 (conc A Int 399)—A bill introduced in the Senate by Senator J Griswold Webb of Clinton Corners, N Y, concurrent Assembly Int No 399, introduced in the Assembly by Assemblyman Frank Lattin of Orleans County, would amend section 12, County Law, by authorizing county supervisors to provide expenses for public health nurses, who shall work under the public health committee of board, providing for appointment of advisory committee of citizens and relative to duties of nurses.

Referred to Internal Affairs Committees of both houses

No action on bill, as yet

No 287

Int 283

IN SENATE,

January 26, 1925

Introduced by Mr Webb—read twice and ordered printed, and when printed to be committed to the Committee on Internal Affairs of Towns, Counties and Public Highways.

#### AN ACT\*

To amend the county law, in relation to public health nurses

*The People of the State of New York represented in Senate and Assembly do enact as follows:*

Section 1 Subdivision forty-four of section twelve of chapter sixteen of the laws of nineteen hundred and nine, entitled 'An act in relation to counties, constituting chapter eleven of the consolidated laws,' such subdivision having been added by chapter one hundred and thirty of the laws of nineteen hundred and twenty-one, and amended by chapter sixty-seven of the laws of nineteen hundred and twenty-four, is hereby renumbered as subdivision forty-four-a, and amended to read as follows:

[44]-44-a The board of supervisors of any county, except a county constituting a general health district created under the public health law, shall have power to appoint and employ and provide for the expenses of such number of public health nurses as it may deem proper. Such nurses shall work under the direction of a committee of members of the board of supervisors to be known as the committee on public health. Any such public health nurse may be assigned by such committee to prenatal care and maternity protection, the reduction of infant mortality, the safeguarding of the health of children, the discovery and visitation of cases of tuberculosis, the prevention and control of communicable disease,

the care of the sick who may otherwise be unable to secure adequate care, the instruction of members of households in which there is a sick person, or to such other nursing duties as may seem appropriate to such committee. Except as hereinafter provided, the state commissioner of health or his authorized representatives shall have power to maintain general supervision over the work of such nurses.

With the approval of such committee the trustee or board of trustees of any common school district or the board of education of any union free school district within the county, may designate any such nurse as a school nurse to perform, in addition to her other duties, the duties of a school nurse for any school or schools under such respective trustee, board of trustees or board of education. Any such nurse so designated shall perform her duties as school nurse under the direction of the appropriate school authorities and under the provisions of the education law and under the regulations prescribed pursuant thereto.

The board of supervisors may appoint an advisory committee of citizens, of whom at least one shall be a physician and at least one a woman, to advise with and assist the hereinabove mentioned committee on public health in the organization and direction of the work of such public health nurses.

§ 2 This act shall take effect immediately.

\* Matter in italics is new matter in brackets [ ] is old law to be omitted

Senate Int No 302—A bill introduced in the Senate by Senator Ernest E. Cole of Bath, N. Y., would amend sections 571, 571-a, 572, 575, Education Law, relative to medical inspection and health service in public schools.

Referred to Public Education Committee

No action on bill, as yet

S Int 302

IN SENATE,

January 26, 1925

Introduced by Mr. Cole

AN ACT

To amend the education law, relative to medical inspection and health service in the public schools

The People of the State of New York represented in Senate and Assembly, do enact as follows:

Section 1 Section five hundred and seventy-one of chapter twenty-one of the laws of nineteen hundred and nine entitled "An act relating to education, constituting chapter sixteen of the consolidated laws," as amended by chapter one hundred and forty of the laws of nineteen hundred and ten, which section was added by chapter six hundred and twenty-seven of the laws of nineteen hundred and thirteen and amended by chapter one hundred and eighty-two of the laws

of nineteen hundred and sixteen, is hereby amended to read as follows:

§ 571 Employment of Medical Inspector

The physicians so employed shall be legally qualified to practice medicine in this state, and shall have [so practiced for a period of at least two years immediately prior to such employment] such further qualifications as may be prescribed by the regents of the university. Any such board or trustees may employ one or more school nurses, who shall be registered trained nurses and authorized to practice as such, and such health experts as may be required. Such nurses and health experts when so employed shall aid the medical inspector of the district and shall perform such duties for the benefit of the public schools as may be prescribed by [such inspector] such board of trustees under rules adopted by the regents of the university.

A medical inspector [or] school nurse or other health experts may be employed by the trustees or boards of education of two or more school districts, and the compensation of such inspector, school nurse or other health experts and the (Remainder same as old law)

§ 2 Section five hundred and seventy-one-a of such chapter, as added by chapter two hundred and sixty-five of the laws of nineteen hundred and twenty-four, is hereby amended to read as follows:

§ 571-a Apportionment of Public Money. In a city or a union free school district employing a superintendent of schools, or [two] one or more common school districts or union free school districts (Remainder same as old law)

§ 3 Sections five hundred and seventy-two and five hundred and seventy-five of such chapter, as added by chapter six hundred and twenty-seven of the laws of nineteen hundred and thirteen, are hereby amended to read as follows:

§ 572 Pupils to Furnish Health Certificates. A health certificate shall describe the condition of the pupil when the examination was made, which shall not be more than [thirty] fifteen days prior to the presentation of such certificate, and state whether such pupil is in a fit condition of bodily health to permit his or her attendance at the public schools. Such certificates shall be submitted within [thirty] fifteen days after his or her entrance in such schools to the principal. (Remainder same as old law)

§ 575 Existence of Contagious Diseases, Return After Illness. Whenever upon investigation a pupil in the public schools shows symptoms of [smallpox, scarlet fever, measles, chicken pox, tuberculosis, diphtheria, influenza, tonsillitis, whooping cough, mumps, scabies or trachoma]

any contagious or infectious disease reportable under the public health law, he shall

Such medical inspectors may make such examinations of teachers, janitors, or other school employees and school buildings and premises as in their opinion the protection of the health of the pupils and teachers may require, or as the rules of the regents of the university may direct

§ 4 This act shall take effect immediately indicates same as old law

---

Senate Int No 308 (conc A Int 386)—A bill introduced in the Senate by Senator James S Truman of Owego, N Y, would add new article 4-a, Workmen's Compensation Law, relative to fibroid phthisis (silicosis)

Referred to Labor and Industry Committee  
No action on bill, as yet

---

Senate Int No 349—A bill introduced in the Senate by Senator John L Karle of Queens County, would amend section 21, Public Health Law, relative to powers and duties of local health boards

Referred to Public Health Committee  
No action on bill as yet

---

Senate Int No 351 (conc A Int 536)—A bill introduced in the Senate by Senator John L Karle of Queens County, concurrent Assembly Int No 536, introduced in the Assembly by Assemblyman Frank H Lattin of Orleans County, would amend section 311, Public Health Law by permitting physician to use vaccine virus to prevent smallpox, under certificate of approval issued by Health Commissioner

Referred to Public Health Committees of both houses

No action on bill as yet.

---

Senate Int No 380 (conc A Int 570)—A bill introduced in the Senate by Senator Daniel J Farrell, of Kings County, concurrent Assembly Int No 570, introduced in the Assembly by Assemblyman Gerald F Dunne of Kings County, would amend section 13 Workmen's Compensation Law, relative to medical and surgical attendance for injured employees, by providing employee shall select physician

Referred to Labor and Industry Committees of both houses

No action on bill as yet

No 385  
IN SENATE

Int 380  
January 28, 1925

Introduced by Mr Farrell—read twice and ordered printed, and when printed to be committed to the Committee on Labor and Industry

AN ACT\*

To amend the workmen's compensation law, in relation to medical attendance and surgical treatment for an injured employee.

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section thirteen of chapter eight hundred and sixteen of the laws of nineteen hundred and thirteen, entitled "An act in relation to assuring compensation for injuries or death of certain employees in the course of their employment and repealing certain sections of the labor law relating thereto, constituting chapter sixty-seven of the consolidated laws," as re-enacted by chapter forty-one of the laws of nineteen hundred and fourteen, and as last amended by chapter six hundred and fifteen of the laws of nineteen hundred and twenty-two, is hereby amended to read as follows

§ 13 Treatment and care of injured employees The employer shall promptly provide for an injured employee such medical, surgical [or] attendance or treatment, or both, by a physician selected by the employee, and such other attendance or treatment, nurse and hospital service, medicine, crutches and apparatus for such period as the nature of the injury or the process of recovery may require If the employer fail to provide the same, after request by the injured employee such injured employee may do so at the expense of the employer The employee shall not be entitled to recover any amount expended by him for such treatment or services unless he shall have requested the employer to furnish the same and the employer shall have refused or neglected to do so, or unless the nature of the injury required such treatment and services and the employer or his superintendent or foreman having knowledge of such injury shall have neglected to provide the same, nor shall any claim for medical or surgical treatment be valid and enforceable as against such employer, unless within twenty days following the first treatment, the physician giving such treatment, furnish to the employer and the industrial commissioner a report of such injury and treatment, on a form prescribed by the industrial commissioner All fees and other charges for such treatment and services shall be subject to regulation by the commissioner as provided in section twenty-four of this chapter, and shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living

§ 2 This act shall take effect immediately

\* Matter in italics is new matter in brackets [ ] is old law to be omitted.

## IN ASSEMBLY

A Int No 64 (conc S Int 11)—See concurrent Senate Int No 11, for digest of bill  
No action on bill as yet

A Int No 120—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would add new section 213, Labor Law, requiring employers to furnish nursing and first aid service in factories, mercantile and other establishments

Referred to Labor and Industries Committee  
No action on bill as yet

A Int No 123—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would add new subdivision 10-a, section 360, Tax Law, by permitting deduction from income for tax purposes of all expenses paid during the year for medical, surgical or dental services

Referred to Taxation and Retrenchment Committee

No action on bill as yet

### MEDICAL INSPECTION IN SCHOOLS BILL

A Int No 127—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would amend sections 570, 571, Education Law, by providing that boards of education and trustees shall appoint physicians and dentists and may employ nurses for service in schools

Referred to Public Education Committee  
No action on bill as yet

A Int No 152—A bill introduced in the Assembly by Assemblyman Morris Weinfeld, would amend section 13, Workmen's Compensation Law, by striking out provision that claim for medical treatment shall not be valid against employer unless physician within 20 days following first treatment furnish report of injury

Referred to Labor and Industries Committee  
No action on bill as yet

A Int 167—A bill introduced in the Assembly by Assemblyman Joseph Gavagan of New York County, would amend sections 40, 115, Workmen's Compensation Law, relative to compensation and time limit in case of occupational diseases

Referred to Labor and Industries Committee  
No action on bill as yet

Int 167

IN ASSEMBLY,

January 14, 1925

Introduced by Mr Gavagan—read once and referred to the Committee on Labor and Industries

## AN ACT

To amend the workmen's compensation law, in relation to compensation for occupational diseases

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section forty of chapter eight hundred and sixteen of the laws of nineteen hundred and thirteen, entitled "An act in relation to assuring compensation for injuries or death of certain employees in the course of their employment and repealing certain section of the labor law relating thereto, constituting chapter sixty-seven of the consolidated laws," as re-enacted by chapter forty-one of the laws of nineteen hundred and fourteen and amended by chapter six hundred and fifteen of the laws of nineteen hundred and twenty-two, is hereby amended to read as follows

§ 40 Time limit Neither the employee nor his dependents shall be entitled to compensation for disability or death resulting from disease unless the disease is due to the nature of his employment and contracted therein within the twelve months previous to the date of disablement, or, in case of apparent recovery from the disease by which the employee is enabled to resume such occupation, unless a relapse or aggravation of such disease was contracted, with resulting disablement, within twelve months from the date of such subsequent disablement, whether under one or more employers

§ 2 Section one hundred and fifteen of such chapter, as so re-enacted and as amended by chapter six hundred and fifteen of the laws of nineteen hundred and twenty-two, is hereby amended to read as follows

§ 115 Limitation of time No limitation of time provided in this chapter shall run as against any person who is mentally incompetent or a minor so long as he has no committee or guardian, nor shall any such limitation of time with respect to a claim for occupational disease begin to run until actual disablement therefrom, nor, in case the nature of the disease was not discovered until after such disablement, until the date of such discovery

§ 3 This act shall take effect immediately

EXPLANATION.—Matter in italics is new, matter in brackets [ ] is old law to be omitted

A Int No 182—A bill introduced in the Assembly by Assemblyman John Meegan of Erie County, would amend subdivision 6, section 15, Workmen's Compensation Law, by providing



compensation for disability shall not exceed \$30 per week, instead of \$20 as at present

Referred to Labor and Industries Committee

No action on bill as yet

Int 182

IN ASSEMBLY,

January 14, 1925

Introduced by Mr Meegan—read once and referred to the Committee on Labor and Industries

#### AN ACT

To amend the workmen's compensation law, in relation to maximum and minimum compensation for disability

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Subdivision six of section fifteen of chapter eight hundred and sixteen of the laws of nineteen hundred and thirteen, entitled "An act in relation to assuring compensation for injuries or death of certain employees in the course of their employment and repealing certain sections of the labor law relating thereto, constituting chapter sixty-seven of the consolidated laws," as re-enacted by chapter forty-one of the laws of nineteen hundred and fourteen, and as last amended by chapter six hundred and fifteen of the laws of nineteen hundred and twenty-two, is hereby amended to read as follows

6 Maximum and minimum compensation for disability Compensation for disability shall not exceed [twenty] thirty dollars per week not be less than eight dollars per week, provided, however, that if the employee's wages at the time of injury are less than eight dollars per week, he shall receive his full weekly wages

§ 2 This act shall take effect immediately

EXPLANATION—Matter in italics is new matter in brackets [ ] is old law to be omitted

A Int No 184—A bill introduced in the Assembly by Assemblyman F A Miller of Kings County, would amend section 118, Workmen's Compensation Law, by authorizing physical examinations and practical tests of claimants to determine loss of use and proportionate loss of use of a member, result and test to be part of record

Referred to Labor and Industries Committee  
No action on bill as yet

#### THE CHIROPRACTIC BILL

A Int No 185—A bill introduced in the Assembly by Assemblyman William Nicoll of Schenectady County, would define and regulate the practice of chiropractic

Referred to Public Health Committee

No action on bill as yet

A Int No 191—A bill introduced in the Assembly by Assemblyman Samuel Rosenman of

New York County, would amend section 21, Workmen's Compensation Law, by providing in proceeding to enforce a claim it shall be presumed that an accidental injury, if proven, arose out of and in course of employment

Referred to Labor and Industries Committee

No action on bill as yet

Int 191

IN ASSEMBLY

January 14, 1925

Introduced by Mr Rosenman—read once and referred to the Committee on Labor and Industries

#### AN ACT

To amend the workmen's compensation law, in relation to presumptions

*The People of the State of New York represented in Senate and Assembly, do enact as follows*

Section 1 Section twenty-one of chapter eight hundred and sixteen of the laws of nineteen hundred and thirteen, entitled "An act in relation to assuring compensation for injuries or death of certain employees in the course of their employment and repealing certain sections of the labor law relating thereto, constituting chapter sixty-seven of the consolidated laws," as re-enacted by chapter forty-one of the laws of nineteen hundred and fourteen, and as last amended by chapter five hundred and sixty-eight of the laws of nineteen hundred and twenty-three, is hereby amended to read as follows

§ 21 Presumptions In any proceeding for the enforcement of a claim for compensation under this chapter, it shall be presumed in the absence of substantial evidence to the contrary

1 That the claim comes within the provision of this chapter,

2 That an accidental injury, if proven, arose out of and in the course of the employment,

[2] 3 That sufficient notice thereof was given,

[3] 4 That the injury was not occasioned by the wilful intention of the injured employee to bring about the injury or death of himself or another

[4] 5 That the injury did not result solely from the intoxication of the injured employee while on duty[ ],

[5] 6 That the contents of verified medical and surgical reports introduced in evidence by claimants for compensation shall constitute prima facie evidence of fact as to the matter contained therein

§ 2 This act shall take effect immediately

EXPLANATION—Matter in italics is new matter in brackets [ ] is old law to be omitted

A Int No 201—A bill introduced in the Assembly by Assemblyman Frederick L Hackenburg of New York County, would amend section 3, Workmen's Compensation Law, by providing

for compensation for disabilities or death resulting from poisoning by benzine or by chlorine or iodine derivatives of petroleum products etc  
 Referred to Labor and Industries Committee  
 No action on bill as yet

Int 201

IN ASSEMBLY,

January 15, 1925

Introduced by Mr Hackenburg—read once and referred to the Committee on Labor and Industries

## AN ACT

To amend the workmen's compensation law, in relation to occupational diseases

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Subdivision two of section three of chapter eight hundred and sixteen of the laws of nineteen hundred and thirteen, entitled "An act in relation to assuring compensation for injuries or death of certain employees in the course of their employment, and repealing certain sections of the labor law relating thereto, constituting chapter sixty-seven of the consolidated laws," as re-enacted by chapter forty-one of the laws of nineteen hundred and fourteen, and last amended by chapter six hundred and fifteen of the laws of nineteen hundred and twenty-two, is hereby amended to read as follows

2 Occupational diseases Compensation shall be payable for disabilities sustained or death incurred by an employee resulting from the following occupational diseases

## Column 1

## Column 2

Description of diseases	Description of process
1 Anthrax	1 Handling of wool, hair, bristles, hides or skins
2 Lead poisoning or its sequelae	2 Any process involving the use of lead or its preparations or compounds
3 Zinc poisoning or its sequelae	3 Any process involving the use of zinc or its preparations or compounds or alloys
4 Mercury poisoning or its sequelae	4 Any process involving the use of mercury or its preparations or compounds
5 Phosphorus poisoning or its sequelae	5 Any process involving the use of phosphorus or its preparations or compounds
6 Arsenic poisoning or its sequelae	6 Any process involving the use of arsenic or its preparations or compounds

## Column 1

7 Poisoning by wood alcohol

8 Poisoning by benzene (benzol) or its homologues or analogues or by nitro-, [hydro- and] hydroxy- or amido-derivatives of benzene ([di-nitro-] benzol, anilin, and others)) or their homologues or analogues, including anilin, phenol, picric acid, trinitrotoluol, or its sequelae

9 Poisoning by carbon bisulphide or its sequelae

10 Poisoning by nitrous fumes or its sequelae

11 Poisoning by nickel carbonyl or its sequelae

12 [Dope poisoning (poisoning by tetrachlor - methane or any substance used as or in conjunction with a solvent for acetate of cellulose)] Poisoning by chlorine, bromine, or iodine derivatives of petroleum products, including carbon tetrachlorine, tetrachlorethane, methyl bromide or its sequelae

13 Poisoning by formaldehyde and its preparations

## Column 2

7 Any process involving the use of wood alcohol or any preparation containing wood alcohol

8 Any process involving the production or use of [a] benzene (benzol) or its homologues or analogues or of nitro-, [hydro-] hydroxy- or amido derivatives of benzene (benzol) or [its preparations or compounds] their homologues and analogues

9 Any process involving the use of carbon bisulphide or its preparations or compounds

10 Any process in which nitrous fumes are evolved

[1] 11 Any process in which nickel carbonyl gas is evolved

12 Any process involving the production or use of [any substance used as or in conjunction with a solvent for acetate of cellulose] chlorine, bromine, or iodine derivatives of petroleum products

13 Any process involving the use of formaldehyde and its preparations

- 14 Chrome ulceration or its sequelae

15 Epitheliomatous cancer or ulceration of the skin or of the corneal surface of the eye, due to tar, pitch, bituane, mineral oil or paraffin, or any compound, product or residue of any of these substances

16 Glanders

17 Compressed air illness or its sequelae

18 Miners' diseases, including only cellulitis, bursitis, ankylostomiasis, tenosynovitis and nystagmus

19 Cataract in glass workers
- Any process involving the use of chromic acid or bichromate or ammonium, potassium, or sodium, or their preparations

Handling or use of tar, pitch, bitumen, mineral oil, or paraffin or any compound, product or residue of any of these substances

Care or handling of any equine animal or the carcass of any such animal

Any process carried on in compressed air

Any process involving mining

Processes in the manufacture of glass involving exposure to the glare of molten glass

Section 1 Chapter eight hundred and sixteen of the laws of nineteen hundred and thirteen, entitled "An act in relation to assuring compensation for injuries or death of certain employees in the course of their employment, and repealing certain sections of the labor law relating thereto, constituting chapter sixty-seven of the consolidated laws," as re-enacted by chapter forty-one of the laws of nineteen hundred and fourteen, and last amended by chapter six hundred and fifteen of the laws of nineteen hundred and twenty-two, is hereby amended by adding to subsection two of section three a new subdivision, to be numbered twenty-two, to read as follows

- 22 Any process involving the use or handling of gasoline, benzine, naphtha, or other petroleum products
- 22 Poisoning by gasoline benzine, naphtha or other volatile petroleum products, or its sequelae

§ 2 This act shall take effect immediately

A Int No 203—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would amend section 3, Workmen's Compensation Law, by providing for compensation in case of infection or inflammation of skin on contact surfaces, due to oils, cutting compound or lubricants or due to dust, liquids, fumes, gases or vapors

Referred to Labor and Industries Committee  
No action on bill as yet

Int 203

IN ASSEMBLY,  
January 15, 1925

Introduced by Mr Reich—read once and referred to the Committee on Labor and Industries

AN ACT

To amend the workmen's compensation law, in relation to occupational diseases

*The People of the State of New York represented in Senate and Assembly do enact as follows*

Section 1 Chapter eight hundred and sixteen of the laws of nineteen hundred and thirteen, entitled "An act in relation to assuring compensation for injuries or death of certain employees in the course of their employment, and repealing certain sections of the labor law relating thereto, constituting chapter sixty-seven of the consolidated laws," as re-enacted by chapter forty-one of the laws of nineteen hundred and fourteen, and last amended by chapter six hundred and fifteen of the laws of nineteen hundred and twenty-two, is hereby amended by adding to subsection two of section three a new subdivision to be numbered twenty-one, to read as follows

\* EXPLANATION—Matter in *italics* is new matter in brackets [ ] is old law to be omitted.

A Int No 202—A bill introduced in the Assembly by Assemblyman William Hart of Richmond County, would amend section 3, Workmen's Compensation Law, by providing for compensation in case of poisoning by gasoline or other volatile petroleum products

Referred to Labor and Industries Committee  
No action on bill as yet

Int 202

IN ASSEMBLY,  
January 15 1925

Introduced by Mr Hart—read once and referred to the Committee on Labor and Industries

AN ACT

To amend the workmen's compensation law in relation to occupational diseases

*The People of the State of New York represented in Senate and Assembly do enact as follows*

- 21 Infection or inflammation of the skin on contact surfaces due to oils, cutting compounds or lubricants, or due to dust, liquids, fumes, gases or vapors
- 21 Any process involving the use or handling of oils, cutting compounds or lubricants, or involving contact with dust, liquids, fumes, gases or vapors

§ 2 This act shall take effect immediately

A Int No 204—A bill introduced in the Assembly by Assemblyman Michael Reilly of Kings County, would amend section 3, Workmen's Compensation Law, by providing for compensation in case of diseases due to inhaling silica dust

Referred to Labor and Industries Committee  
No action on bill as yet

Int 204

IN ASSEMBLY,

January 15, 1925

Introduced by Mr Reilly—read once and referred to the Committee on Labor and Industries

#### AN ACT

To amend the workmen's compensation law, in relation to occupational diseases

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Chapter eight hundred and sixteen of the laws of nineteen hundred and thirteen, entitled "An act in relation to assuring compensation for injuries or death of certain employees in the course of their employment, and repealing certain sections of the labor law relating thereto, constituting chapter sixty-seven of the consolidated laws" as re-enacted by chapter forty-one of the laws of nineteen hundred and fourteen, and last amended by chapter six hundred and fifteen of the laws of nineteen hundred and twenty-two, is hereby amended by adding to subsection two of section three a new subdivision, to be numbered twenty, to read as follows

- 20 Silicosis (fibroid phthisis due to inhaling silica dust), or its sequelae
- 20 Any process involving exposure to the inhalation of silica dust

Section 2 This act shall take effect immediately

A Int No 214—A bill introduced in the Assembly by Assemblyman Lewis G Stapley of Livingston County, would amend section 107, State Charities Law, by authorizing investigations by superintendent or officer designated by him, and authorizing an arrangement for use of laboratory service of hospital

Referred to Judiciary Committee  
No action on bill as yet

#### THE NARCOTIC BILL

A Int No 215 (conc S Int 115)—See con current Senate Int No 115, for digest  
No action on bill as yet

A Int No 216 (conc S Int 116)—See con current Senate Int No 116 for digest  
No action on bill as yet

A Int No 229—A bill introduced in the Assembly by Assemblyman A Spencer Field of New York County, would add new section 579 b, Education Law, providing for county supervisors to supervise education of children with retarded mental development

Referred to Public Education Committee  
No action on bill as yet

A Int No 233—A bill introduced in the Assembly by Assemblyman Paul Kammerer of New York County, would amend section 28, Workmen's Compensation Law, by authorizing industrial board to permit claim for compensation to be filed within two years after accident or death

Referred to Labor and Industries Committee  
No action on bill as yet

A Int No 236 (conc S Int 228)—See con current Senate Int No 228 for digest  
No action on bill as yet

A Int No 237 (conc S Int 231)—A bill introduced in the Assembly by Assemblyman T C Moore of Westchester County, concurrent Senate Int 231, introduced in the Senate by Senator J Griswold Webb of Clinton Corners, N Y, would add new section 16-b, State Charities Law, empowering State Charities Board to visit and inspect places where children, for appearance in court, are held and to establish rules therefor

Referred to Judiciary Committee in the Assembly and to General Laws Committee in Senate

No action on bill as yet

A Int No 301—A bill introduced in the Assembly by Assemblyman Frank H Lattin of Orleans County, would amend section 13, Workmen's Compensation Law, by permitting injured employees, at employer's expense, to engage medical or other attendance

Referred to Labor and Industries Committee  
No action on bill as yet

Int 301  
IN ASSEMBLY,  
January 20, 1925

Introduced by Mr Lattin—read once and referred to  
the Committee on Labor and Industries

AN ACT

To amend section thirteen of the workmen's compensa-  
tion act

*The People of the State of New York, represented in  
Senate and Assembly, do enact as follows*

Section 1 Section thirteen of chapter six hun-  
dred fifteen of the laws of nineteen hundred  
and twenty-two, entitled "An act to amend the  
workmen's compensation law, generally," is here-  
by amended to read as follows

§ 13 Treatment and care of injured employees  
[The employee shall promptly provide for an]  
*An injured employee may, at the expense of the  
employer, employ or engage such medical, sur-  
gical or other attendance or treatment, nurse and  
hospital service, medicine, crutches and apparatus  
for such period as the nature of the injury or the  
process of recovery may require [If the em-  
ployer fail to provide the same, after request by  
the injured employee such injured employee may  
do so at the expense of the employer] The em-  
ployee shall [not] be entitled to recover any  
amount expended by him for such treatment or  
services [unless he shall have requested the em-  
ployer to furnish the same and the employer shall  
have refused or neglected to do so, or unless the  
nature of the injury required such treatment and  
services and the employer or his superintendent  
or foreman having knowledge of such injury  
shall have neglected to provide the same, nor  
shall] No [any] claim for medical or surgical  
treatment shall be valid and enforceable, as  
against such employer, unless within twenty days  
following the first treatment, the physician giving  
such treatment, furnish to the employer and the  
industrial commissioner a report of such injury  
and treatment, on a form prescribed by the in-  
dustrial commission All fees and other charges  
for such treatment and services shall be subject  
to regulation by the commissioner, as provided  
in section twenty-four of this chapter, and shall  
be limited to such charges as prevail in the same  
community for similar treatment of injured per-  
sons of a like standard of living*

§ 2 This act shall take effect immediately

\* EXPLANATION.—Matter in italics is new matter in brackets [ ]  
is old law to be omitted

A Int No 302—A bill introduced in the As-  
sembly by Assemblyman Lewis G Stapley of  
Livingston County, would add new section 151,  
Labor Law, permitting employment of females  
at night in any occupation in which it is lawful  
for males to work at night

Referred to Labor and Industries Committee.  
No action on bill as yet

THE STATE DEPARTMENT OF EDU-  
CATION BILL AMENDING THE  
MEDICAL PRACTICE ACT

A Int No 307 (conc S Int. 211)—See con-  
current Senate Int No 211 for digest  
No action on bill as yet

A Int No 384—A bill introduced in the As-  
sembly by Assemblyman Samuel Mandelbaum of  
New York County, would add new section  
1097-a Greater New York Charter, requiring  
education board to furnish free eyeglasses to  
school children unable to pay therefor

Referred to Cities Committee  
No action on bill as yet

A Int No 386 (conc S Int 308)—A bill in-  
troduced in the Assembly by Assemblyman  
Charles P Miller of Genesee County, concur-  
rent Senate Int No 308, introduced in the Sen-  
ate by Senator James S Truman of Owego,  
N Y, would add new article 4-a, Workmen's  
Compensation Law, relative to fibroid phthisis  
(silicosis)

Referred to Labor and Industries Committees  
of both houses

No action on bill as yet

Int No 386

Introduced by Mr C P Miller  
AN ACT

To amend the workmen's compensation law, in relation  
to fibroid phthisis (Silicosis)

Section 1 Chapter eight hundred and sixteen  
of the laws of nineteen hundred and thirteen, en-  
titled "An act in relation to assuring compensa-  
tion for injuries or death of certain employees in  
the course of their employment, and repealing  
certain sections of the labor law relating thereto  
constituting chapter sixty-seven of the consoli-  
dated laws," as re-enacted by chapter forty-one  
of the laws of chapter six hundred and fifteen  
of the laws of nineteen hundred and twenty-two,  
is hereby amended by the insertion therein of a  
new article, to be article four-a, to read as  
follows

ARTICLE 4-A

FIBROID PHTHISIS (SILICOSIS)

- |            |   |
|------------|---|
| Section 60 | Definitions   |
| " 61       | Fibroid phthisis (silicosis) treated<br>as accident |
| " 62       | Limitation of employments                           |
| " 63       | Right to compensation                               |
| " 64       | Duties of employers                                 |
| " 65       | Duties of employees                                 |
| " 66       | Medical examinations                                |
| " 67       | Board of Examining Physicians                       |
| " 68       | Date of disablement                                 |
| " 69       | Compensation, how payable                           |
| " 70       | Compensation, when not payable                      |
| " 71       | Diseases which are accidents                        |

- 21 Infection or inflammation of the skin on contact surfaces due to oils, cutting compounds or lubricants, or due to dust, liquids, fumes, gases or vapors
- 21 Any process involving the use or handling of oils, cutting compounds or lubricants, or involving contact with dust, liquids, fumes, gases or vapors

§ 2 This act shall take effect immediately

A Int No 204—A bill introduced in the Assembly by Assemblyman Michael Reilly of Kings County, would amend section 3, Workmen's Compensation Law, by providing for compensation in case of diseases due to inhaling silica dust

Referred to Labor and Industries Committee  
No action on bill as yet

Int 204

IN ASSEMBLY, January 15, 1925

Introduced by Mr Reilly—read once and referred to the Committee on Labor and Industries

#### AN ACT

To amend the workmen's compensation law, in relation to occupational diseases

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Chapter eight hundred and sixteen of the laws of nineteen hundred and thirteen, entitled "An act in relation to assuring compensation for injuries or death of certain employees in the course of their employment, and repealing certain sections of the labor law relating thereto, constituting chapter sixty-seven of the consolidated laws" as re-enacted by chapter forty-one of the laws of nineteen hundred and fourteen, and last amended by chapter six hundred and fifteen of the laws of nineteen hundred and twenty-two, is hereby amended by adding to subsection two of section three a new subdivision, to be numbered twenty, to read as follows

- 20 Silicosis (fibroid phthisis due to inhaling silica dust), or its sequelae
- 20 Any process involving exposure to the inhalation of silica dust

Section 2 This act shall take effect immediately

A Int No 214—A bill introduced in the Assembly by Assemblyman Lewis G Stapley of Livingston County, would amend section 107, State Charities Law, by authorizing investigations by superintendent or officer designated by him, and authorizing an arrangement for use of laboratory service of hospital

Referred to Judiciary Committee  
No action on bill as yet

#### THE NARCOTIC BILL

A Int No 215 (conc S Int 115)—See con current Senate Int No 115, for digest  
No action on bill as yet

A Int No 216 (conc S Int 116)—See con current Senate Int No 116 for digest  
No action on bill as yet

A Int No 229—A bill introduced in the Assembly by Assemblyman A Spencer Feld of New York County, would add new section 579 b, Education Law, providing for county supervisors to supervise education of children with retarded mental development

Referred to Public Education Committee  
No action on bill as yet

A Int No 233—A bill introduced in the Assembly by Assemblyman Paul Kammerer of New York County, would amend section 28, Workmen's Compensation Law, by authorizing industrial board to permit claim for compensation to be filed within two years after accident or death

Referred to Labor and Industries Committee  
No action on bill as yet

A Int No 236 (conc S Int 228)—See con current Senate Int No 228 for digest  
No action on bill as yet

A Int No 237 (conc S Int 231)—A bill introduced in the Assembly by Assemblyman T C Moore of Westchester County, concurrent Senate Int 231, introduced in the Senate by Senator J Griswold Webb of Clinton Corners, N Y., would add new section 16-b, State Charities Law, empowering State Charities Board to visit and inspect places where children, for appearance in court, are held and to establish rules therefor

Referred to Judiciary Committee in the Assembly and to General Laws Committee in Senate

No action on bill as yet

A Int No 301—A bill introduced in the Assembly by Assemblyman Frank H Lattin of Orleans County, would amend section 13, Workmen's Compensation Law, by permitting injured employees, at employer's expense, to engage medical or other attendance

Referred to Labor and Industries Committee  
No action on bill as yet

what degree, if any, the general physical capacity of the employee or the applicant for employment is impaired by silicosis. The employer or the employee, as a matter of right, may demand and shall receive a re-examination and a further report from the Board of Examining Physicians. All medical examinations and reports shall be made in accordance with rules prescribed by the industrial board.

§ 67 Board of Examining Physicians. The industrial board shall name a board of examining physicians, to consist of three physicians, graduates of a recognized medical college and with at least five years actual practice, who shall specialize in the diagnosis and treatment of silicosis, and to whom shall be referred only cases involving controversies in relation to the medical aspects of claims arising under this article, unless otherwise herein provided. The industrial board shall fix the fees of members of the Board of Examining Physicians and shall prescribe their duties within the limitations of this section.

§ 68 Date of disablement. For the purposes of this article the date of disablement shall be such date as the industrial board may determine on the hearing on the claim.

§ 69 Compensation, how payable. Compensation shall be payable under this article either in a lump sum or in weekly payments as the industrial board shall determine, in accordance with the following schedule:

1 For an employee whose disability has been diagnosed as the ante-primary stage of silicosis, twenty-six weeks of compensation.

2 For an employee whose disability has been diagnosed as the primary stage of silicosis, fifty-two weeks compensation.

3 For an employee whose disability has been diagnosed as the secondary stage of silicosis, one hundred and four weeks compensation.

4 For an employee whose disability has been diagnosed as the final stage of silicosis, five hundred and twenty weeks compensation.

§ 70 Compensation, when not payable. No compensation shall be paid for the death or disablement of any employee who re-engages in any of the employments enumerated herein after he has been suspended, nor to any applicant for employment whose application has been refused but who engages in any of the employments enumerated herein.

Neither the employee nor his dependants shall be entitled to compensation for death or disability resulting from silicosis unless the disease is due to the nature of the employment and unless he shall have been employed continuously for five years in any of the employments enumerated in this article.

It being the policy and intent of this article to debar from employment in any of the employments herein, for the protection of their health and the conservation of their capacity for work,

any persons found to be physically unfit, an award of compensation hereunder shall be deemed to be final and no claim for compensation for death or disability from silicosis thereafter shall be valid and no further compensation shall be paid, provided, however, that nothing herein stated shall affect the rights of an employee to recover compensation in respect to an accidental injury or death arising out of and in the course of his employment in any other occupation than those enumerated in this article.

§ 71 Diseases which are accidents. Nothing in this article shall affect the rights of an employee to recover compensation in respect to a disease to which this article does not apply if the disease is an accidental personal injury within the meaning of subdivision seven of section two of this chapter.

§ 2 This act shall take effect January 1, 1926.

A Int No 399 (conc S Int 283)—See concurrent Senate Int No 283 for digest.

No action on bill as yet

Int. 399

January 23, 1925

Introduced by Mr Lattin—read once and referred to the Committee on Internal Affairs.

#### AN ACT

To amend the county law, in relation to public health nurses.

*The People of the State of New York, represented in Senate and Assembly do enact as follows:*

Section 1 Subdivision forty-four of section twelve of chapter sixteen of the laws of nineteen hundred and nine, entitled "An act in relation to counties, constituting chapter eleven of the consolidated laws," such subdivision having been added by chapter one hundred and thirty of the laws of nineteen hundred and twenty-one, and amended by chapter sixty-seven of the laws of nineteen hundred and twenty-four, is hereby renumbered as subdivision forty-four-a, and amended to read as follows:

[44] 44-a The board of supervisors of any county, except a county constituting a general health district created under the public health law, shall have power to appoint and employ and provide for the expenses of such number of public health nurses as it may deem proper. Such nurses shall work under the direction of a committee of members of the board of supervisors to be known as the committee on public health. Any such public health nurse may be assigned by such committee to prenatal care and maternity protection, the reduction of infant mortality, the safeguarding of the health of children, the discovery and visitation of cases of tuberculosis, the prevention and control of communicable disease, the care of the sick who may otherwise be unable to secure adequate care, the instruction of members of households in which there is a sick per-

§ 60 Definitions Whenever used in this article

1 "Fibroid phthisis" means an inelastic fibrous condition of the lung tissue caused by the inhalation of particles of free crystalline silica, which shall be referred to as "silicosis"

2 "Ante-primary stage" means that physical signs of damage to the lungs, short of definite physical signs of silicosis, have become evident and that such damage has supervened during and in consequence of employment in any of the employments enumerated herein

3 "Primary stage" means that definite and specific physical signs of silicosis are or have been present and that capacity for work is or has been impaired by that disease in consequence of employment in any of the employments enumerated herein, though not seriously and permanently

4 "Secondary stage" means that definite and specific physical signs of silicosis are or have been present and that capacity for work is seriously and permanently-partially impaired by the disease in consequence of employment in any of the employments enumerated herein, but that the employee is not totally permanently disabled and can engage in other employment

5 "Final stage" means that definite and specific physical signs of silicosis are or have been present and that capacity for work has been totally and permanently impaired by the disease in consequence of employment in any of the employments enumerated herein, and that employee cannot engage in any employment

6 "Suspended" means that an employee, or an applicant for employment, in one of the employments enumerated herein has been examined by a physician and his physical condition has been found to be such that he should not engage in any of the employments enumerated herein, and that such employee has been apprised of his physical condition and advised not to engage in such employments

§ 61 Fibroid phthisis (silicosis) treated as accident The disablement of an employee engaged in any of the employments enumerated in section sixty-two, resulting in fibroid phthisis (silicosis) as herein defined, shall be treated as the happening of an accident within the meaning of this chapter and the practice and procedure provided in this chapter shall apply to all proceedings under this article, except where specifically otherwise provided herein

§ 62 Limitation of employments Notwithstanding the provisions of any other section of this chapter the application of this article shall be limited to the following occupations or employments Miners, quarrymen and tunnel workers, stone masons' work and granite cutting, pottery workers and persons employed in the manufacture of refractory silica bricks and flint knapping

§ 63 Right to compensation If an employee is disabled or dies and his disability or death is caused by silicosis as defined herein, and the disease is due to the nature of the employment as herein described, he or his dependants shall be entitled to compensation in accordance with the provisions of this article

§ 64 Duties of employers It shall be the duty of every employer in any of the employments enumerated herein

1 To cause to have made a medical examination of every person in his employ who is exposed to silica dusts, within three months after this article takes effect, to cause to have made a medical examination of every applicant for employment in any process where silica dusts exist, to cause to have made a biennial medical examination of every person in his employ who is exposed to silica dusts, at such time and in such manner as the commissioner shall determine If such medical examination shall disclose evidence of silicosis in any stage the employee or the applicant for employment shall be suspended

2 To refuse employment to any person in any process wherein silica dusts exist if the medical examination discloses (a) that the chest is not of average development with satisfactory expansion, (b) that there is a deformity or obstruction of the upper air passages or elsewhere which interferes with respiration, (c) that there are signs of present or past disease of the lungs or heart, (d) that there are signs of present or past tuberculosis of any region

3 To use every reasonable means to exhaust or so dispose of silica dusts as to minimize the hazard

4 Violation of this section shall constitute a misdemeanor punishable, for the first offense, by a fine of fifty dollars, for the second offense by a fine of one hundred dollars, and for the third offense by a fine of one thousand dollars or one year in jail, or both

The industrial board shall prescribe forms or make rules for carrying into effect the provisions of this section

§ 65 Duties of employees It shall be the duty of every employee or applicant for employment in any of the employments enumerated herein

1 To submit himself to medical examination as herein provided

2 To furnish true information to his employer or prospective employer regarding his past employment in the employments enumerated herein

The industrial board shall, if necessary, make rules for carrying into effect the provisions of this section

§ 66 Medical examinations There shall be a written report for every medical examination made under the provisions of this article, in which the physician shall definitely certify to





# State Department of Health



## CENSORSHIP OF RADIO STATIONS BROADCASTING HEALTH TALKS NEEDED

Since March, 1922, the New York State Department of Health has broadcasted a health talk weekly from station WGY, Schenectady. The United States Public Health Service and a few other States have maintained similar services. The good which has resulted through spreading reliable information to vast unseen audiences can not be measured, but it is undoubtedly one of the best, if not the best means of promoting the education of the public in matters of health.

Unfortunately, quacks, fakirs and charlatans have not been slow to recognize its advantages, and some broadcasting stations have evidently not had the proper kind of censorship over material broadcasted or else their censors have failed to recognize the difference between the true and the false. Some time ago one of the larger stations on the Atlantic seaboard allowed a food faddist to

broadcast personal notions regarding diet and its supposed effect in the development of cancer. More recently a talk on drugless therapy was given from a station controlled by a newspaper. In this talk misstatements regarding the manufacture of diphtheria antitoxin were made and its value in curing diphtheria ridiculed.

Evidently there is need for some form of control over the kind of material allowed to be broadcast. That some action along this line will sooner or later be demanded is indicated by a recent action of the California State Medical Association in establishing a Medical Radio Broadcasting Committee, which is charged with the promulgation of a set of rules to be observed by the members of the association and the presentation of a resolution regarding the subject to the American Medical Association.

---

## AN INTERESTING CASE OF CEREBROSPINAL MENINGITIS

Dr W H Munson, District State Health Officer, was recently called in consultation by a local health officer to see a boy nearly two years old, who had been taken ill with sore throat and fever. Diphtheria was suspected and 36,000 units of antitoxin were administered. A throat culture was later reported negative. Two days after the onset a rash developed which was well distributed over the body, legs and arms. The child continued to have a fever (102 deg F) with profuse discharge from the nose and throat and with marked enlargement of the cervical glands.

At the time of examination there was a marked discharge of a milky secretion from the throat and nose, which was easily wiped out. No membrane could be seen. Babinski's sign was present. Knee jerks were absent, likewise the cremasteric reflexes. There was apparently rigidity of the back and neck muscles. The rash was like that seen on persons exposed to intense cold,—mottled, dark

purple, irregular in shape,—giving a lace-work effect. It was not elevated and it faded on pressure. It covered the forearms and lower legs, little suggestion of it being left on the body and none on the face. Pupils were mid-wide, regular, with sluggish reaction to light, no strabismus. Mental condition was semi-stuporous. There was marked bilateral enlargement of cervical lymph nodes. There was involuntary passage of urine.

Dr Munson states that his tentative diagnosis was meningitis. He advised spinal puncture and offered to do it, but this was not accepted. Later a spinal puncture was made but owing to the presence of a great deal of blood in the fluid it proved to be of little value as a diagnostic aid. Later he again saw the case with the health officer and a specialist. On this second examination there was no doubt about the diagnosis, as marked retraction of the head, rigid back and pronounced Kernig's sign had developed.

son, or to such other nursing duties as may seem appropriate to such committee. Except as hereinafter provided, the state commissioner of health or his authorized representatives shall have power to maintain general supervision over the work of such nurses.

With the approval of such committee the trustee or board of trustees of any common school district or the board of education of any union free school district within the county, may designate any such nurse as a school nurse, to perform, in addition to her other duties, the duties of a school nurse for any school or schools under such respective trustee, board of trustees or board of education. Any such nurse so designated shall perform her duties as school nurse under the direction of the appropriate school authorities and under the provisions of the education law and under the regulations prescribed pursuant thereto.

The board of supervisors may appoint an advisory committee of citizens, of whom at least one shall be a physician and at least one a woman, to advise with and assist the heretofore mentioned committee on public health in the organization and direction of the work of such public health nurses.

§ 2 This act shall take effect immediately.

A Int No 413 (conc S Int 282)—See concurrent Senate Int No 282 for digest.

No action on bill as yet.

Int 413

January 26, 1925

Introduced by Mr Wallace

#### AN ACT

To amend the public health law, in relation to violations of rules or orders of local boards of health.

*The People of the State of New York, represented in Senate and Assembly, do enact as follows:*

Section 1 Section twenty-one of chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," as last amended by chapter five hundred and forty-nine of the laws of nineteen hundred and thirteen, is hereby amended to read as follows:

§ 21 General powers and duties of local boards of health. Every such local board (remainder same as old law) in junction such violations, or otherwise to enforce such orders and regulations. (New matter begins here.) Every such local board of health may prescribe that a person who wilfully violates or refuses or omits to comply with any lawful order or regulation prescribed by it or a local health officer, shall be guilty of a misdemeanor punishable by a fine not exceeding fifty dollars or imprisonment not exceeding six months, and a court of special sessions in the territory over which such local board

has jurisdiction shall have jurisdiction of such misdemeanor. (New matter ends here.)

§ 2 This act shall take effect July first, nineteen hundred and twenty-five.

A Int No 414 (conc S Int 278)—See concurrent Senate Int No 278 for digest.

No action on bill as yet.

A Int No 422—A bill introduced in the Assembly by Assemblyman Samuel Rosenman of New York County, would amend section 352, Civil Practice Act, by providing physicians and nurses may disclose professional information as witnesses in action to annul marriage on ground of fraud.

Referred to Codes Committee.

No action on bill as yet.

Int 422

January 26, 1925

Introduced by Mr Roseman.

#### AN ACT

To amend the civil practice act, in relation to the competency of testimony of physicians in certain cases.

*The People of the State of New York, represented in Senate and Assembly, do enact as follows:*

Section 1 Section three hundred and fifty-two of the civil practice act is hereby amended to read as follows:

§ 352 Physicians and nurses not to disclose professional information. A person duly authorized to practice physic or surgery, or a professional or registered nurse, shall not be allowed to disclose any information which he acquired in attending a patient in a professional capacity, and which was necessary to enable him to act in that capacity, except, as a witness in an action to annul a marriage on the ground of fraud pursuant to the provisions of section eleven hundred and thirty-nine, unless, (remainder same as old law).

§ 2 This act shall take effect immediately.

A Int No 434—A bill introduced in the Assembly by Assemblyman Jerome C Ambro of Kings County, would amend section 355, Prison Law, by providing for removal to hospitals of prisoners confined either for civil or criminal cause, when they require immediate medical or surgical treatment.

Referred to Penal Institutions Committee.

No action on bill as yet.

A Int No 536 (conc S Int 351)—See concurrent Senate Int No 351 for digest.

No action on bill as yet.

A Int. No 570 (conc S Int 380)—See concurrent Senate Int No 380 for digest.

No action on bill as yet.

A pleurisy with effusion may be the first evidence of tuberculosis

Moist rales, localized above the third rib, constitute the most common sign of beginning tuberculosis. But the lesion may be anywhere else in the lung. This sign is one of the most difficult for an untrained physician to elicit. It requires some degree of skill on the part of the physician, and co-operation from the patient.

It is important to know when an X-ray picture is needed. An X-ray may show evidences of tuberculosis when no physical signs are present. On the other hand, the X-ray will reveal persisting tuberculous lesions which have healed, and yet may continue to give out crackling rales. The determining factor in the diagnosis of active disease is the presence or absence of constitutional disturbance.

Some cases of chronic fibrosis are carriers and spreaders of tuberculosis germs, for their lesions are progressive, and show a continual balance between extension and healing. They have a cough and emphysema with asthma, and are not sick enough to stay at home and take care of themselves. These cases are a menace to the community.

It is important to remember that chest conditions may be secondary to infections of the upper respiratory tract. A persistent bron-

chitis may clear up when the tonsils or sinuses are cured.

I will now show some lantern slides of X-ray pictures in which the X-ray was the determining factor in diagnosis.

Case One showed no physical signs. There was a cough for six months. The patient came for examination because of enlargement of the cervical glands. X-ray showed a dense area in one apex.

Case Two had digestive disturbances and a dry cough. The only physical sign was a slight dullness at one apex. The X-ray showed that apex to have a considerable involvement.

Case Three showed hemoptysis, positive sputum, and fever, with no physical signs. The X-ray showed a dense involvement in the root of one lung.

Case Four had an ischio-rectal abscess which healed in two months. There were no physical signs in the lungs. The X-ray showed an involvement of the middle of the right lower lobe.

In conclusion, remember, when examining a patient, to pick up the small signs and symptoms, even though they stretch over a history of several years, and piece them together into a clinical picture. This is not only a great service to the patient, but a very fascinating and satisfying achievement for the examining physician.

## BRONX COUNTY MEDICAL SOCIETY

The regular meeting of the Bronx County Medical Society was held at Hollywood Gardens January 21, 1925. The meeting was called to order at 9 P. M. the retiring President, Dr. Podvin, in the Chair.

Dr. Podvin addressed the members briefly outlining the work of the past year. He then presented Dr. S. M. Jacobs, the new president, who addressed the Society as follows:

"With the unprecedented growth of the Bronx County Medical Society, with the corresponding increase of members, the question of obtaining suitable quarters for our meetings commanded the attention of the previous administration and the solution of it was left to the incoming administration as a legacy. Though our borough has expanded it lacks adequate meeting places which would befit the dignity of our Society. The idea of building a home which would constitute the Medical Center in the Bronx has been conceived during the administration of my predecessor, Dr. Podvin. Yet ideas however exalted do not constitute the means for their realization. There will be no immediate solution to this momentous question unless each and every member is willing to subscribe to the Building Fund and to the raising of the annual dues from fifteen to twenty-

five dollars; else we will be obliged to lead a nomad's existence—meeting here and there for quite some time to come.

"As the success of the Society depends largely upon the numerical strength and the cooperation of its members, so the scientific sessions depend mainly upon the papers read and cases presented. There were underground rumblings, general dissatisfaction and open criticism that the papers presented were of no interest to the general practitioner and that the Scientific Committee has been lax and derelict in its duties. To overcome what seems to be unwarranted objections, we deemed it advisable to enlist the assistance of men well known in the medical world. Physicians of national reputation have signified their willingness to appear and read papers before this Society during the ensuing year. This, however, does not preclude members from presenting cases and participating in the discussions.

"Medicine from its very inception had to contend with and combat various cults, quacks and medical charlatans. Alchemy, astrology, priestcraft of the middle ages have been superseded by chiropractors, naturopaths, Christian Scientists, who arrogated to themselves the divine power of healing. Yet at no time have the cults made such

# NEWS NOTES

## PERIODIC HEALTH EXAMINATIONS IN NEW YORK COUNTY PRE-CLINICAL SIGNS OF DISEASE OF THE RESPIRATORY SYSTEM

By JAMES ALEXANDER MILLER, M D,  
NEW YORK.

Abstract of the ninth lecture in the Symposium on Periodic Health Examinations given in the New York Academy of Medicine on January 20, 1925, under the auspices of the Medical Society of the County of New York.

Pulmonary tuberculosis is by far the most common respiratory affection with which a physician will have to deal when he makes a periodic health examination. It comes on insidiously, like many other chronic diseases, and one cannot say just when the patient becomes slightly ill. A large responsibility is on the examining physician to determine where the border line is between health and disease.

The physician often runs across tuberculosis unexpectedly. It is such a big problem, and takes such a heavy toll in strength and lives that every physician must have it constantly in mind, be he a family doctor, an insurance examiner, or a physician in an industrial plant.

A family physician often knows a patient so well that he does not notice deviations from normal health. This accounts for many delays in the diagnosis of tuberculosis.

Another factor in delayed diagnosis is that the patient often comes to the physician in a casual manner, and demands merely a tonic because he does not feel just right, and will usually refuse to submit to an examination either from fear or from economy. A delay in diagnosis is not always the fault of the doctor, but still a great responsibility is on him.

There are other suspicious signs of pulmonary tuberculosis besides those in the chest.

If any person is below par in health and vigor, remember tuberculosis as a possibility.

It is a mistake to place undue stress on physical signs in the chest. Most physicians learn physical diagnosis by the examination of tuberculosis chests, and if they do not find physical signs readily, they are likely to conclude that tuberculosis is not present. Early tuberculosis often shows no physical signs on inspection, percussion, palpation, and auscultation. When physical signs are discoverable, tuberculosis has existed for a considerable time in most cases, and on tracing back the history, the physician will find a history of a series of relapsing infections whose evidences will be attacks of indigestion, or repeated colds which last for some time, or so-called malaria,

or cough, or fever, or pleurisy with effusion. There may have been an ischio-rectal abscess, or a spitting of blood which was ascribed to the throat. Such attacks may be spread over ten years, and during all that time tuberculosis may have been their sole cause. When a patient improves in intervals between attacks, the physician flatters himself that he has cured the trouble, but the tuberculosis condition continues exactly the same as before. Yet this is the stage when recovery may be expected in nearly every case. The intermissions in the symptoms and the apparent cures between the attacks are indications that the body has the power to overcome the disease if the physician will guide the patient in his mode of life. A physician has a great opportunity to recognize the tuberculous condition before the patient is worn out with cough, fever, and night sweats.

It is the duty of a physician who makes a periodic examination to get a full picture of the patient's health extending back for several years, and to pay particular attention to constitutional disturbances, such as malaise, fatigue, indigestion, and irritability. He will particularly look for slight signs of which a patient makes light. The very fact that the patient tries to explain them away is evidence that they exist and are annoying him.

There is danger of exaggerating the importance of physical signs. Dr Lawrason Brown gives five cardinal evidences of tuberculosis:

- 1 Positive sputum
- 2 Definite hemoptysis
- 3 Pleurisy with effusion
- 4 Localized rales on coughing at the apex
- 5 Characteristic X-ray changes at an apex

One or more of these signs will be present in almost every case.

The sputum will not usually show tubercle bacilli in the early stage of tuberculosis. The bacilli appear only in a later stage when the tubercles break down and ulceration occurs.

If hemoptysis is present, it is important to determine the source of the blood, whether from the lungs or the nasopharynx.

A pleurisy with effusion may be the first evidence of tuberculosis

Moist rales, localized above the third rib, constitute the most common sign of beginning tuberculosis. But the lesion may be anywhere else in the lung. This sign is one of the most difficult for an untrained physician to elicit. It requires some degree of skill on the part of the physician, and co-operation from the patient.

It is important to know when an X-ray picture is needed. An X-ray may show evidences of tuberculosis when no physical signs are present. On the other hand, the X-ray will reveal persisting tuberculous lesions which have healed, and yet may continue to give out crackling rales. The determining factor in the diagnosis of active disease is the presence or absence of constitutional disturbance.

Some cases of chronic fibrosis are carriers and spreaders of tuberculosis germs, for their lesions are progressive, and show a continual balance between extension and healing. They have a cough and emphysema with asthma, and are not sick enough to stay at home and take care of themselves. These cases are a menace to the community.

It is important to remember that chest conditions may be secondary to infections of the upper respiratory tract. A persistent bron-

chitis may clear up when the tonsils or sinuses are cured.

I will now show some lantern slides of X-ray pictures in which the X-ray was the determining factor in diagnosis.

Case One showed no physical signs. There was a cough for six months. The patient came for examination because of enlargement of the cervical glands. X-ray showed a dense area in one apex.

Case Two had digestive disturbances and a dry cough. The only physical sign was a slight dullness at one apex. The X-ray showed that apex to have a considerable involvement.

Case Three showed hemoptysis, positive sputum, and fever, with no physical signs. The X-ray showed a dense involvement in the root of one lung.

Case Four had an ischio-rectal abscess which healed in two months. There were no physical signs in the lungs. The X-ray showed an involvement of the middle of the right lower lobe.

In conclusion, remember, when examining a patient, to pick up the small signs and symptoms, even though they stretch over a history of several years, and piece them together into a clinical picture. This is not only a great service to the patient, but a very fascinating and satisfying achievement for the examining physician.

## BRONX COUNTY MEDICAL SOCIETY

The regular meeting of the Bronx County Medical Society was held at Hollywood Gardens January 21, 1925. The meeting was called to order at 9 P. M., the retiring President, Dr. Podvin, in the Chair.

Dr. Podvin addressed the members, briefly outlining the work of the past year. He then presented Dr. S. M. Jacobs, the new president, who addressed the Society as follows:

"With the unprecedented growth of the Bronx County Medical Society, with the corresponding increase of members, the question of obtaining suitable quarters for our meetings commanded the attention of the previous administration and the solution of it was left to the incoming administration as a legacy. Though our borough has expanded, it lacks adequate meeting places which would befit the dignity of our Society. The idea of building a home which would constitute the Medical Center in the Bronx has been conceived during the administration of my predecessor, Dr. Podvin. Yet ideas however exalted do not constitute the means for their realization. There will be no immediate solution to this momentous question unless each and every member is willing to subscribe to the Building Fund and to the raising of the annual dues from fifteen to twenty-

five dollars, else we will be obliged to lead a nomad's existence—meeting here and there for quite some time to come.

"As the success of the Society depends largely upon the numerical strength and the cooperation of its members, so the scientific sessions depend mainly upon the papers read and cases presented. There were underground rumblings, general dissatisfaction and open criticism that the papers presented were of no interest to the general practitioner and that the Scientific Committee has been lax and derelict in its duties. To overcome what seems to be unwarranted objections, we deemed it advisable to enlist the assistance of men well known in the medical world. Physicians of national reputation have signified their willingness to appear and read papers before this Society during the ensuing year. This, however, does not preclude members from presenting cases and participating in the discussions.

"Medicine from its very inception had to contend with and combat various cults, quacks and medical charlatans. Alchemy, astrology, priestcraft of the middle ages have been superseded by chiropractors, naturopaths, Christian Scientists, who arrogated to themselves the divine power of healing. Yet at no time have the cults made such

inroads and plied their nefarious trades upon the credulous, ignorant and the unwary as in this enlightened twentieth century. Their success may be attributed partly to our failure to understand the psychology of our patients. In our honest endeavor to combat disease, we have learned to regard a patient as a component of cells and tissues which have been permeated by microbes, we talk to him in terms of serums, vaccines, toxins and antitoxins and are prone to forget that he has a soul. Restricted by no code of ethics and hindered by no conscience, the adherents of the various cults utilize the lay press in promulgating and extolling the virtues of their craft, deriding and minimizing the true value of scientific medicine. It is true that the State through its Legislature should intervene and by legal enactments stop their nefarious activities. Our legislators, however well meaning, possess very little knowledge pertaining to public health and lack knowledge of the rudimentary principles of medicine upon which the health of the community depends. They fall gullable victims to any legislation in behalf of the cults due to the indifference of the medical profession at large and to the pressure exerted upon them by those interested in the passage of such bills. I would urge the Committee on Legislation to invite the respective Assemblymen and Senators and in a heart to heart talk discuss the various health bills that have been introduced affecting the medical profession and thereby the health of the community. I would also urge the Committee on Public Health to inaugurate a campaign of public health education and through the lay press acquaint the public with the true meaning, value and importance of scientific medicine as compared with the teachings of the cults. This should be carried out in a dignified manner lest we be accused of selfish and sinister motives.

"May I digress a moment to utter a word of praise and commend His Honor, our Governor, for his Message to the Legislature suggesting an amendment to the present Medical Practice Act, which would facilitate the prosecution and conviction of all illegal practitioners.

"In this era of preventive medicine, the endeavor of the medical profession is concentrated solely upon the prolongation of human life by halting and arresting disease in its incipency. The first to perceive the efficacy of periodic health examinations from a commercial standpoint was the New York Life Extension Institute. It employs members of our profession to conduct the examinations, exploiting the latter's knowledge for self-aggrandisement. The Metropolitan Life Insurance Company grants periodic examinations to its policy holders gratis. The Cornell Pay Clinic is, as I view it, another health center. The Post-Graduate Hospital announced recently its

intention of introducing a Health Service Clinic "with the purpose of aiding those who cannot afford a private physician" charging a mere pitance of five dollars for an examination to cover "the operating expense of the clinic." It is indeed high time that the members of our Society should awaken from their lethargy and assume the initiative in conducting the periodic examinations of their own patients. Both the Economic and Public Health Committees should devise ways and means for conducting such examinations by the family physicians.

"It is with great reluctance and some misgivings that I am to dwell in brief on an article which appeared recently in a lay periodical affecting the integrity and standing of the family physician. Supposedly an interview with some members of the American College of Surgeons, the author quoting no one in particular, casts aspersions and condemns the entire profession. The failure of the surgeons to repudiate the interview is but a tacit acknowledgment of their guilt. Without dwelling upon the charges, I vehemently resent and condemn the utilization of the lay press to ventilate their grievances. Such articles will have no salutary effect, but on the contrary will tend to undermine the confidence and sever the friendly relations between the patients and the family physician and to create converts to the cults.

"In conclusion permit me to assure you of my sincere appreciation of the honor you have conferred upon me. Sensitive as I am of the honor, I am conscious of the duties and responsibilities it entails. Should I, however, as presiding officer inadvertently overstep my prerogatives, I will merely ask your indulgence, forbearance and, above all, your cooperation."

Drs Benjamin H Archer, Nathan J Lapkin, Leon Peisachowitz, Henry I Scheer, Norman Strauss and Samuel Weinstein, were elected to membership.

#### THE SCIENTIFIC PROGRAM

The Clinical Symptoms of Coronary Occlusion, Louis Hamman, M D

Discussion by Drs Emanuel Libman, Harold E B Pardee, Bernard S Oppenheimer (by invitation), Henry Roth, Boas Ginzburg and J B Cohen

Dr Podvin moved that a vote of thanks be extended to Dr Hamman and the visitors who participated in the discussion.

This motion was unanimously carried by a rising vote.

The meeting adjourned at 11 15 P M

I J LANDSMAN, Secretary

## ACTIVITIES OF THE CAYUGA COUNTY MEDICAL SOCIETY

During the year 1924, the County Medical Society, through its Committee on Public Health and Sanitation, consisting of Dr C F McCarthy, Auburn, chairman, Drs H I Davenport and George C Sincerbeaux, Dr C E Goodwin, Weedsport, and Dr N L Woodford, Union Springs, were instrumental in accomplishing the three following projects

First The formation of a Committee for the eradication of bovine tuberculosis in Cayuga County Its representative on this Committee, the Chairman of the Committee on Health and Sanitation, appeared before the Board of Supervisors and obtained an appropriation of \$5,000 for the year 1924, and a like appropriation for this year, 1925 The Chairman of the Health and Sanitation Committee is a member of this Committee on the eradication of bovine tuberculosis, employing a full time county veterinarian Thousands of head of dairy cattle have already been examined for tuberculosis The County Medical Society obtained the petition of twenty-

one fraternal organizations of Auburn and Cayuga County in favor of this project

Second The County Medical Society was represented by Drs McCarthy, Sincerbeaux and Davenport on the Commission that prepared the milk code for the City of Auburn, which went into effect January 1st of this year, being a form of the Model Milk Code, allowing only a raw tuberculin tested and pasteurized milk to be sold within the City of Auburn

Third The County Medical Society, at the largely attended meeting held June 27, 1924, unanimously passed a resolution in favor of placing laboratories under state supervision and state aid The Medical Society made a vigorous campaign in favor of this, and obtained appropriation for the first year of \$12,000 It is represented on the Board of Managers by Dr H I Davenport for the term of five years, and Dr C F McCarthy for the term of four years

C F MCCARTHY

---

## THE MEDICAL SOCIETY OF THE COUNTY OF QUEENS

At the regular meeting of the Medical Society of the County of Queens, held at Jamaica, N Y, on January 28th, Dr Alfred C Beck read a paper entitled "The Management of the Late Toxemias of Pregnancy" Dr Beck divides the late toxemias into two classes

In the first class, including the patients suffering from nephrosis, the symptoms are apt to appear suddenly in patients previously in good health, and convulsions are apt to appear soon after onset of symptoms, following delivery or recovery patients rapidly improve and are not particularly prone to have recurrences in future pregnancies The patients in the other group, or those suffering from nephritis, are apt to show symptoms of toxemia early in pregnancy, with a gradual increase of severity, develop convulsions late, and after delivery or recovery improve slowly, and are apt to have repetition of the toxemia in future pregnancies Dr Beck emphasizes the importance of prophylaxis in the treatment, and in the presence of symptoms of toxemia, i.e, high bloodpressure, albuminuria, headache, oedema, or visual disturbance, advises eliminative and dietary treatment with rest and termination of the pregnancy, if the patient grows worse rapidly In the treatment of eclampsia, Dr Beck reported 48 cases treated consecutively at the Long Island College Hospital, the treatment including large doses of morphine, early phlebotomy, and avoidance of any interference that

might give rise to a convulsion This gave a much lower mortality than other methods of treatment

Dr T C Chalmers reported a case of influenza-pneumonia, type II, with adherent pericardium, the report being followed by a discussion by Dr T Stuart Hart and Dr L E LeWald

The President announced the appointment of Dr E A Flemming as Chairman of the Membership Committee, Dr D E McMahanas, Chairman of the Legislative Committee, and Dr W C A Steffen, as Chairman of the Committee on Publicity and Public Health Instruction, the last committee to undertake the publication of a monthly bulletin, to begin immediately

A resolution was adopted putting the Society on record as opposed to the so-called Narcotic, Medical Inspection, and Chiropractic Bills, and instructing the Secretary to urge the legislators from the County to vote against these bills

The following resolution was passed

"Resolved, that the approved sign for members of the Queens County Medical Society shall consist of the physician's name, with the title Dr, or preferably M D, that no other sign relating to the specialties shall be placed outside the building or in the window, but that if a member practicing one of the specialties desires to display such a sign inside the building, it shall be permissible"

J S THOMAS



# THE DAILY PRESS



The Poughkeepsie *Eagle*, January 17th, contains an account of the completion of the first student field practice in rural nursing, which was conducted in Pleasant Valley under the auspices of the Pleasant Valley Health Committee and the Teachers' College of Columbia University. The clipping gives the following description of the work

"The Dutchess County Health Association plans to receive a limited number of students for similar field practice at regular intervals. These nurses are enrolled students at Teachers' College who have taken a year's course in public health nursing as part of their college work. All of them have had previous successful experience in public health nursing in city work. The three months period in Dutchess County is for the purpose of giving them experience in rural nursing, which presents many problems quite different from city nursing due to extent of territory and the homes which have to be visited. Rural public health nursing has developed so rapidly in the past five years that it is only recently that educational institutions have recognized the fact that special preparation for this field will eliminate a great deal of the trial and error method which has prevailed hitherto. The Dutchess County Health Association is thus making a generous contribution to nursing education as it offers a practice field in rural sections through its affiliation with Teachers' College."

We have commented favorably on the publicity that has been given to the Mental Clinics which have been conducted under the auspices of the State Hospital Commission and the State Commission for Mental Defectives. The Glens Falls *Times*, January 22, contains an account of the Clinics which are held every month in Glens Falls. The article says

"Dr. R. D. Helmer, senior assistant physician of the Utica State Hospital, will see those who come for advice concerning mental or nervous conditions. He will be assisted by Miss Eva Schied, social worker, from that hospital. Dr. E. DuBois Elliott will see persons interested in backward or problem children, and will be assisted by Miss Luella Oagley of the State Commission for Mental Defectives.

"Children who have difficulty in doing school work, who are irritable, quarrelsome, hard to manage, nervous or retarded in mental or physical development, will find help at this clinic. All children should be accompanied by some-

one who can give the examiner a good history of the child's development and habits.

"Adults who show early symptoms of mental or nervous disorder and those whose mental condition is more marked, will also find this clinic to be of inestimable value to them, as the main object is to give advice and treatment to prevent further development. All consultations are confidential and no fee is charged.

"The aim is to co-operate with all local physicians and others who are interested in persons suffering from mental or nervous afflictions and to do everything possible along the lines of prevention. In cases where there is a family physician advice is given the patient and he is referred back to his physician for further care and treatment.

"The clinic is also for persons who are paroled from the State hospitals and who require further supervision and care to enable them to adjust themselves to outside surroundings. The number of clinics is gradually being extended throughout the State and from two to five clinics are being conducted by each State hospital every month in various localities. All of the physicians at these clinics are well trained in mental conditions and are competent to give the necessary advice.

"It is recommended that these clinics be used freely as consultation centres and that the general public avail themselves of their use."

We quote the article at some length because it is well calculated to educate the people generally in the possibility of diagnosing and treating nervous disorders. People generally do not realize that the development of the troubles can be arrested and that mental disorders may often be cured. We hope to see more articles like that in the Glens Falls *Times*.

The Geneva *Times*, January 22, contains an account of the address of Dr. Robert S. Breed, City Bacteriologist, before the Kiwanis Club on the subject of milk. He emphasized the care of milk bottles by the customers before the bottles are returned to the dairy. This is a phase of the problem which is not mentioned as often as it should be. The people who buy milk have a great responsibility in providing a pure milk supply. The article says

"There is a city ordinance which provides that milk bottles must be kept clean, and we



are now engaged in a campaign to keep milk bottles in better condition. We have more trouble with the men than with the women. All that we ask is to have the milk user rinse out the bottle so that it can be thoroughly sterilized when it is returned to the dealer. The ordinance says that milk bottles must be used for nothing other than milk containers, yet many times children are permitted to use them as playthings to scoop water out of the gutter. Women often come in to grocery stores and ask to have milk bottles filled with kerosene or vinegar.

"Men working on buildings are also offenders. They take milk with them for lunch and then throw the bottles away. The bottles lie around for some time and then are finally picked up and taken back to the station. Coffee is also allowed to dry into stains on the bottles and all these bottles must be washed by hand before they can be sterilized. The whole responsibility is not placed upon the public, for the drivers must collect the bottles and not permit them to stand around."

The relation of oysters to typhoid fever continues to be a leading topic for discussion, especially in the newspapers published in and around New York City. The agitation has led Departments of Health to plan thorough investigations of sewage discharging upon oyster grounds, and it may be expected that the certification of oyster grounds by the Health Departments will be a reliable indication that oysters from those sources may safely be eaten raw or in any other way. If this is done, the only remaining source of danger is the dishonesty of dealers in substituting oysters from polluted waters for those from certified grounds.

While many of the articles that have appeared in the newspapers have tended to increase the unreasoning fear of oysters, the following editorial from the *Utica Observer-Dispatch* is sane and sensible.

"The oyster industry has been shattered by the suspicion that has been cast upon oysters in connection with the typhoid cases in New York, Chicago, and some other cities. Thousands of people who are usually well employed throughout the winter and until the coming of warm weather, are out of work, and large sums of money invested in oyster beds and dredging and shipping equipment is making no return.

"And the worst of it all is that there is no positive evidence that oysters caused the disease.

"It may be that there is some particular section where oyster beds have become contaminated, and the one spot has caused all the mischief. Officials of the Department of Agriculture and the Public Health Service have made close examination of Long Island oyster beds and report especially as to those at Great South Bay that there is no contamination. Baltimore, which is a great oyster center, declared that there is no contamination in the beds of the Chesapeake Bay. There has been no falling off in the consumption of oysters in Baltimore and the surrounding cities and towns, and there has been no appearance of typhoid. The industry in the Chesapeake, which a week ago was flat, is again picking up and several plants have resumed work.

"There has been no danger whatever from properly cooked oysters, and it has been stated that if typhoid has resulted anywhere from the use of oysters, it has been from those eaten raw.

"The trouble teaches a tremendous lesson. If this great source of food, either shellfish or fish, cannot be kept free from contamination, then the public has lost the power to protect itself. Somewhere there has been failure and neglect. Polluted streams, bays, coves, inlets have been tolerated for the sake of saving somebody an expenditure that would prevent the pollution."

F O

# BOOK REVIEWS

**THREE PROBLEM CHILDREN** Narratives from the Case Records of a Child Guidance Clinic Publication No 2 of the Joint Committee on Methods of Preventing Delinquency, 50 East 42nd Street, New York City Octavo of 146 pages Price, \$1.00

Modern psychiatric knowledge is producing increasing evidence that adult criminality has its genesis in childhood and in the very roots which cause unhappiness, maladjustment, and conduct problems in children. A comprehensive survey of the sociological mental and physical factors in the behavior difficulties in children will lead to an understanding of the causes of not only juvenile delinquency but also of adult maladjustment and criminality, and will tend to the institution of effective prophylactic measures.

In publishing *Three Problem Children*, the Joint Committee on Methods of Preventing Delinquency has successfully demonstrated the feasibility of the application of modern psychiatric knowledge to the management of behavior difficulties in children. The book presents three case histories from the records of the large number of children who have been brought to the Bureau of Children's Guidance because they were presenting conduct disorders which could not be corrected by the parents or teachers. The first history is of a congenitally syphilitic girl, of normal intelligence but of poor heredity, retarded in school, very unhappy and on the verge of a serious mental break. The second is of a boy of superior intelligence, overstimulated and overpraised, raised in an unhappy and unwholesome environment, who was failing in school. The third is of a boy of inferior intelligence but possessing special aptitudes and abilities, who was embarking on a delinquent career.

The method of approach to the solution of the problems presented by each of these children is presented in a clear and literary style, and in a convincing, logical manner. The importance of the psychiatrist, the psychologist, and the social service worker in the management of conduct disorders is demonstrated in a forceful manner. This book will appeal to all interested in conduct disorders both in children as well as in adults. Because it is written in a style that will attract not only professional people but also laymen, the book is bound to contribute materially to the proper management of delinquency and maladjustments.

IRVING J SANDS, M.D.

**MATERNITY NURSING IN A NUTSHELL.** By ELIZABETH H WICKHAM, R. N. 28 illustrations. F. A. Davis Co., Philadelphia, 1924. Price, \$1.50 net.

The parts of this little work relating to maternity nursing, per se, are good, but the usefulness and value of the chapters relating to maternity diagnosis and treatment have been sacrificed because of brevity.

G. W. PHELPS

**NEW VIEWS ON DIABETES MELLITUS** By P. J. CAMMIDGE, M.D., and H. A. H. HOWARD, B.Sc. Octavo of 611 pages, illustrated. London, Henry Frowde & Hodder & Stoughton. New York, Oxford University Press, 1923. Cloth, \$6.50.

This work is based upon a large experience in the disease. The authors state that in their investigations they have made over 15,000 analyses of specimens from more than 1,200 cases of diabetes and glycosuria. Normal and abnormal carbohydrate metabolism are fully discussed and more space is given to the "non-pancreatic" causes of hyperglycemia and glycosuria than is the custom of most American writers. About one-half of the book is devoted to the treatment of true diabetes

and other glycosurias. Many views expressed are based upon original work.

The writers believe that it is never wise to allow the proportion of fat to carbohydrate to exceed 3 to 2. More fat than this is stated to be followed by ketonuria and lowering of carbohydrate tolerance.

In renal glycosuria they have found an absolute reduction in the calcium content of the blood and in true diabetes a relative reduction arising from dilution of the whole blood. The administration of calcium salts alone by mouth had little or no effect upon the percentage of calcium in the blood, but when in addition, a tenth of a grain of parathyroid was given at night, the desired result was brought about in some instances. The basis of this treatment is the belief that the persistently low proportion of calcium in the blood might be dependent upon parathyroid insufficiency.

Citing Allen's experiments by which he showed that ligation of the pancreatic duct prevents the appearance of diabetes and checks an existing glycosuria resulting from partial pancreatectomy in dogs, the authors have conceived this theory that by giving belladonna or atropine, they could conserve the functioning pancreatic remnant solely for the production of its internal secretion by preventing the formation of the external secretion. Given at a suitable interval before meals, this drug is said to be capable of preventing the rise in the sugar content of the blood which would otherwise have occurred.

W. E. McCOLLUM

**DISEASES OF THE MALE ORGANS OF GENERATION** By KENNETH M. WALKER, M.A., M.B. B.C. Octavo, 234 pages, illustrated. London, Henry Frowde & Hodder & Stoughton. New York, Oxford University Press, 1923. Cloth, \$4.00.

This brief little work of some two hundred pages covers the subject of the non-venereal diseases of the male seminal tract. It is a condensed, practical, clinical treatise, written in a manner intended for the student and busy general practitioner. It is a storehouse of valuable information both in diagnosis and treatment. The medicinal and minor surgical procedures are given greater space than the major surgical for obvious reasons.

The author expresses the belief that the subject of Andrology, or the study of disease of the seminal tract will one day receive greater attention and recognition, as being, in a large measure, independent of that of the urinary tract.

AUGUSTUS HARRIS

**GYNOECIOLOGY** By DAVID THOMPSON, O.B.E., M.B. Large Octavo, 519 pages, illustrations and plates. London, Henry Frowde & Hodder & Stoughton. New York, Oxford University Press, 1923. Cloth, \$12.75.

It is impossible, in a few lines, to express a fair estimate of this exhaustive and strictly scientific work.

The five hundred pages are devoted largely to an extensive compilation of the author's laboratory research and reference work from 1916 to 1921, and include nearly two thousand references.

The book is divided into six parts, some of which are written by collaborators, and which cover every phase of the subject.

The reviewer feels that he has not seen the equal of a book of its kind up to the present time. Its value as a reference for pathologists, bacteriologists, practitioners, and urologists is beyond question.

AUGUSTUS HARRIS

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 5

NEW YORK, N Y

FEBRUARY 13, 1925

## REVIEW OF FOUR YEARS' WORK WITH RADIUM IN GYNECOLOGY\*

By THOMAS P FARMER, M.D.,

SYRACUSE, N Y

SINCE October, 1919, we have employed radium in the gynecological clinics at the Syracuse Memorial Hospital, St Joseph's Hospital, Syracuse, and the Syracuse Free Dispensary attached to the Medical Department of Syracuse University. While the majority of the cases concerned in this analysis were in these different services, some others were referred by outside surgeons and some of the cases were treated at other hospitals, both in Syracuse and in other places. The amount of radium at our disposal has been 100 milligrams, of which two tubes each containing 25 milligrams were purchased in September, 1919, a similar tube acquired early in 1920, and two needles, representing together 25 milligrams, bought in December of the same year.

During this time 165 gynecological patients have been treated either in whole or in part by this method. The conditions and number of patients treated for each were as follows:

	No Cases	%
Cancer of cervix uteri	80	49
" of fundus uteri	11	7
" of ovary	6	4
" of vulva	13	8
" of bladder	3	4
" of urethra	4	
Fibroids	19	11
Hemorrhage of menopause	28	17
Caruncles	1	
	<hr/> 165	

The period covered by this report has been divided into years beginning from October 1st. Consequently the current or fifth year represents only a trifle over a six months' period. The number of cases treated by years is as follows:

October 1, 1919, to October 1, 1920, 36 cases, 22 per cent

October 1, 1920, to October 1, 1921, 47 cases, 29 per cent

October 1, 1921, to October 1, 1922, 29 cases, 18 per cent

October 1, 1922, to October 1, 1923, 27 cases, 16 per cent

October 1, 1923, to date, 25 cases, 15 per cent (6 months)

The difference between the larger number of cases treated during the first two years as compared with the smaller number during the following two years is explained by the fact that we were not asked later to treat so many far advanced cases of cancer of the cervix as we were during the first two years, and also by the use of radium by others who had earlier sent us cases, as well as the purchase of radium by the State Institute for the Study of Malignant Disease, at Buffalo.

The seemingly indicated large increase of cases for the current year might be explained by better appreciation of the value of radium on the part of the profession and public, as also a better recognition of the indication for its use, not only in cancer of the cervix but especially in hemorrhage cases.

### CANCER OF CERVIX UTERI

The eighty cases of cancer of the cervix were divided as follows, according to years:

First year, 26 cases, 32 per cent

Second year, 22 cases, 28 per cent

Third year, 15 cases, 19 per cent

Fourth year, 8 cases, 10 per cent

Fifth year, 9 cases, 11 per cent

The average age of these cases was 51.85 years, the youngest patient being 23 and the oldest 73 years of age. Seventy-seven patients were married, their average age being 52 years. Three patients were unmarried, their average age being 45.3 years. Gross evidence of delay in diagnosis and instituting some appropriate treatment on the part of the profession was markedly evident in

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester April 23, 1924.

11 cases (14 per cent) Four of these cases were given wrong advice In two cases polypi were either insufficiently removed to furnish proper material for pathological examination, or no such examination was made These cases were of four and two years' standing This is in contrast to two other cases where by proper excision of the base of the polyp a very early diagnosis was made One case was treated for over one year for various conditions, the pelvic pain being finally ascribed to a floating kidney One case was treated over a long period by the application of gold leaf Two cases had prolonged courses of local treatments, one of these being referred to a hospital for curettment, without the local condition being recognized Another case of five years' standing with text-book symptoms, I was asked to see as an acute appendix On the other hand, this experience has been offset by cases, without manifest evidence of the disease, recognized early as a result of a careful examination by the physician Delay on the part of the public has been even more apparent, the majority of cases having presented signs demanding medical advice for from three to six months before doing so

Several cases gave histories of having had difficult or instrumental labors and one case followed child-birth immediately In several cases uterine lesions, possibly precancerous, had been recognized and their correction advised but not accomplished In one case the cervix had been amputated 12 years before and in another 18 months before One case of very short duration was admitted with recent symptoms suggesting a ruptured pelvic abscess Forty-seven of the cases resided in Syracuse or its suburbs, while thirty-three cases came from elsewhere

Of the cases (26) treated during the first year, 12 had no operation Of these one is living, three years and eight months afterwards, one died four years and three months later of broncho-pneumonia, free from any evidence of cancer

Ten died as follows

One case under two months

One case between two and four months

Two cases between four and six months

Two cases between six and eight months

One case between eight and ten months

Two cases between ten and twelve months

One case, date of death unknown

Three cases showed a complete clinical cure after radium and were later operated

One is living, four years and five months afterwards

One died three years and seven months afterwards

One died—date of death unknown—lived about two years

Eleven cases were treated post-operatively Of these

Five cases are known to be dead, but exact date of death unknown.

One case, not known whether living or dead

Three cases died under 8 months

One case died under 18 months

One case living 3 years and 10 months after radium was used for a vaginal recurrence, or 5 years after the original operation

Seven cases had one treatment

Eight cases had two treatments

Six cases had three treatments

Two cases had four treatments

One case has had five treatments

One case has had six treatments

One case has had seven treatments

Of the cases living over 3 years, of which there were five (one of which died of pneumonia and one of a recurrence)

Two cases had one treatment

Two cases had two treatments

One case had five treatments (due to vaginal metastasis)

Of the cases treated during the second year (22) 18 had no operation

Two cases are living, both over 2 years and 8 months afterwards

Sixteen cases are dead, as follows

One case, date of death unknown

One case died under two months

One case died between two and four months

Three cases died between four and six months

Five cases died between six and eight months

One case died between eight and ten months

Three cases died between twelve and eighteen months

One case died between twenty-four and thirty months

One early case was treated six weeks before operation and showed a complete clinical cure at that time This patient is now living, three years afterwards

Three cases were treated post-operatively

One living two years and ten months after radium treatment, or three years, two months after operation (recurrence)

One died between eight and ten months

One died between ten and twelve months

Eight cases had one treatment

Nine cases had two treatments

Three cases had three treatments

Two cases had four treatments

Of the cases living over two and a half years

Two cases had no operation

One case was treated before operation

One case was treated after operation

Two of these cases had one treatment, one case had three treatments, and one case had four treatments (vaginal metastasis)

Fifteen cases were treated during the third year

Thirteen cases had no operation

Five cases now living eighteen to thirty months afterwards

Eight cases dead, as follows

One case, date of death not known

One case died under two months

One case died between four and six months

Two cases died between six and eight months

One case died between twelve and eighteen months

Two cases died between eighteen and twenty-four months

Two cases were treated post-operatively

One case died, date of death unknown

One case treated shortly after operation, living one year and nine months afterwards

Seven of these cases had one treatment

Five cases had two treatments

Two cases had three treatments

One case had seven treatments (six treatments at another clinic in the West, from which patient was referred)

Of the six cases living over eighteen months (five without operation, and one post-operative)

Three cases had one treatment

Two cases had two treatments

One case had three treatments

Of the eight cases treated during the fourth year

Four had no operation, all living nearly one year, but two show advancing recurrence

One case was operated after a clinical cure followed radium, and has formed both vesical and vaginal fistulae

Three cases, all recurrent, were treated post-operatively

One case living

One case living, but disease has advanced

One case died, two months after recurrence, six years after operation

Four of these cases had one treatment.

Four of these cases had two treatments

During the present year, nine cases have been treated, four without operation, all living, and five following a previous curettment and cauter operation. Eight of these cases had one treatment and one case had three treatments

Fistulae have formed in eight cases (10%)

Fistulae formed in two cases in which there was no operation 4.0% (2.5%), and in six cases which were operated 20.7% (7.5%)

Five cases during the entire series were operated, following a complete clinical cure, the result of radium

One case is living, four years and five months afterwards

One case is living, three years afterwards

One case is living, one year afterwards, but with recurrence

One case died of recurrence, three years and seven months afterwards

One case died of recurrence, date of death unknown

Fourteen cases had a hysterectomy prior to radium treatment, of which twelve presented metastasis at the time of the radium treatment. Seven of these cases have died, one is in a very advanced condition, three are living and condition of one is unknown. These patients presented themselves for treatment in periods of from six months to six years after operation

Of the two cases without metastasis, one died over four years after operation, and one is living two years after operation

The average age of the cases living over three years is 53 years, and of cases living over two years is 51 years, ranging from 39 to 68 years

The average number of treatments of cases living over three years was 2.2, and of cases living over two years was 2.27

Fifty cases have died, as follows

Ten cases, date of death unknown

Four cases died under two months afterwards

Two cases died between two and four months afterwards

Six cases died between four and six months afterwards

Twelve cases died between six and eight months afterwards

Three cases died between eight and ten months afterwards

Three cases died between ten and twelve months afterwards

Five cases died between twelve and eighteen months afterwards

Two cases died between eighteen and twenty-four months afterwards

One case died between twenty-four and thirty months afterwards

One case died between forty-two and forty-eight months afterwards

One case died over forty-eight months afterwards of pneumonia

Twenty-nine cases are living

Two cases, two months after treatment

Two cases, between two and four months after treatment

Four cases, between four and six months after treatment

One case, between six and eight months after treatment

Four cases, between ten and twelve months after treatment

Three cases, between twelve and eighteen months after treatment.

Five cases, between eighteen and twenty-four months after treatment

One case, between twenty-four and thirty months after treatment

Four cases, between thirty and thirty-six months after treatment

Two cases, between forty-two and forty-eight months after treatment

One case, over forty-eight months after treatment

The outcome of one case is not known

#### CANCER OF FUNDUS UTERI

Of the eleven cases of cancer of the fundus, ten patients were married and one single. The average age was 60.4 years. The youngest case was 48 and the oldest 77 years. Six cases were from Syracuse and five from out of the city.

Delay, from the standpoint of the physician was evident in four cases, two of which had received several X-ray treatments for supposed fibroids without diagnostic curtailment.

Two of these cases, from the history, were thought to be hemorrhage cases, the preliminary curettment proving otherwise.

Five of these cases were treated during the second year.

Two of these cases were treated during the third year.

One of these cases was treated during the fourth year.

Three of these cases were treated during the fifth year.

Six cases received one treatment.

Two cases received two treatments.

One case received three treatments.

Two cases received four treatments.

Three of these cases died.

One lived eleven months (post-operative).

One lived four months (treated over long period with X-ray for fibroid).

One lived seventeen days (post-operative).

Seven cases are living.

One case, three years and one month afterwards (no operation).

One case, two years and eleven months afterwards (no operation).

One case, two years and eleven months afterwards (later operated).

One case, one year and ten months afterwards (no operation).

Four cases, treated within last eight months.

#### CANCER OF OVARY

Six cases, five patients married, one patient single (sarcoma), average age, 54.2 years.

Three patients operated.

One died eleven months afterwards.

One died five months afterwards.

One living one year afterwards—condition advancing metastases.

Three patients not operated.

Two died within one year.

One case living over one year—diagnosis is questionable.

#### CANCER OF THE VULVA

The thirteen cases of cancer of the vulva were all in married women. The average age was 67 years. The youngest patient was 48 and the oldest 86 years. Three patients were over 80 years of age. Four of the cases were of a papillary type, their average age being 57 years (10 years below the average age for the entire group).

Four cases had been operated previously, all of which had recurrences within six months, except one, age 55, of twelve years duration, with three previous operations. This was a case of the papillary type.

All of the cases with two exceptions are known to have died in from three months to one year and nine months after the initial radium treatment. One case, whose present condition is unknown, showed complete local healing for over one year. One case is living, one year later, with recurrence.

#### CANCER OF THE BLADDER AND URETHRA

The average age of three cases of cancer of the bladder was 67 years. Two of these cases died within a short period, and one case recently treated is living, unimproved. Two of these cases were treated by radium, applied through the urethra, and cross-firing through the vagina, and one case through a supra-pubic wound.

The average age of four cases of cancer of the urethra was 66 years. Only two of these cases were diagnosed by histological examination. In the other two cases the diagnosis was made by endoscopic examination by the urologist and, therefore, not definite. Two cases are dead, one case is living with a recurrence after nearly a year of control, and one case, which was completely controlled is living. No evidence of growth at present time.

#### FIBROIDS

Of the nineteen cases of fibroids.

Five were treated during the first year.

Four were treated during the second year.

Five were treated during the third year.

Two were treated during the fourth year.

Three were treated during the fifth year.

The average age was 46 years, ranging from 35 to 54 years, although one case, not a good operative risk, age 30, was given a treatment preliminary to removal.

Sixteen cases were married women. Three cases were single women.

The treatment was repeated in only three cases.

All obtained relief except as follows.

One case, age 30, not a good operative risk,

mentioned above, who later had a hysterectomy done

One case, with a very large tumor, extremely anemic and inoperable. Later, after improvement in general condition, a hysterectomy was done, and a fibroid uterus, associated with a sarcome was removed

Two cases died shortly after radium treatment, both being entirely unsuited for operation, one a patient with advanced arterio-sclerosis and nephritis, who had a progressive anemia of long standing, due to hemorrhage, unrelieved by repeated curettments and X-ray, the other a very large fibroid with marked anemia uncontrolled by X-ray treatments. In this case a large fibroid had been removed ten years before. Although there was no autopsy, the probability of sarcoma must be considered

One case cured now three years had a fibroid in the posterior half of the cervix which recurred twice within two years. The microscopical diagnosis in this case was malignant leiomyoma

#### HEMORRHAGE OF MENOPAUSE

Hemorrhage of the menopause and allied condition occurred in twenty-eight cases, as follows

No cases during first year

Eight cases during the second year

Four cases during the third year

Eight cases during the fourth year

Eight cases during the fifth year

Twenty-two cases were married women. Six cases were single

One patient was 22 years of age and two were 25 years of age. In two of these cases both tubes and one ovary had been previously removed. The other patient had a polyp. These cases were treated with 25 milligrams of radium for a period of four to eight hours. All showed a restoration of normal menstruation

The average age of the other twenty-five cases was 43.2 years, ranging from 35 years to 56 years

The pathological conditions encountered were glandular hyperplasia, hypertrophic endometritis and polyp

All cases were adequately controlled with one treatment

Two of the cases had been curetted once, two twice, and one case three times without relief. Several cases had had many X-ray treatments

#### CONCLUSIONS

With 15% of our first year cases of cancer of the cervix living nearly four years, 18% of the series of the second year living nearly three and one-half years, and 40% of the series of the third year living nearly two years or over, and considering that all of these cases, with one exception, were definitely inoperable and many of the cases far advanced, it would seem that there should be no doubt in the opinion of the surgeon as to the operability of a case of cancer of the cervix before performing a pan-hysterectomy on

such cases. Our experience indicates that it is as unsafe as it is unwise to operate a borderline case, relying upon radium to control recurrences. It must be borne in mind that when a hysterectomy has been performed, the chances of using radium in adequate dosage have been greatly decreased, and that the chances of the formation of fistulae have been greatly increased. In view of the fact that many fairly well advanced cases are now perfectly well over a period of two, three and four years, an initial radium treatment should not be refused any case, unless markedly advanced. Our experience would indicate that very little if anything is accomplished by operating a case which has shown complete clinical cure after radium has been used. Possibly harm may be done by such procedure. Cases that have been operated should receive post-operative radium treatment as soon as seems safe after hysterectomy, and not wait for recurrence. Smaller dosage is indicated in such cases. Reliance should be placed upon the first radium treatment. The chances for cure seem to decrease with the number of treatments necessary. We have abandoned the repetition of treatments at stated intervals, only repeating the treatment when conditions would indicate. At the time of the first treatment, the patient should be prepared as for operation, anesthetized, most carefully examined, the uterine cavity explored if this seems indicated, the cervix entirely curetted of all diseased tissue and the radium applied with great care as to its position. We are not convinced that the use of needles introduced into the tissue of the cervix has improved our results. These cases should be examined at intervals of from three to six weeks for a period of six months, after which they should be examined at longer periods. These examinations should be made with the patient in the knee chest position, as a recurrence in the vaginal vault becomes more apparent in this way.

While we are not ready to abandon our position advocating hysterectomy in all except advanced cases of carcinoma of the fundus, still the highly satisfactory results accomplished with radium in three of our eleven cases would urge us to have the surgeon bear definitely in mind the possible good results to be obtained by this method in such cases presenting undue surgical hazards, such as the very old, the extremely obese patient, or those presenting constitutional conditions which represent surgical contraindications.

Except for the control of vaginal metastasis with the consequent checking of hemorrhage and discharge, radium offers no relief to the patient with cancer of the ovary, in our experience. Early exploratory operation seems to us justifiable on the grounds that the diagnosis may not be correct.

Despite the unfavorable results from surgical

treatment of cancer of the vulva, we feel that radium has nothing further to offer in this condition. In considering the end results, undoubtedly the patient obtains greater relief by the surgical removal of the growth than by its destruction, if possible, by radium. While we have had fairly satisfactory results in one case, it is quite possible that the same result would have been accomplished by surgery, and perhaps in a shorter time. We, therefore, feel that radium is only advisable in cases where surgery is absolutely contraindicated. On the other hand, it would seem well to teach the profession that such growths cannot be removed by a small operation under local anesthesia, but demand a radical, wide excision.

Radium has been used without relief in our cases of cancer of the bladder. We would feel that the only cases of this condition offering any hope are those occasional ones of a papillary type which are well localized and which can be excised, after which radium may be applied through the suprapubic wound.

Although it is doubtful if any of our cases of epitheloma of the urethra are being absolutely cured, radium here offers a more satisfactory way of destroying the growth than surgical removal.

Our experience in the use of radium in the treatment of fibroids confirms indications laid down by Dr. John G. Clark and his associates several years ago, and we feel that radium should only be applied in cases near the menopause with the tumor not larger than a three months' preg-

nancy, in which bleeding is the leading symptom, and pain bilateral to the uterus is absent. In such cases our results have been highly satisfactory. Not only are the results in larger tumors unsatisfactory, but our experience would indicate, possibly dangerous. These tumors in our experience are not only resistant to radium treatment, but usually complicated by other growths or lesions demanding surgical treatment. Nevertheless, such cases when inoperable because of the anemia resulting from uncontrolled hemorrhage may be made operable as the result of a radium treatment, which, however, should be used most cautiously.

Our results in the use of radium in the treatment of cases of hemorrhage of the menopause and allied conditions not due to cancer or large fibroids, has been most highly satisfactory. We have failed to have a case which has not been successfully controlled by one treatment and feel that radium should be looked upon as a treatment par excellence in this condition.

Our experience would indicate that radium in the treatment of suitable gynecological conditions is becoming more definitely established, that its indications and contraindications are better recognized and the results from its use gradually improving. It is felt that as a result of the acquiring of this knowledge by the profession and the improvement in the technique and the use of radium, not only will we improve our results in the treatment of benign conditions, but that the aspect of such hopeless conditions as cancer of the cervix will become much brighter.

## SOME NEGLECTED PHASES OF COMA IN DIABETES MELLITUS\*†

By WILLIAM S. McCANN, M.D.,

ROCHESTER, N. Y.

COMA in diabetes has become so intimately associated in our minds with acidosis that when one sees an unconscious patient with diabetes the treatment of acidosis is automatically thought of. So much emphasis has been laid on the use of insulin in diabetic coma in recent months that this is a timely occasion on which to recall that coma in diabetes is not always associated with or due to acidosis or intoxication with the acetone bodies.

Coma may occur in diabetes from the same causes which operate in non-diabetic individuals. A study of a large series of cases has revealed the truth and importance of this statement. It is particularly important to bear in mind the possibilities of cerebral vascular accidents and of uremic coma in individuals

with diabetes. One unfortunate case was seen recently in which a cerebral accident had occurred, the resulting coma being mistakenly attributed to diabetes. When insulin was given marked hypoglycemia resulted which did not respond to glucose injections, and death occurred. Death may have been due to the vascular accident, but it is not pleasant to think that the hypoglycemia may have been a heavily contributing factor.

The occurrence of uremia in diabetes presents a condition which is very difficult to analyze. As you know, uremia is usually associated with an acidosis, and in diabetic coma due to ketosis there is usually a considerable disturbance of renal function. The evaluation of such cases calls for all the refinements of clinical analysis.

There are two forms of coma in diabetes which are peculiar to the disease. The com-

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester, April 23, 1924.

† From the Medical Clinic of the Johns Hopkins Hospital, Baltimore.



mon form is due to ketosis and acidosis. A much more rare form is that due to spontaneous hypoglycemia. It is probable that coma from induced hypoglycemia will be frequently encountered during the widespread use of insulin.

In March, 1921, a patient with severe diabetes of two years' duration, entered the service of Dr. E. F. DuBois in Bellevue Hospital, where he was seen and studied by the writer. He had been under the care of Dr. Joslin, and later of Dr. Allen. The weight was about half of its normal value. Five days were required to render the urine sugar-free and the blood sugar normal by fasting. During the succeeding three days the diet was built up slowly, considerable amounts of bran biscuits being used. Diarrhea developed. On the following day the blood sugar was 0.08 per cent. About 11 a. m. the patient became drowsy and later semiconscious. The urine contained neither sugar nor acetone. After stimulation he roused and took food and passed the night well. On the morning of the next day the blood sugar percentage was 0.06 per cent. The patient became stuporous about 9 a. m., respirations were slow, pupils small but reacted to light. There was no odor of acetone nor glycosuria, nor acetonuria. A stool was passed involuntarily. The patient did not respond either to stimulation or to hypodermoclysis and Murphy drip, in both of which glucose was given. Death occurred.

This case was reported to Dr. Joslin, who replied that he had witnessed three cases of spontaneous hypoglycemia, one of the patients recovering and subsequently developing a high carbohydrate tolerance. These cases were reported subsequently by Joslin.

The next opportunity to witness this interesting phenomenon occurred at Johns Hopkins Hospital. A man of 46 years, who had had diabetes for six years, entered the hospital because of an intractable diarrhea of four months' duration. For four years he had been greatly undernourished, with frequent days of starvation. At the time of admission he weighed only eighty-seven pounds, less than half his normal weight. On examination, nothing of great importance was found, other than extreme emaciation and moderate peripheral arteriosclerosis. The stools were very bulky, containing undigested food. The patient's blood sugar ranged from 0.054 to 0.286 per cent on a constant diet. The days of low sugar occurred with exacerbations of the diarrhea. The  $\text{CO}_2$  combining power was normal at all times, there was no acetonuria, and no glycosuria when the hypoglycemia occurred. The hypoglycemia of 0.054 per cent was not associated with any unusual symptoms.

On the day of the patient's death he was feeling quite as usual up to 4 p. m. At 4:30 he was unconscious with shallow respirations and weak pulse. At 8 o'clock the blood sugar was found to be less than 0.02 per cent, non-protein nitrogen 0.27 per cent, and  $\text{CO}_2$  C. P. 64 vol per cent. Stimulants were given without effect. Glucose was given intravenously. The patient died two hours later.

Autopsy showed extreme atrophy of the pancreas, very early lobular pneumonia with fibrinous pleurisy.

These cases serve very well to illustrate a type of true diabetic coma about which very little has been said. The occurrence of spontaneous hypoglycemia though rare, is sufficiently common so that one should always be on the alert to detect it while there is still time to prevent collapse by the administration of glucose.

A neglected phase of the subject of diabetic acidosis concerns the renal function. Before taking it up it would be well to consider the behavior of the kidneys during acid excretion. It has been known for a long time that the excretion of an increased amount of acid in the urine usually results in a change in the nitrogen partition of the urine, that is, the proportion of the nitrogen excreted as ammonia increases. In 1915 Palmer and Henderson<sup>(3)</sup> published an interesting study of the ratio of urinary ammonia to acid excretion in normal individuals and in patients with nephritis. Comparing their figures for patients with advanced nephritis and renal acidosis with those of normal subjects one finds that the urine of the former was more acid and gave a higher titratable acidity and that the amount of ammonia excreted was relatively much less than in the case of normals. The full significance of these findings was not appreciated at the time and the interest in renal acidosis was directed toward the evidence of acid retention developed by Marriot and Howland<sup>(3)</sup>, Denis and Minot<sup>(4)</sup> and Greenwald<sup>(5)</sup>. It was not until Nash and Benedict<sup>(6)</sup> had brought forward convincing evidence that the kidney is the site of formation of the urinary ammonia that a completely satisfactory explanation for renal acidosis was available. In the light of this knowledge it seems probable that two factors, acid retention and reduced ability to form ammonia, play a part in the production of renal acidosis.

In diabetic ketosis rapid compensation for the over-production of acids is effected by means of the respiration and circulation. Hyperpnea and a more rapid rate of blood flow make up for the diminished capacity of the blood for carrying carbonic acid. Some volatile ketones are eliminated through the lung.

In this manner the hydrogen-ion concentration of the blood may be kept normal for a time in spite of a considerable acid production

While the lungs regulate the reaction of the blood, the maintenance of the alkaline reserve is to a large extent dependent upon the kidneys. In diabetic ketosis the kidneys must eliminate not only the normal acid products of metabolism but an excessive amount of organic acids, chiefly derived from fats. In so far as the kidney fails to eliminate them they remain in combination with the bases of the blood diminishing the alkaline reserve. Unfortunately the excretion of acid cannot be accomplished without the simultaneous excretion of some base. Apparently the kidney cannot secrete urine with a hydrogen ion concentration greater than pH 4.8. At this pH most of the inorganic acidity is due to acid phosphate in which one mol of phosphoric acid is combined with one mol of base. By excreting acid phosphate some base is spared to the blood. The organic acids, which are weakly dissociated might conceivably be excreted to a certain extent free. Beyond a certain point, however, the excretion of these acids would require base in the urine. In so far as the kidney supplies base in the form of  $\text{NH}_3$ , the bases of the blood are conserved for the maintenance of the alkaline reserve. In so far as the kidney fails to furnish base as  $\text{NH}_3$ , the alkaline reserve may be depleted, provided no alkali gains entrance with the ingesta. It appears, therefore, that the kidney plays a major role in determining the outcome of severe diabetic ketosis. It is of the highest importance that all factors which may affect renal function be taken into consideration in the management of such cases.

In true diabetic acidosis there are several factors which may have a profound effect upon renal function. A review of the fatal cases of diabetic coma in the medical clinic of the Johns Hopkins Hospital showed that practically all had albuminuria and cylindruria. In some cases there was hematuria as well, with a true acute nephritis at autopsy. In other cases no nephritis was found at autopsy in spite of markedly abnormal urinary findings. The rest nitrogen of the blood is usually increased. Almost invariably patients with profound diabetic acidosis had an oliguria. There are two things occurring regularly in these cases which may account for the urinary abnormalities and evidences of renal insufficiency. These are marked dehydration and vascular hypotension. Marriot<sup>(7)</sup> has observed marked albuminuria and cylindruria in the state of anhydremia in infants.

The evidence of dehydration in diabetic coma is usually quite well marked. Low

ocular tension is one of the best indices of desiccation. The eyeball frequently feels like an over-ripe grape. The tension of the eye becomes more normal with the administration of large amounts of fluid. Low blood pressure is also usually found in these cases. Some have thought that the low ocular tension may be dependent upon the low blood pressure rather than upon the dehydration per se. Whether that is true or not, both the blood pressure and ocular tension rise when fluids are given abundantly. The red cell count and hemoglobin of these patients are almost always lower after the administration of fluids than before the institution of treatment, showing that there was probably a considerable concentration of the blood.

The effect of dehydration and of the low blood pressure on kidney function is very considerable. With the marked oliguria usually observed a considerable acid retention occurs and a nitrogen retention as well. There is also evidence that dehydration affects the ammonia forming function adversely.

It must also be borne in mind that the circumstances under which coma in diabetes is apt to arise are very frequently such that an acute nephritis or an acute exacerbation of a chronic nephritis is set up. This is especially true when coma follows an infection, furunculosis, carbuncles, tonsillitis, sinus and middle ear infections, and with diabetic gangrene. Investigations are now in progress to determine to what extent various forms of kidney disease affect the functions of acid excretion and ammonia formation. So far as these studies have gone the evidence indicates that even in mild nephritis the ammonia function may be impaired. While it may be sufficient to preserve the alkaline reserve during the excretion of normal acid metabolites it may not be able to maintain the alkaline reserve during periods of abnormal acid excretion such as occur in diabetes.

Much further study is necessary to determine what factors chiefly impair the ammonia-forming function of the kidney. The problem is at present under investigation in the clinic in Baltimore, and a more detailed report will have to be postponed. In the following table of data from a case of severe diabetic coma the gross relationship to the alkaline reserve of fluctuations in the  $\text{NH}_3$  acid ratio is very well illustrated.

Reference to Table 1 shows very clearly that when the ratio of ammonia to total acid excreted was low a decrease in alkaline reserve occurred and vice versa. These observations illustrate an important phase of the relationship of kidney function, especially of the ammonia forming function, to the alkaline reserve of the blood.

TABLE I—ELIZABETH S

Date	Fluid Intake	Urine Volume cc.	Titrateable Acidity cc. N/10	Organic Acids cc. N/10	NH <sub>3</sub> cc. N/10	Ratio NH <sub>3</sub> acid	CO <sub>2</sub> CP Vol. %	Insulin units 12 hours
Dec 29	9885	2375					10	60
" 30	4430	1805					10-14	225
" 31	3300	1650	75	997	1505	1.4	14-49	75
Jan. 1	3375	2040	722	3207	1260	0.3	49-42	0
" 2	4480	2700	334	3650	1695	0.4	42-18	195
" 3		1530	0	1822	2550		18-47	100
" 4		1570	57	752	1255	1.2	47-	100
" 5		2220	226	1452	1786		-43	100

The points which in our experience are most frequently neglected in management of coma in diabetes, are as follows

1 Exclusion of causes of coma other than ketosis, such as spontaneous hypoglycemia, uremia, cerebral vascular accidents, etc. There are two distinct forms of true diabetic coma, one commonly recognized in association with acidosis, and the other form not associated with acidosis but with hypoglycemia occurring suddenly and spontaneously

2 Attention to kidney function, especially direction of efforts to combat dehydration and to improve circulation by copious administration of fluids, by vein, subcutaneously and by Murphy drip, and the use of digitalis

These are the measures which are instituted first in the Medical Clinic at Johns Hopkins. Insulin is given at frequent intervals, usually every two hours, so that the patient receives 10-12 units per hour until the hyperglycemia is reduced. It is customary to add glucose to

the physiological saline solution given by vein or by Murphy drip, so that the patient receives 6-8 grams of glucose per hour. As soon as the patient recovers sufficiently to take food by mouth, fluids are administered copiously by that route, a maintenance diet is given in liquid form, consisting of orange juice, cream, and lactose, and occasionally glycerine, made up in the proportions of Woodyatt's formula (8) (9)

#### BIBLIOGRAPHY

- 1 Joslin *Medical Clinics of N. A.*, 1921, 4 1923
- 2 Palmer and Henderson *Jour Biol Chem.*, 1915, 21 37
- 3 Marriott and Howland *Arch Int Med.*, 1916, 18 708
- 4 Denis and Minot *Arch Int Med.*, 1920, 26 99
- 5 Greenwald *Jour Biol Chem.*, 1915, 29 21
- 6 Nash and Benedict *Jour Biol Chem.*, 1921, 48 463
- 7 Marriott *Physiol Reviews*, 1923, 3 275
- 8 Woodyatt *Arch Int Med.*, 1921, 28 125
- 9 McCann, Hannan, Perlzweig, and Tompkins *Arch Int Med.*, 1923, 32 226.

## OBSERVATIONS OF 101 CASES OF NASAL INFECTION, EXCLUSIVE OF DIPHTHERIA, IN CHILDREN \*

By WILLIAM A. KRIEGER, M.D., F.A.C.S.

POUGHKEEPSIE, N. Y.

IN presenting this subject to the pediatric section, it is my desire to review briefly the anatomy of the paranasal sinuses and the lymphatic supply to these parts, to emphasize a few points, which can be easily recognized by the men not doing special nose and throat work, and to present a few cases, which have occurred in my private practice, illustrating these points

According to Schaeffer the maxillary sinus is evident about the seventieth day of fetal life. After the fifteenth year, it may be considered as the adult stage

One must also bear in mind that the frontal sinus is genetically and topographically ethmoidal before it is frontal and in this sense is conspicuously present at birth in all cases. As a rule, one cannot be certain of the actual frontal sinus

until the sixth to the twelfth month of postfetal life.

The sphenoidal sinus is genetically demonstrable as early as the fourth month of fetal life. However, by the end of the third year the rudiment of the sphenoidal sinus is surrounded by bone save ventrally toward the nasal fossa where an opening, the primitive ostium sphenoidale, exists. During the fourth year it becomes the primitive sphenoidal sinus. The dorsolateral aspect of the sphenoidal sinus may thus early come into intimate relationship with the ophthalmic and maxillary nerves and be a potent factor in childhood neuralgias of the trigeminal nerve, even as early as the third year. Moreover, the pterygoid (Vidian) canal with its contained nerves and vessels likewise early—sixth or seventh years—establish close relationship with the developing sphenoidal sinus. It is obvious

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester, April 23 1924

that the sphenoidal sinus is early of importance clinically and that by the second or third year has assumed proportions sufficiently large to become the seat of pathologic processes and to retain infectious material in its cavity

The initial ethmoidal out-pouchings are in evidence as early as the fourth month of fetal life, by the seventh month the evaginations have taken shape in the form of hollow tubular-like, blindly ending sacs, with ostia in communication with the points of initial outgrowth. These tubular sacs may be truly said to be ethmoidal cells.

Conforming with the double function of the nasal cavity proper there are two areas of the lining mucous membrane that differ in structure—the *pars respiratoria* and the *pars olfactoria*. In this paper, I shall deal more particularly with the former—the *pars respiratoria* or respiratory portion. The stratiform flat epithelium of the nasal vestibule gradually assumes the characteristics of the respiratory mucous membrane, e.g., a stratiform ciliated cylindrical epithelium. The nasal respiratory mucous membrane varies greatly in thickness in the several parts of the nasal fossa. Over the inferior concha, portions of the middle concha, and the adjacent portions of the septum, the membrane frequently reaches a thickness of several millimeters, elsewhere it may be considerably less than a millimeter. The respiratory mucous membrane readily thickens under pathologic conditions, often obtaining a thickness of from four to six times normal. One of the characteristics of the nasal respiratory mucous membrane is the extremely rich blood supply of the *tunica propria*. The arteries of the deeper strata send their branches through the *propria* to form a capillary network beneath the epithelium and around the neighboring glands. From the arterial network the blood flows into a superficial venous plexus, thence to a deeper one. Careful study indicates that these venous plexuses or blood sinuses assume the character and role of an erectile tissue—the *plexus cavernosi concharum*. Nerve reflexes control the filling and emptying of the cavernous tissue. It is well known that certain stimuli through the reflexes rapidly deplete the thickness of an engorged mucosa and that in certain psychic states similar depletion is experienced, and *vica versa*. The great masses of blood are doubtless of great importance in warming the inspired air. This, indeed, may be the chief function of the erectile tissue. Of course, a possible phylogenetic relationship must be kept in mind. Numerous glands are found in the *tunica propria* of the respiratory mucous membrane.

The paranasal (accessory) sinuses are lined by mucous membrane directly continuous with that of the nasal fossa, including the maxillary, the frontal and the sphenoidal sinuses, and the

ethmoid labyrinth. The mucous membrane lining the several paranasal sinuses and cells resembles that of the nasal fossa, save that it is much thinner and contains fewer glands. Moreover, it does not assume the characteristics of an erectile tissue. In spite of the extreme delicacy and thinness of the mucous membrane of the paranasal sinuses and its firm adherence to the *perosteum*, it is readily influenced and greatly thickened by pathologic processes. It is particularly prone to thickening, rapidly so in the vicinity of the ostia of the maxillary and sphenoidal sinuses owing to the greater looseness of the structures at these points.

The lymphatics of the nasal cavity ramify the entire *muco perosteum*, both olfactory and respiratory, including that of the septum. It has also been fairly well established that the lymphatic network extends into the paranasal sinuses in communication with the nasal cavity. The lymphatic vessels are located in the connective tissue of the *tunica propria* and their richness is in direct proportion to the thickness of the mucosa. At places the mucosa is infiltrated with lymphatics and occasionally very minute solitary nodules are found. In man the main collecting vessels of the lymphatic network of the nasal fossae form ventral and dorsal groups. The lymphatic network in the region ventral and caudal to the pharyngeal ostium of the auditive tube receives drainage from a considerable portion of the nasal fossa. From this region go forth the largest and most important collecting trunks from the lymphatic network, to terminate in either the deep cervical chain or in the retropharyngeal nodes. It has been shown by Most that at whatever point the nasal mucosa is punctured, the retropharyngeal nodes are colored by the injected material. Sappey long since pointed out the involvement of the large lateral retropharyngeal nodes ventral to the atlas in diseases of both the nose and the pharynx. The frequent infection of the retropharyngeal nodes is readily explained when one recalls their extensive lymphatic area. They receive as afferents almost all the collecting vessels from the nasal mucous membrane and from the cavities in connection with the nasal fossae. Moreover, afferents from the lymphatic network of the cavity of the tympanum, the auditive tube, and the nasopharynx pass to these regional nodes.

Flexner, in discussing the mode of infection in epidemic meningitis, states that in all probability the micro-organism passes directly to the nervous system by way of the lymphatic connections between the naso-pharyngeal mucosa and the meninges.

There is little definite knowledge of the lymphatics of the accessory sinuses of the nose. Studies of Most indicate that the lymphatic drainage from all the paranasal sinuses and cells is

into the retropharyngeal nodes. Clinical evidence bears out this conclusion.

With the knowledge we have of the nasal mucous membrane, the lymphatic supply, their relation to the paranasal sinuses and the early development of the same, the question of nasal infection in children becomes paramount. Every internist and pediatrician should familiarize himself with the use of the head mirror and the nasal speculum, in order to differentiate the normal from the pathologic nose. Take, for example, the ordinary clinic. Much time is spent in child hygiene, careful attention is given to weight, minute directions are provided as to diet, the tongue depressor is in constant use, but in few—very few—will you find a routine examination of the nose. If a child has any difficulty whatsoever in breathing, it is immediately marked for tonsillectomy and adenoidectomy, regardless of any infection that may be in the nose or paranasal sinuses. This is particularly noticeable in the examinations given by welfare workers. Contrary to the belief of some, I refuse to operate on these cases until I have been able to rid them of nasal infection. I believe that lung complications, such as pneumonia and pulmonary abscess, are due to the aspiration of infectious material from the nose. It is my habit not to do tonsil and adenoid operations on children from December first to April first because almost everyone in my locality, during these months is either carrying or is constantly exposed to nose and throat infections. I believe, from my own experience and from the opinion of others, that such conditions as scarlet fever, measles and whooping cough are primarily nose and throat infections and that, if treated as such many complications would be avoided and epidemics of contagious diseases very markedly reduced. Many of these cases may be considered latent sinus infection. With cleansing and aeration of the nose, the infection subsides and the sinuses return to a normal condition. While I do not in any way discredit the T & A operation when necessary, I have yet to be convinced that such an operation clears up the nasal infection, excellent authorities to the contrary notwithstanding. However, I have often observed tonsils and adenoids diminish in size and inflammation by clearing up the nasal or paranasal sinus infection. I have repeatedly seen children advised for T & A operation, who on palpation of the pharynx had no adenoid tissue present, but did have very definite nasal infection. Breathing and general health improved under careful nasal hygiene. My personal experience therefore leads me to believe that cervical adenitis and pharyngitis are never primary, but are the sign posts pointing the way to the seat of the real condition. By referring to the lymphatic supply and the natural drainage of the nose and the paranasal sinuses, it seems to me that the saying "catarrhal con-

ditions associated with adenoids" should be "adenoids or lymphatic hypertrophy associated with nasal infections." I feel it extremely important to listen to the parents' description of the child's symptoms and actions. Frequently a child will describe its headaches almost to the letter as Sluder describes them in his book, "Headaches and Eye Disorders of Nasal Origin." The nose seems to be the last thing to be considered. I have seen glasses prescribed many times for children when headaches and diminished vision were caused by nasal infection.

A child whose general physical examination is negative and has a history of one or more prominent symptoms, such as fever, loss of appetite, irritability, cough, enlarged glands, etc. deserves a careful nasal examination.

To illustrate some of these conditions, I shall recite a few cases representative in my series.

1 Cough as the prominent symptom, 21 cases, age ranging from two to ten years, all of which recovered under nasal treatment.

Case No 1 H. L. C., age two years. Cough resembling whooping cough, so markedly that the cough was accompanied by vomiting. History of two weeks duration. No other symptoms. Culture showed staphylococcus as predominating organism. After the first thorough cleansing of the nose and suction the vomiting ceased and within a week the cough had entirely disappeared. This child was under observation for three weeks, with no return of the cough. Has not been operated for tonsils and adenoids.

Case No 2 R. D. P., age 6 years. Cough and difficult breathing from birth. T & A operation at eighteen months. Cough and difficult breathing still present. First seen by me January 1924 both nostrils showed a great deal of muco-purulent discharge, and on examination of the throat a large mass of muco-pus could be seen coming down from the naso-pharynx. The sinuses on transillumination were clear. Culture showed staphylococcus as the predominating organism. The cough and difficult breathing subsided promptly under treatment, but it took several months to obtain what might be called a fairly healthy nose.

2 Temperature as prominent symptom 38 cases ranging in age from six weeks to ten years. All recovered under nasal treatment.

Case No 1 B. A. E., age six weeks. History of "sniffles" for about two weeks. December, 1923, temperature 104° physical examination negative, referred to me for examination, ears being suspected. On examination ears were negative, throat negative, left nostril negative. The right nostril in the region of the middle fossa, contained a small amount of pus. This was cultured and showed staphylococcus. Suction was applied with a very noticeable drop in temperature. This was continued several days in succession, with a resultant normal temperature. Treat-

ment was discontinued for three days and then a recurrence was noticed, treatment by suction was again instituted and the child observed with occasional treatment for a month, with no recurrence to date

Case No 2 F M R, age seven months This case had been treated for "teething" for four days Dr Card was called to see this child and found physical examination negative Temperature 105° Considerable nasal discharge and dyspnoea He immediately referred this case to me Examination showed the ears negative, with a great deal of muco-pus in both nostrils and throat Culture of the nose showed staphylococcus Suction was applied to the nose daily for three days, with a constant decline of the temperature to normal Dyspnoea disappeared almost immediately, absent after the second treatment This child had completely recovered within a week

3 Enlarged cervical glands as the prominent symptom 18 cases, ranging in age from one to seven years, all of which improved and returned to normal under nasal treatment.

Case No 1 R. A., age fourteen months Examination showed marked enlargement of both anterior and posterior chain, bilateral Tonsils large, almost obstructing the view of the pharynx Muco-pus could be seen on the posterior pharyngeal wall, and both nostrils were almost blocked with muco-pus This child had no elevation of temperature Culture was taken and report showed no K L present Under nasal treatment, glands returned to normal, tonsils reduced in size, so that pharynx could be readily seen, nasal fossae became clear within a month

Case No 2 C D, age sixteen months This case is almost identical with Case No 1, except that it took about three months for the glands to disappear entirely, although the nose and throat cleared promptly

4 Malnutrition prominent symptom, 9 cases, age ranging from six months to nine years All showed improvement under nasal treatment

Case No 1 J W, age seven years This was an undernourished child with an acute otitis media which went on to mastoid involvement and was operated Had been operated for T & A three years before No adenoids present, but many lymphoid follicles in the posterior pharyngeal wall There were large tonsil remains Cultures of the mastoid wound and nose showed pneumococcus and streptococcus On recovery from the mastoid operation, the tonsil remains were removed This child has been kept under observation and nasal treatment all winter and is gaining rapidly in weight and is returning to a quite normal condition

Case No 2 F M, age six months When I first saw this child, she had a bilateral acute purulent otitis media of about ten days duration, both nostrils filled with muco-purulent discharge

which showed staphylococcus and pneumococcus This child presented the appearance of marasmus Under ear and nasal treatment the acute otitis recovered, as did the nasal condition and the general physical condition of the child is rapidly improving

5 Those with eye symptoms predominating, 6 cases ranging in age from one to five years Four with dacryocystitis, one phlyctenular conjunctivitis, and one with conjunctivitis and palpebral eczema All of these cases had a nasal infection The eye symptoms were treated locally, but the main treatment was directed to the nose The eye symptoms disappeared promptly and in direct ratio to the subsidence of the nasal condition

6 Asthma as prominent symptom, 9 cases, age ranging from three to ten years These cases I classify under the head of vaso-motor rhinitis The result of treatment is varying and at times very discouraging There is always, I believe, some endocrine disturbance which seems at times to be aggravated by certain foods, sometimes by various proteins, and sometimes it is impossible to get a reaction to any test

All cases that I have seen have had secondary nasal infections Tonsil and adenoid operations, in my experience, have had absolutely no beneficial effect. The cases that I have seen and examined before operation, I have found no adenoid tissue on palpation

Case No 1 Z M, age ten years History of asthma for past six years, operated on twice for tonsils and adenoids, with no remission of symptoms When I first saw this boy the nasal fossae were both blocked, there was present a clear, glary mucous, the entire nasal mucosa had the typical grayish-white, spongy appearance, which is characteristic in the cases No pus was found in the nose However, nasal cleansing was instituted to prevent secondary infection and on varying doses of pituitary and adrenal extract he has been almost entirely free of his nasal obstruction and asthmatic symptoms

Case No 2 C S, age three years This child was brought to me for a tonsil and adenoid operation about six months ago I advised against operation, as the nasal condition showed the same characteristics as Case No 1 About three months later, I saw the child again with the history that the tonsils and adenoids had been removed, but the child had the same symptoms that she had before operation, except that in addition there was an eczema about the face, eyes, ears, knees and elbows The parents were now willing to listen to reason Nasal treatment was instituted, the eczema was treated locally With the help of pituitary and suprarenal extract, the asthma has disappeared, as has the nasal obstruction, and the eczema is almost entirely recovered

7 Scarlet fever, from the standpoint of complications, 8 cases

Case No 1 E M, age twelve years About the seventh day following onset, developed pain in left ear I was called to see him for this complication The ears were found to be negative, but there was definite tenderness in the region of the sterno-mastoid muscle, the nose looked quite clean, as it had been under treatment from the onset of the disease The following day there was definite cervical glandular enlargement on the left side This remained and increased slightly with some involvement of the right cervical glands for four days On the fifth day he complained of some pain in his right eye, with some redness of the upper lid at the inner canthus Ophthalmoscopic examination revealed no fundus changed On the following day there was redness, edema and tenderness of both lids with a palpable mass at the nasal angle of the orbit Examination of the nose showed a septal spur pressing the middle turbinate tightly against the outer wall of the middle fossa, the whole nostril was filled with pus, temperature was 102°, and the child looked septic I considered it unwise to attempt to remove the septal spur with the amount of infection in the nose, so removed a portion of the naso-antral wall beneath the inferior turbinate, not removing any of the inferior turbinate I then washed through the antrum, the solution apparently going through the ostium and washing the middle fossa, the contents of which came out through the left nostril I continued this washing daily for a week with a remission of temperature, subsidence of the eye symptoms and reduction of the mass at the nasal angle of the orbit Ten (10) days after the drainage of the antrum, he had a sudden rise of temperature, with no pain, but a full feeling in the right ear On examination I found an acute tympanotitis of the right ear I did a

myringotomy and found free pus This condition cleared in three days, temperature returned to normal and convalescence from this point was uneventful

Case No 2 E W, age 6 years History of scarlet fever, following which she had had an afternoon temperature ranging from 100° to 102° over a period of eight weeks On examination, I found the ears negative, large infected tonsils, a great amount of muco-pus coming down from the naso-pharynx, both nostrils containing considerable muco-pus On instituting nasal treatment the afternoon rise in temperature disappeared, tonsils reduced markedly, nasal fossae returned to normal appearance Tonsils and adenoids were removed April 9th, 1924

In the treatment of these cases, I am convinced that suction is one of the most important adjuncts at our disposal After thoroughly cleansing the nose an application of one of the Silver preparations (Silvol 10% to 15%, or Argyrol 25%) while in the very severe cases, particularly the sluggish or very acute cases, I find iodine, carefully applied, of great benefit For home treatment, I advise nasal irrigations (normal salt solution), followed by installation of chlorazene ¼%, or some bland oil spray Internally, emulsion of cod liver oil, or some of the iron or arsenic preparations, fresh air and sunshine

In conclusion, I cannot too strongly urge (1) the routine examination of the nose, throat and lymphatics, (2) the constant and thorough cleansing and medication of the nose during the cold months when epidemics are prevalent, (3) the culturing of the nose to eliminate K. L., and obtain if possible the organism present, (4) fresh air and sunshine, even when temperature is present, (5) the internal use of cod liver oil

## ENDEMIC GOITER AS A PUBLIC HEALTH PROBLEM\*

By O P KIMBALL, M D

CLEVELAND, OHIO

Since the first practical application of the principle of goiter prevention in man in 1917 the use of preventive measures has been remarkably extended There has been a striking uniformity in the results obtained in this country and in Europe, and each year the published data have added further emphasis to the teaching of Marine that "endemic goiter is the easiest known disease to prevent"

The established facts regarding the function and chemistry of the thyroid gland when preventive measures were inaugurated may be summarized as follows

\*Read at the Annual Meeting of the Medical Society of the State of New York at Rochester April 22 1924

1 It seemed to be a well established fact that the thyroid maintained and controlled the metabolism above the myxedema level

2 It was known that the thyroid gland played an important part in the normal growth and development of childhood, and in some way influenced the changes at puberty and adolescence Whether these latter changes were brought about solely by the maintenance of the metabolism at its normal rate, or whether it was due to some function of the sex glands, or whether both influences were concerned was not known exactly

3 A remarkable relationship between the thyroid function and its iodine content had

been established for soon after it had been found that the normal thyroid contained iodine, we had demonstrated that the normal function of the thyroid was dependent on iodine

4 It had been found that the histological changes which always accompany the formation of a goiter were due to a deficiency of iodine. This was so universally true, not only in man but in all animals studied, that it became possible to speak of the variations in thyroid function, in terms of the iodine content. It was found that as long as the iodine content remained at or above 1 mg per gram of the dried gland (1 e, 0.1 per cent), no active hyperplasia took place, and that as soon as the iodine content fell below this amount active hyperplasia began.

5 The unusual thyroid activity during adolescence and during pregnancy and the consequent iodine deficiency and resultant hyperplasia at these periods were generally recognized. It was in accordance with these definitely proven physiological principles that the principle of goiter prevention was developed.

One of the first practical measures for the prevention of goiter was applied in 1910 at the Lakeside Maternity Dispensary when throughout pregnancy each patient received one ounce of syrup of hydriotic during each alternate month. During recent years this measure has been used in every maternity dispensary in Cleveland.

Marine's well-known study of the possibility of the prevention of goiter in fish was carried on in the Pennsylvania State Fish Hatcheries from 1909 to 1911. As the direct result of these and other studies in animals in 1916 the prevention of goiter was first considered as a problem of education and public health and the principle established by the earlier studies was practically applied in the schools of Akron, Ohio, with results which were so unmistakable that they left no doubt as to the value of the practical application of the principle of goiter prevention as a public health measure.

The questions of importance at the beginning of this preventive work were (1) How much iodine is needed, and (2) how is it best administered? Not having any standard, we arbitrarily decided to use two grams of sodium iodide given over a period of ten days each spring and fall.

From our observation and study during the first year of this test we concluded that a much smaller amount of iodine given once a week throughout the school year would be sufficient and a better method of administration, that is, by this method we could keep the thyroid constantly saturated and not run the risk of seeing an occasional ill effect from

the larger dose. However, even with the dose given at first (3 grs NaI daily), the only ill effect we encountered was an iodine rash in one of each thousand cases under treatment.

In 1918, when this preventive measure was initiated in the schools of Zurich, Switzerland, tablets containing 5 mgs of iodine each were administered once a week. The results as reported by Dr Klinger have been very striking. In 1921, in several of the schools in the Cleveland district we introduced the method used in Switzerland, using the same chocolate Iodostarine tablets, each containing 10 mgs of iodine and administering one tablet per week throughout the school year.

This method of administration has made this preventive work so easy and even popular among the school children, that its application has extended very rapidly throughout the endemic goiter districts of this country and Canada. For instance, this method has been used systematically in the schools of Grand Rapids, Michigan, for two years, during which time fifteen thousand children have been taking 10 mgs of iodine once a week. The Health Commissioner states that this is the most practical and popular health measure he has ever introduced.

Under the guidance of the State Health Department approximately one-third of the schools of West Virginia are applying this health measure. This is the case in Washington and Utah also. Several other State Boards of Health are making special studies, surveys and plans in order to apply the preventive method in the most practical way.

Since 1920, in accordance with the suggestion of Dr H. G. Sloan of Cleveland, the Eli Lilly Company have manufactured an iodized table salt which contains sodium iodide in the proportion of one part to five thousand. This, however, has never had more than a limited drug store sale, and no conclusions can be drawn as to the result of its use.

The State Health Department of Michigan has been studying this phase of the question for four years. During the past year they have made a detailed study of the iodine content of the water in four counties in different parts of the state—Midland, Wexford, Houghton and Macomb—according to the method recently worked out by McClendon. The final analysis which has been sent to me by the State Health Department is as follows. In Midland County a complete analysis of the water throughout the county shows an iodine content of approximately 12 parts per billion. The goiter survey of all the school children in this county (3,645) shows the incidence of goiter to be 32.7 per cent. Wexford County has no iodine in the water, and the incidence of goiter in all children (3,984) is 55.6 per



cent Houghton County has no iodine in the water and shows an incidence of goiter among all the children (13,725) of 64+ per cent. In Macomb County the water contains the greatest amount of iodine, approximately 20 parts per billion, and the incidence of goiter in all children (10,258) is only 26 per cent.

These studies give direct evidence of what we have thought to be the case, that is, that endemic goiter is due to a deficiency of iodine in food and drink. The amount of iodine in the water is the best index to the available iodine in any region because of the high solubility of iodine salts.

The State Health Department of Michigan has also been studying the possibility of making the iodine content of their food equal to that in districts where endemic goiter does not occur. They feel that the most practical method would be to increase the iodine content of the table salt, and to this end they have studied the amount of salt used by the average normal person, the iodine content of the various salt beds in Michigan and other states, and the practical problem of getting such an iodized salt into universal use.

No law has been made to force the wholesale dealers to sell only iodized salt. Yet by the close co-operation of the Department of Health, the State Medical Association, the salt manufacturers and the wholesale dealers it has been brought about that after May 1, 1924, all table salt sold in Michigan will contain a sufficient amount of iodine—as it is hoped—to prevent goiter, and the purpose of this salt and the need for it has been explained in announcements sent by the Health Department to all parents, physicians and teachers in the State. That these men have attained this end by willing co-operation without increasing the cost of the salt to consumers, is a high achievement on the part of the Health Department of the State of Michigan.

It should be borne in mind, however, that this is only the beginning of this plan, and we must not draw final conclusions as to its value until the event proves the case. Certain practical objections to this method of prevention which suggest themselves are the following. *First* No one knows just how much sodium iodide to put into the salt, because the amount of salt used by different healthy individuals is variable, for instance, if the proportion of sodium iodide in the salt is one per 10,000, then a normal individual who uses  $7\frac{1}{2}$  pounds of salt yearly will get approximately 300 mgs of iodine, which should prevent goiter. On the other hand, the adolescent girl who uses only half as much salt, may develop goiter. *Second* If the proportion of sodium

iodide in the salt is made one per 5,000 in order to prevent goiter among the children who eat comparatively small amounts of salt, then some adults who eat three times the average amount of salt may get into serious difficulty, especially if some abnormality of the thyroid already exists. All that we can do is to bear these points in mind and to hold our final judgment in abeyance until it can be based upon a sufficient accumulation of experience over a sufficiently long period.

During the past there has been considerable discussion as to the possibility of overcoming this deficiency by putting some form of iodine into the city water supply. A careful consideration of this method as it would be applied to any large city makes it appear that it would be wholly inadequate and very wasteful.

In this State no uniform method of goiter prevention could be applied as in Michigan for approximately only five counties of New York have a real endemic goiter problem. For the same reason this can never be made a Federal health measure, for endemic goiter does not exist in the majority of the states.

It would seem that the greatest good can be accomplished by a regular campaign of education regarding the cause and prevention of goiter in the counties in which goiter is endemic, under the direct supervision of the Health Departments of those counties, and the extension to every school in those counties of the practical preventive measure which is now being practiced in Syracuse, namely, the administration to each pupil of 10 mg of iodine—one iodostarine chocolate tablet—once a week. As a result of such a persistent educational and practical campaign, within a very few years the people will be caring for their own deficiency by the use of iodized salt if that proves to be efficient or by whatever other method the state or local Health Department may advise.

One of the most important, if not the most important phase of this whole goiter problem is the prevention of congenital goiter by the administration of iodine throughout the period of pregnancy. The importance of this point has never been sufficiently emphasized, and so this preventive measure is rarely used. It should be borne in mind that by this means it is possible to prevent most of the adenomatous goiters which are so unamenable to treatment. The administration of ten mgs of iodine per week throughout pregnancy and the period of lactation will prevent goiter in the mother and will insure a normal thyroid in the child. A proper and persistent educational campaign directed by the Health Department will soon lead every expectant mother to anticipate and demand this treatment.

been established for soon after it had been found that the normal thyroid contained iodine, we had demonstrated that the normal function of the thyroid was dependent on iodine

4 It had been found that the histological changes which always accompany the formation of a goiter were due to a deficiency of iodine. This was so universally true, not only in man but in all animals studied, that it became possible to speak of the variations in thyroid function, in terms of the iodine content. It was found that as long as the iodine content remained at or above 1 mg per gram of the dried gland (i.e., 0.1 per cent), no active hyperplasia took place, and that as soon as the iodine content fell below this amount active hyperplasia began.

5 The unusual thyroid activity during adolescence and during pregnancy and the consequent iodine deficiency and resultant hyperplasia at these periods were generally recognized. It was in accordance with these definitely proven physiological principles that the principle of goiter prevention was developed.

One of the first practical measures for the prevention of goiter was applied in 1910 at the Lakeside Maternity Dispensary when throughout pregnancy each patient received one ounce of syrup of hydriotic during each alternate month. During recent years this measure has been used in every maternity dispensary in Cleveland.

Marine's well-known study of the possibility of the prevention of goiter in fish was carried on in the Pennsylvania State Fish Hatcheries from 1909 to 1911. As the direct result of these and other studies in animals in 1916 the prevention of goiter was first considered as a problem of education and public health and the principle established by the earlier studies was practically applied in the schools of Akron, Ohio, with results which were so unmistakable that they left no doubt as to the value of the practical application of the principle of goiter prevention as a public health measure.

The questions of importance at the beginning of this preventive work were (1) How much iodine is needed and (2) how is it best administered? Not having any standard, we arbitrarily decided to use two grams of sodium iodide given over a period of ten days each spring and fall.

From our observation and study during the first year of this test we concluded that a much smaller amount of iodine given once a week throughout the school year would be sufficient and a better method of administration—that is, by this method we could keep the thyroid constantly saturated and not run the risk of seeing an occasional ill effect from

the larger dose. However, even with the dose given at first (3 grs NaI daily), the only ill effect we encountered was an iodine rash in one of each thousand cases under treatment.

In 1918, when this preventive measure was initiated in the schools of Zurich, Switzerland, tablets containing 5 mgs of iodine each were administered once a week. The results as reported by Dr Klinger have been very striking. In 1921, in several of the schools in the Cleveland district we introduced the method used in Switzerland, using the same chocolate Iodostarine tablets, each containing 10 mgs of iodine and administering one tablet per week throughout the school year.

This method of administration has made this preventive work so easy and even popular among the school children, that its application has extended very rapidly throughout the endemic goiter districts of this country and Canada. For instance, this method has been used systematically in the schools of Grand Rapids, Michigan, for two years, during which time fifteen thousand children have been taking 10 mgs of iodine once a week. The Health Commissioner states that this is the most practical and popular health measure he has ever introduced.

Under the guidance of the State Health Department approximately one-third of the schools of West Virginia are applying this health measure. This is the case in Washington and Utah also. Several other State Boards of Health are making special studies, surveys and plans in order to apply the preventive method in the most practical way.

Since 1920, in accordance with the suggestion of Dr H G Sloan of Cleveland, the Eli Lilly Company have manufactured an iodized table salt which contains sodium iodide in the proportion of one part to five thousand. This, however, has never had more than a limited drug store sale, and no conclusions can be drawn as to the result of its use.

The State Health Department of Michigan has been studying this phase of the question for four years. During the past year they have made a detailed study of the iodine content of the water in four counties in different parts of the state—Midland, Wexford, Houghton and Macomb—according to the method recently worked out by McClendon. The final analysis which has been sent to me by the State Health Department is as follows. In Midland County a complete analysis of the water throughout the county shows an iodine content of approximately 12 parts per billion. The goiter survey of all the school children in this county (3,645) shows the incidence of goiter to be 32.7 per cent. Wexford County has no iodine in the water, and the incidence of goiter in all children (3,984) is 55.6 per

policy, the plaintiff (employer) requested the insurance company to defend. The policy appears to have been a standard policy, and the insurance company declined, stating that it was not liable for payments to physicians. The employer permitted the doctor's action to go by default, and a judgment was recovered against the employer. Thereupon, the employer sued the insurance company, and the court held that the insurance company under its policy was obligated to defend and to pay the amount of the medical services. The employer thereupon obtained judgment against the insurance company.

It appears, therefore, that the physician, when authorized by the employer, has an absolute right against the employer, and under the standard policy the employer has a recourse against the insurance company. The procedure would undoubtedly be that after the physician sued the employer, the latter would send the papers to the insurance company, which would defend and would have to pay any judgment recovered. But there being no provision in the law or any privity between physician and the insurance company, the doctor could not directly force the insurance company to pay.

The Industrial Commissioner clearly has jurisdiction where the employee retains the physician. Section 13 covers that point, and provides the following requisites:

- (a) The employer must fail to provide medical treatment,
- (b) After request by the injured employee,
- (c) Form C-4 must then be filed,
- (d) Apparently no authorization is then required.

If these requirements are then complied with, the Commissioner has jurisdiction and apparently sole jurisdiction, not to make an award to the physician, but to give the physician a lien upon the compensation awarded to the workman to be paid therefrom in the manner fixed by the Commission as provided by Section 24 of the Statute.

It has been the practice of the referees of the Department of Labor to hear and decide cases presented by physicians who have not been paid for services, even when they have been authorized by the employer. The insurance carriers have been in the practice of defending these cases, and all parties have, with negligible exceptions, abided by the decision of the referees. In these cases the referees are apparently acting "extra jure" but in the interests of justice and common sense, otherwise the courts would be clogged with a multitude of petty cases. Furthermore, the physicians are beginning to realize the value of the written authorization, a bit of paper which guarantees their fee. These cases, then, if taken to the courts, would almost invariably be decided in favor of the physician with costs against the employer—a condition which would eventually

become very expensive for the insurance carrier, to say nothing of the antagonism that might be justifiably aroused in the employers who would be dragged into court by the doctor. It would be well, however, if all the physicians interested would communicate with their representative in the State Legislature to have the Law amended so that the referee would have legal jurisdiction in the determination of physicians' fees when the physician holds a written authorization from the employer. This would obviate the possibility of delay and annoyance in the collection of such fees, should present conditions be changed, or should a referee refuse to hear the doctor on the ground of "no jurisdiction."

At the present time there are two medical referees sitting on cases of this nature. Their duties, however, seem to include hearing cases of claims of injured employees, so that at times, they are not available for the purpose of hearing doctors' claims for medical services. At these times "lay" referees are assigned to hear the physicians' cases, and often their decisions are "bizarre," to put it mildly.

Physicians who desire a fair adjudication of their claims should write to the Industrial Commissioner and respectfully request that only medical referees be permitted to hear medical cases, whether it is the doctor's fee or any other medical question involved.

Section 13 of the law states that the physician treating a case is compelled to notify both the commission and the employer in writing within 20 days from the initial treatment. However, when the physician holds a written authorization from the employer he will be considered to have complied with the above requirement under the present attitude of the medical referees, for the reason that such authorization constitutes a contractual relation between physician and employer. Therefore knowledge of the accident on the part of the employer is assumed. The law requires the employer to notify the commission in the event of an accident. Knowledge of the accident on the part of the commission is therefore assumed. It is very essential to obtain authorization in writing. The written authorization should be in the following form—

Doctor .....  
Address

Please render .....  
of .....  
(Name of Patient)  
(Home Address)

such surgical treatment as is required  
Employer  
Address .....  
Insurance Co

Once the physician is in possession of a written authorization from the employer he is free

# THE PHYSICIAN AND THE COMPENSATION LAW

By ALBERT E. MAN, M.D.,  
NEW YORK, N. Y.

**S**INCE the advent of the New York State Compensation law about 10 years ago, revolutionary changes have come about in the relation of the physician to the patient who happens to be an employee, under the meaning of the word as defined under that law.

The inter-relation of Physician—Employer—Employee—Insurance Carrier (company) and the Department of Labor, which supervises these relationships, has proven to be an obstacle in the way of many physicians in their relationships with this class of patient, because the necessity of recognizing the newly related bodies, *i.e.* employer, carrier and Labor Department, has insinuated a new and apparently unassimilable element into their (the doctors') routine.

A working knowledge of the Compensation Law should be part of the doctor's stock of information just as is a similar knowledge of the Federal and State Prohibition and Narcotic laws. The acquisition of such knowledge is not a formidable undertaking; and indeed because it is practical to set it forth in a brief space, it shall be included in this paper. It will be well first, to define the terms—Employer—Employee—and the Insurance Carrier.

**Employer**—An employer is one who engages individuals to work. He has a certain number of employees under his supervision who are working for him for a fixed wage—so much a week, or so much a month, or so much a year, or doing piece work. The legal definition is as follows: "Employer," except when otherwise expressly stated, means a person, partnership, association, corporation, and the legal representatives of a deceased employer, or the receiver or trustee of a person, partnership, association or corporation, employing workmen in hazardous employments including the state and a municipal corporation or other political subdivision thereof (Subd 3 am'd by L 1914, ch 316).

**Employee**—An employee is one who contracts with an employer to work for such a wage. The legal definition is as follows: "Employee" means a person engaged in one of the occupations enumerated in section three or who is in the service of an employer whose principal business is that of carrying on or conducting a hazardous employment upon the premises or at the plant, or in the course of his employment away from the plant of his employer, and shall not include farm laborers or domestic servants (Subd 4 am'd by L 1916, ch 622, and L 1922, ch 615).

**Carrier**—By a carrier is meant the Insurance Company—the insurance representative of the employer. Article 1, Subd 12, states "Insurance Carrier" shall include the state fund, stock cor-

porations or mutual associations with which employers have insured, and employers permitted to pay compensation directly under the provisions of subdivisions three or four of section fifty (Subd. 12 am'd by L 1922, ch 615).

The New York State Compensation law requires all employers to insure against the contingency of paying an injured employee for loss of time, loss of a part of the body, and medical expenses to which he is entitled.

Under the New York Compensation law it is the employer who furnishes medical attention and should he fail to provide adequate medical attention the employee may provide it for himself. Under the law, when an employee is injured he is required to report the accident to his employer, and to file any claim within 30 days in writing. He is required to request medical services from the employer.

On the law as it has up to date been decided, where a contractual relation exists between the physician and the employer, the Industrial Commission has no jurisdiction to determine the physicians' fees or to award them. However, the law has not been enunciated by the highest courts.

The cases in point are Appellate Term cases. No doubt, the parties in those cases did not care to go further and were satisfied with the decisions. However, until a higher court of the State passed upon the question, these cases are decisive. These cases are:

*Felstein vs Buick Motor Co*, 187 NYS, p 517.

In that case the facts were that the plaintiff, a physician, sued the employer for professional services rendered at the request of the employer. The defendant resisted the claim, contending that the physician's *exclusive* remedy was by application to the Industrial Commissioner, and that therefore the Civil Court had no jurisdiction. Mr Justice Wagner writing the opinion, states:

"Recourse to a court of law, therefore follows as the *sole* remedy in the absence of a proper, express and comprehensive provision for enforcement under the act."

This means that where the physician is employed by the employer (and a contractual relation may exist in each individual case or over a definite period of time) the only remedy of the physician is by Civil action against the employer. Having reached that point, we come to the case of:

*Zamkin vs U S F & G Co*, 201 NYS, p 712.

There a workman of the plaintiff was injured. The plaintiff engaged a physician but refused to pay. The physician sued the plaintiff. Under its

- 11 State in patient's own words how the accident occurred
- 12 Give an accurate and complete description of nature and extent of the injury
- 13 Is the claimant's present disability a result of the injury above described
- 14 Will the injury result in
  - (a) Permanent defect if so, what
  - (b) Facial or head disfigurement
- 15 On what date do you think the injured person will be able to resume his usual work
- 16 On what date do you think the injured person will be able to resume any work

Form C-4 is considered *Prima Facie* evidence before the commission and if sent to the commissioner within 20 days following the beginning of treatment will be accepted as a rule in place of the physician's personal attendance at any hearing that may take place

However this practice is taken advantage of mainly, in regard to claims of injured for compensation due them exclusive of the doctor's fees and it is advisable in the event of a physician's bill being the subject of controversy that the physician or his representative be present at the hearing

There exists at the present time a condition of affairs in the relations of the physician and the insurance carrier, which while it does not come under the head of the compensation law is a direct outgrowth of it and of major importance to the physician. The condition referred to is the (so-called) "lifting of cases" on the part of the insurance carrier. Some physicians who feel that they have suffered unjustly from this practice refer to it as "stealing cases."

Many insurance carriers maintain clinics and a staff of physicians. As soon as they are notified of an accident, they get in touch with the patient and attempt to persuade him to quit the doctor attending him and come to the clinic.

Under pressure the patient often acquiesces and the doctor has lost a patient. This practice can only be combatted if the doctor anticipates it and warns the patient in advance to ignore any

threats, blandishments or other methods employed to this end.

In justice to the insurance carriers, it must be said, however, that they have to contend at times with medical men who are not too scrupulous. It is claimed that some doctors overcharge and pad their bills, that is, they charge for more visits than the patient makes. It is claimed that some doctors are notorious in this respect and of course the insurance companies soon find them out.

The majority of insurance companies, however, particularly the large ones of the better class, do not molest the patients of physicians whom they find to be honest. The first or second time an insurance company has dealings with a doctor, it may, by way of being on the safe side "lift" the case. Once the doctor is found to be honest and efficient he should have little trouble from this source.

At the same time it is a fact that there exist a few small and even an occasional large insurance company that evade their obligations routinely. This type of insurance carrier is a nuisance of the first class.

There are over sixteen thousand physicians in New York State, a body of men representing the most intelligent and influential of our citizens. Under proper leadership their combined efforts could quickly and easily eliminate through legal channels any man or group of men who are imposing on the community. Steps are now being taken to this end. Forcing an injured workman to accept the services of an insurance carrier physician might easily be construed as requiring him to testify against himself in the event of any hearing concerning his claim for compensation. The physician's testimony in an accident case is of prime importance.

The co-operation of the physicians of the State is invited to put an end to improper practices wherever they occur.

The writer will be glad to receive and turn over to the proper authorities communications that will further this object. Only by such action may justice and fairness be guaranteed to the physician and his patient.

to proceed as with any other patient, and apparently will be upheld in his actions by the courts should any reasonable bill or treatment be questioned by the employer

Unless the authorization is revoked in writing, the physician may employ nurses, trained or practical, may furnish apparatus or dressing to any amount necessary, may call consultants of his own choosing and as often as necessary, and may treat the patient unmolested until cured, regardless of the time necessary. The insurance carrier has no right to interfere on any ground, while treatment is in progress

Reasonableness of fee is required under the law, and while there exists no schedule of fees, these are limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living" (Section 13)

The following three paragraphs are extracted from article 24—"A physician called by the injured employee cannot sue the employer or insurance carrier—but a physician employed by the employer to treat his injured employee is not limited—and may sue the employer,"

An employer cannot maintain an action against a third party for medical services of the employer to his employee injured by the third party—nor can the Industrial Board give relief in such case

Dispensaries licensed under the State Charities Law—may receive and treat Workmen's Compensation cases"

A physician who treats a workman brought into a hospital clinic in an ambulance or other conveyance, if on duty at the time, should send in his personal bill, just as though the case were brought to his private office

Insurance carriers have no right to order an employer to send his injured employees to doctors designated or employed by the carrier. In fact it is a recognized principle that "the insurance carrier has no voice in the selection of the physician" (Case of Mezheritsky vs Mezheritsky and Miller, etc)

Certain injuries occurring to workmen are not compensatable and in such cases the physician must look to the employee for his fee. The accident or disease in order to be compensatable must arise out of or in the course of his employment. As this feature of the law is of great moment to physicians, we will present some illustrative cases culled from decisions that have been made

Injury and personal injury mean only accidental injuries arising out of and in the course of employment and such disease or infection as may naturally and unavoidably result therefrom

According to definition approved by the Appellate Division and the Court of Appeals, an accident is "an unlooked for mishap or an untoward event which is not expected or designed," being limited so that "an act done deliberately and wil-

fully by a third party may be an accident from the viewpoint of employer and employee."

Loss of vision due to strong light is not an accident, neither is swelling of an elbow due to constant twisting of cans, neither is illness due to repeatedly dipping the fingers in poisonous solutions. For want of evidence showing causal connection, the courts have reversed awards for frog felon alleged to have been due to constant use of a screw driver

A wound not incurred in the employment but permitting infection in the employment may be a compensatable accident, also puncturing or bursting of a blister, permitting infection, also cracking of the skin, admitting a poisonous powder, also heat prostration, also frostbite, also dizziness due to working position, also strain due to prolonged overreaching and lifting, also fright, also exposure to an excessive draft of cold air, also chill from working in icy water, also drinking water polluted with typhoid germs, also inhalation of dust, also asphyxiation, also inhalation of poisonous fumes or gases

While the above points are stated briefly and without elaboration they really constitute the sum total of the Workmen's Compensation law as far as the physician is concerned

In order for the physician to benefit to the fullest extent the following summary of his obligations should be observed —

1 Secure written authorization, signed by the employer in person or his authorized agent, foreman or manager

2 Keep fees within reason—examples

\$2 to \$3 for dressings

\$75 to \$100 for hernia operations

\$100 to \$150 for limb amputations

\$200 to \$300 for kidney removal

3 Send bills to employer and duplicate bill with surgeon's report on Bureau of Workmen's Compensation form C-4, to insurance carrier

4 If insurance carrier does not reply or fails to pay, request a hearing from the Industrial Commissioner in writing

5 Keep an accurate record of the case and be prepared to answer the following questions, which constitute the body of form C-4

1 Name of injured person

2 Present address

3 Name of employer

4 Office address

5 Date of accident

6 Was first treatment rendered by you  
When

7 If not, by whom  
Address

8 When did you first treat claimant

9 Who engaged your services

10 Was injured person removed to hospital  
Name and address

- 11 State in patient's own words how the accident occurred
- 12 Give an accurate and complete description of nature and extent of the injury
- 13 Is the claimant's present disability a result of the injury above described
- 14 Will the injury result in
  - (a) Permanent defect if so, what
  - (b) Facial or head disfigurement
- 15 On what date do you think the injured person will be able to resume his usual work
- 16 On what date do you think the injured person will be able to resume any work

Form C-4 is considered *Prima Facie* evidence before the commission and if sent to the commissioner within 20 days following the beginning of treatment will be accepted as a rule in place of the physician's personal attendance at any hearing that may take place

However this practice is taken advantage of mainly, in regard to claims of injured for compensation due them exclusive of the doctor's fees and it is advisable in the event of a physician's bill being the subject of controversy that the physician or his representative be present at the hearing

There exists at the present time a condition of affairs in the relations of the physician and the insurance carrier, which while it does not come under the head of the compensation law is a direct outgrowth of it and of major importance to the physician. The condition referred to is the (so-called) 'lifting of cases' on the part of the insurance carrier. Some physicians who feel that they have suffered unjustly from this practice refer to it as 'stealing cases'

Many insurance carriers maintain clinics and a staff of physicians. As soon as they are notified of an accident, they get in touch with the patient and attempt to persuade him to quit the doctor attending him and come to the clinic

Under pressure the patient often acquiesces and the doctor has lost a patient. This practice can only be combatted if the doctor anticipates it and warns the patient in advance to ignore any

threats, blandishments or other methods employed to this end

In justice to the insurance carriers, it must be said, however, that they have to contend at times with medical men who are not too scrupulous. It is claimed that some doctors overcharge and pad their bills, that is, they charge for more visits than the patient makes. It is claimed that some doctors are notorious in this respect and of course the insurance companies soon find them out

The majority of insurance companies, however, particularly the large ones of the better class, do not molest the patients of physicians whom they find to be honest. The first or second time an insurance company has dealings with a doctor, it may, by way of being on the safe side 'lift' the case. Once the doctor is found to be honest and efficient he should have little trouble from this source

At the same time it is a fact that there exist a few small and even an occasional large insurance company that evade their obligations routinely. This type of insurance carrier is a nuisance of the first class

There are over sixteen thousand physicians in New York State, a body of men representing the most intelligent and influential of our citizens. Under proper leadership their combined efforts could quickly and easily eliminate through legal channels any man or group of men who are imposing on the community. Steps are now being taken to this end. Forcing an injured workman to accept the services of an insurance carrier physician might easily be construed as requiring him to testify against himself in the event of any hearing concerning his claim for compensation. The physician's testimony in an accident case is of prime importance

The co-operation of the physicians of the State is invited to put an end to improper practices wherever they occur

The writer will be glad to receive and turn over to the proper authorities communications that will further this object. Only by such action may justice and fairness be guaranteed to the physician and his patient



# EDITORIALS



The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

*Editor-in-Chief*—NATHAN B VAN ETEN, M.D., New York  
*Associate Editor*—ORRIN SAGE WIGHTMAN, M.D., New York  
*Executive Editor*—FRANK OVERTON, M.D., Patchogue

### COMMITTEE ON PUBLICATION

E ELIOT HARRIS, M.D, *Chairman* New York  
ORRIN SAGE WIGHTMAN, M.D. New York  
EDWARD LIVINGSTON HUNT, M.D. New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

*President*—OWEN E JONES, M.D. Rochester  
*First Vice President*—GEORGE A. LEITNER, M.D. Piermont  
*Second Vice President*—LUZERN COVILLE, M.D. Ithaca  
*Speaker*—E. ELIOT HARRIS, M.D. New York  
*Vice Speaker*—GEORGE M FISHER, M.D. Utica  
*Secretary*—EDWARD LIVINGSTON HUNT, M.D. New York  
*Assistant Secretary*—WILBUR WARD, M.D. New York  
*Treasurer*—CHARLES GORDON HEYD, M.D. New York

### CHAIRMAN, STANDING COMMITTEES

*Arrangements*—FREDERICK H FLAHERTY, M.D. Syracuse  
*Public Health and Medical Education*,  
JOSHUA M. VAN COTT, M.D., Brooklyn  
*Scientific Work*—ANDREW MACFARLANE, M.D. Albany  
*Medical Economics*—HENRY LYLE WINTER, M.D. Cornwall  
*Legislation*—JAMES N VANDER VEER, M.D. Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex-President and the Councilors of the District Branches.

*First District*—EDWARD C. RUSHMORE, M.D. Tuxedo Park  
*Second District*—FRANK H LASHER, M.D. Brooklyn  
*Third District*—ARTHUR J BEDELL, M.D. Albany  
*Fourth District*—CHARLES C TREMBLEY, M.D. Saranac Lake  
*Fifth District*—NELSON O BROOKS, M.D. Oneida  
*Sixth District*—GEORGE H FOX, M.D. Binghamton  
*Seventh District*—WILLIAM I. DEAN, M.D. Rochester  
*Eighth District*—HARRY R. TRICK, M.D. Buffalo

### COUNSEL

GEORGE W WHITESIDE Esq., 27 William St. New York  
Telephone, Broad 1744

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St. New York

### EXECUTIVE OFFICER

JOSEPH S LAWRENCE, M.D. 51 Chapel Street, Albany

### SECTION OFFICERS

*Medicine*  
*Chairman*—ROBERT L. LEVY, M.D. New York  
*Secretary*—L. WHITTINGTON GORHAM, M.D. Albany

*Surgery*  
*Chairman*—MARSHALL CLINTON, M.D. Buffalo  
*Secretary*—EDWARD S VAN DUYN, M.D. Syracuse

*Obstetrics and Gynecology*  
*Chairman*—HAROLD C BAILEY, M.D. New York  
*Secretary*—NATHAN P SEARS, M.D. Syracuse

*Pediatrics*  
*Chairman*—JOSEPH C. PALMER, M.D. Syracuse  
*Vice-Chairman*—ROGER H DENNETT, M.D. New York  
*Secretary*—ARTHUR W BENSON, M.D. Troy

*Eye, Ear, Nose and Throat*  
*Chairman*—ARTHUR G BENNETT, M.D. Buffalo  
*Secretary*—EUGENE E HINMAN, M.D. Albany

*Public Health, Hygiene and Sanitation*  
*Chairman*—PAUL B BROOKS, M.D. Albany  
*Secretary*—ARTHUR D JACQUES, M.D. Lynbrook

*Neurology and Psychiatry*  
*Chairman*—EUGENE N BOUDREAU, M.D. Syracuse  
*Secretary*—CLARENCE O CHENEY, M.D. Utica

## THE LEGISLATION DEPARTMENT OF THE JOURNAL

The principal reason for publishing this Journal weekly during the months of winter and early spring is to inform our members regarding legislative bills which affect public health or the medical profession. To list the bills as they are introduced, and to print the more important ones require fifteen pages of each issue. About the usual number of bills have been introduced and the same subjects covered as in the past. One year's grist of the legislative mill is about like that of any other year.

We expect to continue to print descriptions of the bills as fast as they are introduced, and to comment on them from time to time during their progress, or retrogression through the legislature.

The more important bills are nearly the same as they were in 1924, and our comments last year will apply equally well this year. However, our members may expect that in the future an increasing proportion of our space will be given to comments and explanations of the bills.



## IDEALS OF A COUNTY MEDICAL SOCIETY

Of what does a County Medical Society consist?

The ideal county medical society consists of all the physicians who live in the county. This ideal is almost reached in a few counties. The average county society enrolls from 65 to 70 per cent of the physicians of a county. There are about 15,000 physicians in New York State of whom somewhat less than 11,000 belong to the county medical societies.

A county medical society has all kinds of physicians in its membership list. There are general practitioners and specialists, insurance men and public health workers, surgeons and laboratory technicians, salaried doctors and fee collectors, young doctors seeking business and retired physicians who cannot drive their old patients away. The membership includes scientists and sports, smokers and haters of nicotine, church goers and golfers, farmers and society butterflies—every conceivable class is represented except the rascals,—and there are so few rascals in the profession that the name of one who happens to afflict a community immediately becomes a by-word of scorn among physicians.

What are the common bonds between the members of a county society? They may be classed as internal and external.

The internal bonds are those of congeniality. Physicians share in the common aims and ideals of the profession and carry the secrets of the inmost lives of every person in the community. No other group of persons are trusted as the doctors are. They naturally form a fraternity in which each trusts the other and confidence is seldom abused. The County Medical Society is the basic medical fraternity which is open to practically every physician in the state, and its sociability and friendship appeal to an increasing proportion of the physicians of New York State.

Then, too, there are the tangible bonds between the members of the county medical societies—a subscription to the *NEW YORK STATE JOURNAL OF MEDICINE*, defense in mal-practice suits, and a share in the post-graduate instruction afforded by the programs of the meetings. What physician can afford to miss these opportunities?

The external bonds between members of county medical societies are those of a common civic duty. Physicians are public spirited and

are willing to donate their share of services to the community. The ministers of the Gospel contribute inspiration toward righteous living, the lawyer leads in village improvements, the firemen save property and lives, and the physician is willing and anxious to advise the community in regard to pure milk, wholesome water, sewage disposal, and protection against contagious diseases.

While the physician is willing to contribute his medical skill to the community, he has small influence except in a collective way. The practice of *civic medicine* is done principally by means of medical societies. The great bond which justifies the existence of medical societies in the eyes of the public is the appeal of its civic activities. Any physician is proud to belong to a medical society which accomplishes things in a community.

What can a physician contribute to a county medical society? The society has need of many kinds of gifts. One physician has superior ability as a financier—he will be chairman of the ways and means committee, another has the gift of writing, and he will be chairman of the publicity committee, one is a good mixer and a politician, and he will be chairman of a legislative committee. For every position which requires a special talent, some physician can be found who has both the skill and the desire to fill it.

And when the positions are all filled by local specialists, the great mass of members will be proud of their medical society and will gladly support its activities with their dues and their influence, and will feel that their leaders are voicing the ideals and aspirations which they have but cannot express.

It is the object of the State Medical Society to express the aims and policies of the county societies, to advise them regarding lines of work to undertake and to give publicity to the work which they have accomplished. We have watched with great satisfaction the growth of a sense of civic responsibility among the members of the county medical societies throughout the entire State of New York. County societies are rapidly making their influence felt in the community, and are bringing honor to the medical profession and the respect of the community to the individual physicians.



# LEGAL



By **GEORGE W. WHITESIDE, Esq.**  
Counsel, Medical Society of the State of New York

## CONVICTION UNDER HARRISON NARCOTIC LAW, AND ITS EFFECT ON A PHYSICIAN'S LICENSE

The license of any medical practitioner is automatically revoked should he suffer conviction of a felony. This is a very severe punishment that is inflicted in addition to the sentence that the criminal court imposes as a penalty for the conviction.

One naturally thinks of a felon as a debased person who is safer behind prison bars than at large in society, and that naturally such a person should not be permitted to practice medicine or law. The felony one has in mind in this way involves acts of moral turpitude, acts that in themselves are wrong—statute or no statute. It is wrong to take human life, to steal, to grievously injure another without cause, whether or not the statute says so.

But there are many felonies in the commission of which there is no wrong other than the wrong of doing something the law prohibits. To illustrate a physician the day before the Harrison Narcotic Law became effective prescribed nar-

cotics for a patient, ethically and properly, for the patient's good. The same act the next day became unlawful unless the physician had conformed to the new statute. For such violation he could be convicted of a felony and lose his license to practice. Thus by mere legislative act a man is made a felon over night, and yet he has done nothing inherently immoral or wrong.

It seems clear that so long as our Legislatures and Congress are making acts that are legal and proper today felonies tomorrow, the law that works automatic forfeiture of a doctor's license for conviction of felony should be modified so that the Regents would have power to inquire into the facts and revoke his license only when the physician so convicted has been guilty of moral turpitude. In this way the drug peddler would still feel the full rigor of the law, as he should, but the doctor, whose offense has been inadvertent, would not be given the same treatment and his professional career and life ruined.

## OPERATION WITHOUT CONSENT

This action was instituted against two physicians, and the complaint charged that one of them was engaged to remove a growth from the plaintiff's breast and that without the plaintiff's knowledge or consent and contrary to her expressed directions, desires and wishes this surgeon engaged another surgeon to perform the operation, that by reason of the negligence of defendants the second surgeon in attempting to perform the operation upon the plaintiff contrary to her directions and without her knowledge or consent made a four-inch incision in the plaintiff's body several inches from the point of the growth on the plaintiff's breast and that they failed to remove the growth on the breast or in any way remedy this condition of the plaintiff, that by reason of the negligence of the defendants in their operation at a different place upon her body without her consent, plaintiff claims that she suffered injury, that the condition for which she was to be operated upon was not relieved, that it was necessary for her to submit to a further operation to relieve such condition and that she was required to expend moneys for medical nursing and hospital care.

The plaintiff had consulted the first physician for a lump in her right breast near the median line which had been there for several years. She was advised that it was best that she be operated upon for the removal of the lump. Arrangements were subsequently made for the performance of the operation and the plaintiff entered the hospital. The first physician arranged with another surgeon to perform the operation. The plaintiff protested against the performance of the operation by the second surgeon. She was advised, however, that the anaesthesia would be given by the first physician and she then consented to the operation for the removal of the lump on her breast. The plaintiff was anaesthetized and both physicians examined her while under the anaesthesia, but could not locate the swelling complained of. The second physician, however, felt a small mass about four inches lower than the one complained of by the plaintiff. An operation was performed upon the mass which was located about four inches below the point complained of and a small tumor removed. The incision was closed and the plaintiff made a good recovery,

leaving the hospital in about ten days. Subsequently the suit for operation without consent was instituted against both physicians. The consent of the plaintiff to perform a specific operation did not carry with it consent for the surgeons to

perform the operation which they did and under the authorities of this state the same was an operation without consent or an assault. Before trial the matter was compromised by a payment to the plaintiff by the defendants.

---

### SALPINGITIS CLAIMED DUE FROM STEM PESSARY INSERTED BY PHYSICIAN

In this action it was charged that the plaintiff a married woman, had consulted the defendant, a physician, who advised her with respect to her physical condition arising from the insertion in her person of an article described by the plaintiff as a button and which, it was claimed, had been inserted by the defendant about two years prior thereto. It was further claimed that after examination by the defendant, he advised that it was necessary for the plaintiff to be operated upon by reason of the condition caused by the button, that the defendant did perform an operation upon the plaintiff which, it is claimed, was carelessly and negligently done, causing injury to the plaintiff.

The plaintiff had sought the defendant's advice and upon a physical examination made by him he found within her person a metal stem pessary. From the patient's history and his examination he concluded that she had previously thereto been pregnant and had had an incomplete abortion. The uterus was found to be large and soft and somewhat swollen on one of the sides. The pessary was removed and the patient advised to remain in bed, that the physician would see her within a few days to determine what had developed. She was then advised that it would be necessary to perform a curettage, and under a general anaesthesia the uterus was cleaned by manipulation and by a dull curette, there being extracted small pieces of decomposed membrane. At this time she had a slight rise in temperature. The patient was put to bed and a few days there-

after her temperature became normal. She subsequently complained of pain in the region of the ovaries and tubes. The patient was ordered to bed and an ice bag applied. When the defendant returned the following day another physician was attending the plaintiff and the defendant was discharged from further treatment of the case. The defendant's treatment of the plaintiff took place during the first ten days of June. Towards the end of June she entered hospital where the attending surgeon performed a salpingo oophorectomy with drainage. Upon examination there was found that the plaintiff was suffering from salpingitis and that the operation was necessary. The patient remained at the hospital for about six weeks. The pathological report showed an acute suppurative salpingitis and a smear of pus bacteriologically examined showed the presence of pus cells.

Upon the trial of the action the plaintiff offered testimony in support of the allegations of her complaint. She also compelled the appearance under a subpoena of the surgeon who had performed the operation, who testified to the operation performed by him, but refused to testify as an expert or offer any opinion as to the cause of the plaintiff's condition. The defendant in his own behalf testified to his version of his examination, treatment and care of the plaintiff and supported his testimony by that of experts. After several hours of deliberation the jury vindicated the defendant by rendering a verdict in his favor.



# LEGAL



By **GEORGE W. WHITESIDE, Esq.**  
Counsel, Medical Society of the State of New York

## CONVICTION UNDER HARRISON NARCOTIC LAW, AND ITS EFFECT ON A PHYSICIAN'S LICENSE

The license of any medical practitioner is automatically revoked should he suffer conviction of a felony. This is a very severe punishment that is inflicted in addition to the sentence that the criminal court imposes as a penalty for the conviction.

One naturally thinks of a felon as a debased person who is safer behind prison bars than at large in society, and that naturally such a person should not be permitted to practice medicine or law. The felony one has in mind in this way involves acts of moral turpitude, acts that in themselves are wrong—statute or no statute. It is wrong to take human life, to steal, to grievously injure another without cause, whether or not the statute says so.

But there are many felonies in the commission of which there is no wrong other than the wrong of doing something the law prohibits. To illustrate, a physician the day before the Harrison Narcotic Law became effective prescribed nar-

cotics for a patient, ethically and properly, for the patient's good. The same act the next day became unlawful unless the physician had conformed to the new statute. For such violation he could be convicted of a felony and lose his license to practice. Thus by mere legislative act a man is made a felon over night, and yet he has done nothing inherently immoral or wrong.

It seems clear that so long as our Legislatures and Congress are making acts that are legal and proper today felonies tomorrow, the law that works automatic forfeiture of a doctor's license for conviction of felony should be modified so that the Regents would have power to inquire into the facts and revoke his license only where the physician so convicted has been guilty of moral turpitude. In this way the drug peddler would still feel the full rigor of the law, as he should, but the doctor, whose offense has been inadvertent, would not be given the same treatment and his professional career and life ruined.

## OPERATION WITHOUT CONSENT

This action was instituted against two physicians, and the complaint charged that one of them was engaged to remove a growth from the plaintiff's breast and that without the plaintiff's knowledge or consent and contrary to her expressed directions, desires and wishes this surgeon engaged another surgeon to perform the operation, that by reason of the negligence of defendants the second surgeon in attempting to perform the operation upon the plaintiff contrary to her directions and without her knowledge or consent made a four-inch incision in the plaintiff's body several inches from the point of the growth on the plaintiff's breast and that they failed to remove the growth on the breast or in any way remedy this condition of the plaintiff, that by reason of the negligence of the defendants in their operation at a different place upon her body without her consent, plaintiff claims that she suffered injury, that the condition for which she was to be operated upon was not relieved, that it was necessary for her to submit to a further operation to relieve such condition and that she was required to expend moneys for medical nursing and hospital care.

The plaintiff had consulted the first physician for a lump in her right breast near the median line which had been there for several years. She was advised that it was best that she be operated upon for the removal of the lump. Arrangements were subsequently made for the performance of the operation and the plaintiff entered the hospital. The first physician arranged with another surgeon to perform the operation. The plaintiff protested against the performance of the operation by the second surgeon. She was advised, however, that the anaesthesia would be given by the first physician and she then consented to the operation for the removal of the lump on her breast. The plaintiff was anaesthetized and both physicians examined her while under the anaesthesia, but could not locate the swelling complained of. The second physician, however, felt a small mass about four inches lower than the one complained of by the plaintiff. An operation was performed upon the mass which was located about four inches below the point complained of and a small tumor removed. The incision was closed and the plaintiff made a good recovery.

Assembly Int 184—Workmen's Compensation Law, authorizing physical examinations and practical tests of claimant to determine loss of use of a member, result and test to be part of record Digest printed in January 23rd Journal

Assembly Int 185—Defining and regulating the practice of Chiropractic Bill printed in January 23rd Journal

Assembly Int 191—Workmen's Compensation Law, in re enforcing claims Bill printed in February 6th Journal

Assembly Int 201—Workmen's Compensation Law, in re compensation for disabilities or death resulting from poisoning, etc Bill printed in February 6th Journal

Assembly Int 202—Workmen's Compensation Law, in re compensation for poisoning by gasoline or other volatile petroleum products Bill printed in February 6th Journal

Assembly Int 203—Workmen's Compensation Law, providing for compensation in case of infection or inflammation of skin on contact surfaces, due to oils, cutting compound, etc Bill printed in February 6th Journal

Assembly Int 204—Workmen's Compensation Law, providing for compensation in case of diseases due to inhaling silica dust Bill printed in February 6th Journal

Assembly Int 214 — State Charities Law, authorizing investigations by superintendent or officer designated by him, and authorizing an arrangement for use of laboratory service of hospital Bill printed in February 6th Journal

Assembly Int 215—Public Health Law, in re habit forming drugs, conc Senate Int 115 Bill printed in January 23rd Journal

Assembly Int 216—Insanity Law, requiring licensing of private institutions for treatment of drug addicts, conc Senate Int 116 Bill printed in January 23rd Journal

Assembly Int 229—Education Law, providing for county supervisors to supervise education of children with retarded mental development Digest printed in January 30th Journal

Assembly Int 233—Workmen's Compensation Law, authorizing industrial board to permit claim for compensation to be filed within two years after accident or death Digest printed in January 30th Journal

Assembly Int 236—State Charities Law, empowering State Charities Board, among other things, to visit and inspect all institutions in which children are received or cared for, and to establish rules therefor, conc Senate Int 228 Digest printed in January 30th Journal

Assembly Int 237—State Charities Law, empowering State Charities Board to visit and inspect places where children, for appearance in court, are held and to establish rules therefor, conc Senate Int. 231 Digest printed in January 30th Journal

Assembly Int 301—Workmen's Compensation Law, permitting injured employees, at employer's expense, to engage medical or other attendance Bill printed in February 6th Journal

Assembly Int 302—Labor Law, permitting employment of females at night in any occupation in which it is lawful for males to work at night Digest printed in January 30th Journal

Assembly Int 307 — Public Health Law, amending Medical Practice Act, conc. Senate Int 211 Bill printed in January 30th Journal

Assembly Int 384—Greater New York Charter, requiring education board to furnish free eye glasses to school children unable to pay therefor Digest printed in January 30th Journal

Assembly Int 286—Workmen's Compensation Law, relative to fibroid phthisis (silicosis) Bill printed in January 30th Journal

Assembly Int 399—County Law, in re expenses of public health nurses Bill printed in February 6th Journal

Assembly Int 413—Public Health Law, empowering local health boards to prescribe that a person wilfully violating or omitting to comply with lawful order or regulation prescribed by it or a local health officer shall be guilty of a misdemeanor Bill printed in February 6th Journal

Assembly Int 414—Criminal Code, giving Special Sessions Courts jurisdiction in cases of wilful violation to comply with lawful order of local health board or officer, where penalty does not exceed \$50 nor imprisonment six months Bill printed in February 13th Journal

Assembly Int 434—Prison Law, providing for removal to hospitals of prisoners confined either for civil or criminal cause, when they require immediate medical or surgical treatment Bill printed in February 13th Journal



# LEGISLATION



By JAMES N. VANDER VEER, M.D.  
Chairman, Committee on Legislation.

## INDEX OF BILLS OF INTEREST TO THE MEDICAL PROFESSION IN SENATE

Senate Int 11—Labor Law, in re hours of employment of females Digest printed in January 23rd Journal

Senate Int 115—Public Health Law, in re habit forming drugs Bill printed in January 23rd Journal

Senate Int 116 — Insanity Law, requiring licensing of private institutions for treatment of drug addicts Bill printed in January 23rd Journal

Senate Int 211—Public Health Law, amending Medical Practice Act Bill printed in January 30th Journal

Senate Int 228—State Charities Law, empowering State Charities Board to visit and inspect all institutions in which children are received or cared for Digest of bill printed in January 30th Journal

Senate Int 263—Insanity Law, relative to qualifications of examiners in lunacy Bill printed in February 6th Journal

Senate Int 266—Workmen's Compensation Law, providing for expenses for rehabilitating injured employees Digest printed in February 6th Journal

Senate Int 278—Criminal Code, in re violations of orders of local health boards Bill printed in February 6th Journal

Senate Int 282—Public Health Law, empowering local health board to prescribe that a person wilfully violating or omitting to comply with any lawful order or regulation prescribed

by it or a local health officer shall be guilty of a misdemeanor Bill printed in February 6th Journal

Senate Int 283—County Law, in re providing expenses of public health nurses Bill printed in February 6th Journal

Senate Int 302—Education Law, relative to medical inspection and health service in public schools Bill printed in February 6th Journal

Senate Int 308—Workmen's Compensation Law, relative to fibroid phthisis (silicosis) Bill printed in January 30th Journal, under conc. Assembly Int 386

Senate Int 349—Public Health Law, relative to powers and duties of local health boards Bill printed in February 13th Journal

Senate Int 351—Public Health Law, permitting physician to use vaccine virus to prevent smallpox, etc Bill printed in February 13th Journal

Senate Int 380—Workmen's Compensation Law, in re medical and surgical attendance for injured employees, by providing employee shall select physician Bill printed in February 6th Journal

Senate Int 473—Public Health Law, relative to drugless therapy Bill printed in February 13th Journal

## IN ASSEMBLY

Assembly Int 64—Labor Law, in re hours of employment of females, conc Senate Int 11 Digest printed in January 23rd Journal

Assembly Int 120—Labor Law, in relation to furnishing nursing and first aid services in factories and mercantile and other establishments Bill printed in January 23rd Journal

Assembly Int 123—Tax Law, permitting deductions from income for tax purposes of all expenses paid during the year for medical, surgical or dental services Bill printed in January 23rd Journal

Assembly Int 127—Education Law, providing

that boards of education and trustees shall appoint physicians and dentists and may employ nurses for service in schools Bill printed in January 23rd Journal

Assembly Int 152—Workmen's Compensation Law, striking out provision that claim for medical treatment shall not be valid against employer unless physician within 20 days following first treatment furnish report of injury Digest printed in January 23rd Journal

Assembly Int 182—Workmen's Compensation Law, providing compensation for disability shall not exceed \$30 per week, instead of \$20 as at present Bill printed in February 6th Journal

No 29

Int 29

IN SENATE,

January 7, 1925

Introduced by Mr Wales—read twice and ordered printed, and when printed to be committed to the Committee on Codes

AN ACT

To amend the penal law, in relation to intoxicating liquor

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 The penal law is hereby amended by inserting therein a new article, to be article one hundred and thirteen, to read as follows

ARTICLE 113

INTOXICATING LIQUOR

- |              |   |
|--------------|---|
| Section 1210 | Definition of intoxicating liquor                               |
| 1211         | Definition of intoxicating liquor to conform to federal statute |
| 1212         | Prohibited transactions in intoxicating liquor                  |
| 1213         | Exceptions, application of article                              |
| 1214         | Sale on a physician's prescription                              |
| 1214-a       | Prescriptions for intoxicating liquor                           |
| 1214-b       | Records required  |
| 1214-c       | Transportation restrictions                                     |
| 1214-d       | Illegal advertisements in respect of intoxicating liquor        |
| 1214-e       | Unlawful utensil, et cetera, for manufacture                    |
| 1214-f       | Unlawful solicitations of orders                                |
| 1214-g       | Maintenance of place where violations are committed             |
| 1214-h       | Possession or taking orders in violation of article             |
| 1214-i       | Nonbeverage preparations  |
| 1215         | Register of permit  |
| 1216         | Possession as evidence, burden of proof                         |
| 1217         | Injunction proceedings  |
| 1218         | Penalties   |
| 1219         | No double jeopardy  |

§ 1210 Definition of intoxicating liquor When used in this article the phrase "intoxicating liquor" shall be construed to include alcohol, brandy, whiskey, rum, gin, beer, ale, porter and wine, and in addition thereto any spirituous vinous, malt or fermented liquor liquids and compounds, whether medicated, proprietary patented or not, and by whatever name called containing one-half of one per centum or more of alcohol by volume which are fit for use for beverage purposes

§ 1211 Definition of intoxicating liquor to conform to federal statute Notwithstanding the provisions of the preceding section, the phrase intoxicating liquor, for the purpose of this

article, shall have the meaning defined by the congress from time to time hereafter for the purpose of enforcing the provisions of the eighteenth amendment to the constitution of the United States If this section be held to be invalid, it is hereby provided that other provisions of this article which are not expressly held to be invalid shall continue in full force and effect

§ 1212 Prohibited transactions in intoxicating liquor 1 Any person who barter, transports, imports, exports, delivers, furnishes, manufactures or sells any intoxicating liquor to be used for beverage purposes, or who barter, transports, imports, exports, delivers, furnishes, manufactures or sells any intoxicating liquor for non-beverage purposes, unless he shall be the holder of a permit therefor from the proper federal authorities and shall have registered such permit as provided in this article, shall be punishable for a first offense by a fine of not more than one thousand dollars, or by imprisonment for not more than six months, and for a second and subsequent offense by a fine of not less than two hundred dollars nor more than two thousand dollars, and by imprisonment for not less than thirty days nor more than five years

2 Any person who possesses any intoxicating liquor to be used for beverage purposes, or who possesses any intoxicating liquor for nonbeverage purposes, unless he shall be the holder of a permit therefor from the proper federal authorities and shall have registered such permit as provided in this article, shall be punishable upon conviction for the first offense by a fine of not more than fifty dollars, and upon conviction for a second offense by a fine of not less than one hundred dollars nor more than one thousand dollars, or imprisonment for not more than ninety days or both, and upon conviction for any subsequent offense by a fine of not less than five hundred dollars and imprisonment for not less than three months nor more than two years

§ 1213 Exceptions, application of article Nothing in this article shall be construed to forbid

1 The possession of intoxicating liquor in one's private dwelling or abode while the same is occupied by him as a dwelling, provided such intoxicating liquor was legally his property before the enactment of this section and is for use only for the personal consumption of the owner thereof and his family residing in such dwelling and of his bona fide guests when entertained by him therein

2 The manufacture and possession of nonintoxicating cider and fruit juices by a person exclusively for use in his home

3 The temporary possession of cider by the manufacturer thereof and its sale by him to a manufacturer of vinegar, who is the holder of a permit from the proper authorities of the United

Assembly Int 678—Public Health Law, requiring that every person employed in preparing or handling of food in any factory or other place shall, at time of entering employment and every six months thereafter, be examined by a physician to determine whether person has a communicable disease 'Bill printed in February 13th Journal

Assembly Int 748—Education Law, relative to medical inspection and health service in public schools, conc Senate Int 302 Digest printed in February 13th Journal

Assembly Int 756—Public Health Law, providing for cleanliness in shellfish industry and for medical examination of workers, conc Senate Int 530 Digest printed in February 13th Journal

## SUMMARY OF BILLS INTRODUCED IN LEGISLATURE IN SENATE

Senate Int No 11 (conc Assembly Int 64)—A bill introduced in the Senate by Senator Seabury C Mastick of Westchester County, concurrent Assembly Int No 64, introduced in the Assembly by Assemblyman Herbert R Shonk of Westchester County, would amend sections 172, 181, Labor Law, by prohibiting employment of females over 16 years of age more than 48 hours a week in factories and mercantile establishments, except that for not exceeding eight weeks in any year, divided into not more than six days or 54 hours a week or nine hours a day provided notice of such extension of working hours be sent to Industrial Commissioner at least three days before

Referred to Labor and Industries Committee of both houses No action on bill as yet

*Comment* Unless comment or request should come from any member of the Society relative to the above bill, the Committee on Legislation will drop it from the list and not revive it save as there may be amendments offered thereto which concern the medical profession

Senate Int No 29 (conc Assembly Int 527)—A bill introduced in the Senate by Senator B Roger Wales of Binghamton, N Y, concurrent Assembly Int 527, introduced in the Assembly by Assemblyman Edmund B Jenks, of Broome County, would add new article 113, Penal Law, relative to intoxicating liquor

Referred to Codes Committees of both houses

*Comment* This is an act to amend the Penal Law by inserting a new article to be known as Article 113, beginning with section 1210, which defines intoxicating liquors naming certain liquids "whether medicinal, proprietary, patent or not, and by whatever name called, containing one-half of one per cent of alcohol by volume which are fit for use for beverage purposes"

Section 1211, however, gives the latitude that this construction shall have the meaning defined

by Congress from time to time hereafter for the purpose of enforcing the provisions of the 18th amendment \* \* \* If this section be held to be invalid, "it is hereby provided that other provisions of this article which are not expressly held to be invalid shall continue in full force and effect"

Section 1212, subsection 1, notes the prohibitive transaction in intoxicating liquors to be used for beverage purposes \* \* \* "or sells any intoxicating liquor for non-beverage purposes unless he shall be the holder of a permit therefor from the proper federal authorities, and so on \* \* \*

Subsection 2 provides for conviction and fine of any person who possesses any intoxicating liquor to be used for beverage purposes "or who possesses any intoxicating liquor for non-beverage purposes unless he shall be a holder of a permit," etc

Section 1213 excepts, first, the possession of intoxicating liquor in one's private dwelling or abode, etc

Subsection 2 mentions non-intoxicating cider and fruit juices exclusively for use in his home

Subsection 3, the temporary possession of cider to be sold to a manufacturer of vinegar, etc

Subsection 4 relates to a manufacturer of intoxicating liquor

Subsection 5 has to do with possession, storage and removal of lawfully acquired liquor

Subsection 6, the purchase of sacramental wines by a minister, priest, rabbi, etc

Subsection 7, the purchase and sale of warehouse receipts

Section 1214, 1214-a, 1215 and 1216 are printed here in full



A consignee shall not accept nor receive any package containing any intoxicating liquor upon which there appears a statement known to him to be false, and no carrier nor other person shall consign, ship, transport or deliver any such package, knowing such statement to be false

No person shall give to any carrier or any officer, agent or person acting or assuming to act for such carrier an order requiring the delivery to any person of any intoxicating liquor or package containing such liquor consigned to, or purporting or claimed to be consigned to a person, when the purpose of the order is to enable any person not an actual bona fide consignee to obtain such liquor

§ 1214-d Illegal advertisements in respect of intoxicating liquor No person shall advertise anywhere, or by any means or method, intoxicating liquor, or the manufacture, sale, keeping for sale or furnishing of the same, or where, how, from whom or at what price the same may be obtained No one shall permit any sign or billboard containing such advertisement to remain upon one's premises But nothing in this section shall prohibit manufacturers and wholesale druggists holding permits to sell intoxicating liquor from furnishing price lists, with description of such liquor for sale, to persons permitted to purchase such liquor, or from advertising alcohol in business publications or trade journals circulating generally among manufacturers of lawful alcoholic perfumes, toilet preparations, flavoring extracts, medicinal preparations and like articles

§ 1214-e Unlawful utensils, et cetera, for manufacture No person shall advertise, manufacture, sell or possess for sale any utensil, contrivance, machine, preparation, compound, tablet, substance formula, direction or recipe advertised, designed or intended for use in the unlawful manufacture of intoxicating liquor

§ 1214-f Unlawful solicitation of orders No person shall solicit or receive, or knowingly permit his employee to solicit or receive, from any person any order for intoxicating liquor or give any information of how such liquor may be obtained in violation of this article.

§ 1214-g Maintenance of place where violations are committed No person shall maintain any room, house, building, boat, vehicle, structure or place where intoxicating liquor is manufactured, sold, given away, kept or bartered in violation of this article, and all intoxicating liquor and property kept and used in maintaining the same is hereby declared to be a common nuisance, and any person who maintains such a common nuisance shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than one thousand dollars or be imprisoned for not more than one year or both

If a person has knowledge or reason to believe that his room, house, building, boat, vehicle, structure or place is occupied or used for the manufacture or sale of such liquor contrary to the provisions of this article, and suffers the same to be so occupied or used, such room, house, building, boat, vehicle, structure or place shall be subject to a lien for and may be sold to pay all fines and costs assessed against the person guilty of such nuisance for such violation, and any such lien may be enforced by action in any court having jurisdiction

§ 1214-h Possession or taking orders in violation of article No person shall, with intent to effect a sale of intoxicating liquor by himself, his employee, servant or agent, for himself or any person, company or corporation, keep or carry around on his person, or in a vehicle, or other conveyance whatever, or leave in a place for another to secure, any intoxicating liquor, or travel to solicit, or solicit, or take, or accept orders for the sale, shipment or delivery of intoxicating liquor, in violation of this article

§ 1214-i Non beverage preparations The articles enumerated in this section after having been manufactured and prepared for the market, shall not be subject to the provisions of this article, if they correspond with the following descriptions and limitations, namely

1 Denatured alcohol or denatured rum produced and used as provided by laws and regulations now or hereafter in force.

2 Medicinal preparations manufactured in accordance with formulas prescribed by the United States Pharmacopoeia, National Formulary or the American Institute of Homeopathy that are unfit for use for beverage purposes

3 Patented, patent, and proprietary medicines that are unfit for use for beverage purposes

4 Toilet, medicinal, and antiseptic preparations and solutions that are unfit for use for beverage purposes

5 Flavoring extracts and syrups that are unfit for use as a beverage or for intoxicating beverage purposes

6 Vinegar and preserved sweet cider

Provided, however, that any person who shall knowingly sell any of the articles mentioned in subdivisions one, two, three or four of this section for beverage purposes, or any extract or syrup for intoxicating beverage purposes, if the article, extract or syrup contains one-half of one per centum or more of alcohol by volume, shall be guilty of a violation of section twelve hundred and twelve and punishable accordingly

§ 1215 Register of permit 1 Every person holding a permit from the authorities of the United States under the national prohibition act shall, within thirty days after this article takes effect, and every person thereafter obtaining any such permit shall within ten days after obtaining

States, which he has registered under the provisions of this article, or the possession of such cider by such manufacturer of vinegar during the process of its development into vinegar

4 The temporary possession by a manufacturer of intoxicating liquor for the purpose of reducing the alcoholic content thereof so that before it is withdrawn from the factory or otherwise disposed of it shall contain less than one-half of one per centum of alcohol by volume, if such manufacturer is the holder of a permit from the proper authorities of the United States and such permit is registered as provided in this article

5 The possession, storage and removal of lawfully acquired liquor for personal consumption by the owner thereof, his family and bona fide guests, where such liquor was acquired by such owner before the seventeenth day of January, nineteen hundred and twenty. The burden of proof, however, shall be upon the owner, in any action concerning the same, to prove that such liquor was lawfully acquired, possessed and used

6 The purchase of sacramental wines by any minister, priest, rabbi, clergyman or officer of a religious society, or the acceptance, manufacture, possession or use in the state of such wines, or the delivery of such wines in the state or the acceptance thereof for delivery. The term "sacramental wines," as used herein, includes and means wines used for or in religious services

7 The purchase and sale of warehouse receipts covering intoxicating liquor on deposit in government bonded warehouses

§ 1214 Sale on a physician's prescription. Intoxicating liquor shall not be sold at retail for medical purposes except as follows

1 By a duly licensed pharmacist of the state of New York in good standing or a corporation, association or copartnership, a member or employee of which is a duly licensed pharmacist of the state of New York in good standing and in personal charge of the premises where such liquor is sold, upon the prescription of a duly licensed physician of the state of New York actively engaged in the practice of his profession

2 Not more than one pint of spirituous liquor to be taken internally shall be prescribed or sold under a physician's prescription for use by the same person within a period of ten days, and no such liquor shall be sold for external use until the same has been made unfit for internal use

3 No prescription shall be filled more than once

4 Any pharmacist filling a prescription shall at the time indorse upon it, over his signature, the word "canceled," together with the date when the liquor was delivered, and make the same a part of the record that he is required to keep as herein provided

5 The pharmacist shall permanently attach to the container of such liquor so sold a label stating the name and address of the person selling and purchasing such liquor, the name and address of the physician issuing the prescription and the date of such sale, and such label shall not be removed from such container until the contents of the container are entirely consumed

6 Every pharmacist who fills a prescription for such liquor shall keep a record, alphabetically arranged, in a book kept for that purpose, which record shall show the date of filling, amount and kind of liquor prescribed, to whom sold, the name of the physician issuing the prescription and the number of the prescription and prescription book. Such record shall be kept open to inspection by the district attorney or sheriff of the county or any magistrate or peace officer

§ 1214-a Prescription for intoxicating liquor. It shall not be lawful to issue a prescription for intoxicating liquor unless the person issuing the prescription is a physician duly licensed to practice medicine in the state of New York, and actively engaged in the practice of such profession, not unless he be the holder of a permit to prescribe liquor from the proper federal authorities, and no physician shall prescribe such liquor unless after careful examination of the person for whose use such prescription is sought, or, if such examination is found impracticable, then upon the best information obtainable, he in good faith believes that the use of such liquor as a medicine by such person is necessary and will afford relief to him from some known ailment.

§ 1214-b Records required. No person shall manufacture, purchase for sale, sell or transport any intoxicating liquor without making at the time a permanent record thereof showing in detail the amount and kind of such liquor manufactured, purchased, sold or transported, together with the names and addresses of the persons to whom sold, in case of sale, and the consignor and consignee in case of transportation. Such record shall at all times be open to inspection as in this article provided

§ 1214-c Transportation restrictions. No person shall use or induce any carrier, or any agent or employee thereof, to carry or ship any package or receptacle containing intoxicating liquor without notifying the carrier of the true nature and character of the shipment. No carrier shall transport nor shall any person receive such liquor from a carrier unless there appears on the outside of the package containing such liquor the following information

Name and address of the consignor or seller, name and address of the consignee, kind and quantity of such liquor contained therein

A consignee shall not accept nor receive any package containing any intoxicating liquor upon which there appears a statement known to him to be false, and no carrier nor other person shall consign, ship, transport or deliver any such package, knowing such statement to be false

No person shall give to any carrier or any officer, agent or person acting or assuming to act for such carrier an order requiring the delivery to any person of any intoxicating liquor or package containing such liquor consigned to, or purporting or claimed to be consigned to a person, when the purpose of the order is to enable any person not an actual bona fide consignee to obtain such liquor

§ 1214-d Illegal advertisements in respect of intoxicating liquor No person shall advertise anywhere, or by any means or method, intoxicating liquor, or the manufacture, sale, keeping for sale or furnishing of the same, or where, how, from whom or at what price the same may be obtained No one shall permit any sign or billboard containing such advertisement to remain upon one's premises But nothing in this section shall prohibit manufacturers and wholesale druggists holding permits to sell intoxicating liquor from furnishing price lists, with description of such liquor for sale, to persons permitted to purchase such liquor, or from advertising alcohol in business publications or trade journals circulating generally among manufacturers of lawful alcoholic perfumes, toilet preparations, flavoring extracts, medicinal preparations and like articles

§ 1214-e Unlawful utensils, et cetera, for manufacture No person shall advertise, manufacture, sell or possess for sale any utensil, contrivance, machine, preparation, compound, tablet, substance formula, direction or recipe advertised, designed or intended for use in the unlawful manufacture of intoxicating liquor

§ 1214-f Unlawful solicitation of orders No person shall solicit or receive, or knowingly permit his employee to solicit or receive, from any person any order for intoxicating liquor or give any information of how such liquor may be obtained in violation of this article

§ 1214-g Maintenance of place where violations are committed No person shall maintain any room, house, building, boat, vehicle, structure or place where intoxicating liquor is manufactured, sold, given away, kept or bartered in violation of this article, and all intoxicating liquor and property kept and used in maintaining the same is hereby declared to be a common nuisance, and any person who maintains such a common nuisance shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than one thousand dollars or be imprisoned for not more than one year or both

If a person has knowledge or reason to believe that his room, house, building, boat, vehicle, structure or place is occupied or used for the manufacture or sale of such liquor contrary to the provisions of this article, and suffers the same to be so occupied or used, such room, house, building, boat, vehicle, structure or place shall be subject to a lien for and may be sold to pay all fines and costs assessed against the person guilty of such nuisance for such violation, and any such lien may be enforced by action in any court having jurisdiction

§ 1214-h Possession or taking orders in violation of article. No person shall, with intent to effect a sale of intoxicating liquor by himself, his employee, servant or agent, for himself or any person, company or corporation, keep or carry around on his person, or in a vehicle, or other conveyance whatever, or leave in a place for another to secure, any intoxicating liquor, or travel to solicit, or solicit, or take, or accept orders for the sale, shipment or delivery of intoxicating liquor, in violation of this article

§ 1214-i Non beverage preparations The articles enumerated in this section after having been manufactured and prepared for the market, shall not be subject to the provisions of this article, if they correspond with the following descriptions and limitations, namely

1 Denatured alcohol or denatured rum produced and used as provided by laws and regulations now or hereafter in force

2 Medicinal preparations manufactured in accordance with formulas prescribed by the United States Pharmacopoeia, National Formulary or the American Institute of Homeopathy that are unfit for use for beverage purposes

3 Patented, patent, and proprietary medicines that are unfit for use for beverage purposes

4 Toilet, medicinal, and antiseptic preparations and solutions that are unfit for use for beverage purposes

5 Flavoring extracts and syrups that are unfit for use as a beverage or for intoxicating beverage purposes

6 Vinegar and preserved sweet cider

Provided, however, that any person who shall knowingly sell any of the articles mentioned in subdivisions one, two, three or four of this section for beverage purposes, or any extract or syrup for intoxicating beverage purposes, if the article, extract or syrup contains one-half of one per centum or more of alcohol by volume, shall be guilty of a violation of section twelve hundred and twelve and punishable accordingly

§ 1215 Register of permit. 1 Every person holding a permit from the authorities of the United States under the national prohibition act shall, within thirty days after this article takes effect, and every person thereafter obtaining any such permit shall within ten days after obtaining

the same, exhibit or cause to be exhibited such permit to the county clerk of the county in which he resides if he be a resident of the state, and if he be a nonresident with the secretary of state, and at the same time deliver a true copy thereof to such officer. Such officer shall keep a record of such permits and register therein the name and address of each person to whom such a permit is issued, the date of the permit, the date of its expiration, and a brief description of the nature of the permit, and shall file such copy in his office. Upon the suspension or revocation of any such permit, the person to whom such permit was issued shall, within five days after such suspension or revocation takes effect, serve upon the officer by whom such registration is made, either personally or by mail, a written notice of such suspension or revocation, which shall be noted by such officer on such record. The officer shall be entitled to collect a fee of one dollar for making the registration provided for in this section. Such register and copies of permits filed as herein provided shall be open to public inspection at all times during office hours.

2 The permit referred to in subdivision one of this section means what is commonly known as the "basic" permit and does not include a subsidiary or installment permit, for a particular transaction, issued to the holder of the basic permit, but any other provision of this article which refers to a permit, except as to the registration thereof, shall be deemed to mean each and every permit required by act of congress to authorize the transaction to which such provision relates.

§ 1216 Possession as evidence, burden of proof. The possession of liquors by any person not legally permitted under this article to possess liquor shall be prima facie evidence that such liquor is kept for the purpose of being sold, bartered, exchanged, given away, furnished or otherwise disposed of in violation of the provision of this article, and the burden of proof shall be upon the possessor in any action concerning the same to prove that such liquor was lawfully acquired, possessed and used.

§ 1217 Injunction proceedings. 1 A person who shall maintain a common nuisance, as defined by section twelve hundred and fourteen-g of this chapter, may be enjoined from maintaining such nuisance in the manner prescribed in this section. The attorney-general or the district attorney of the county in which the nuisance is maintained may present a verified petition to a justice of the supreme court or a special term of the supreme court of the judicial district in which such county is situated, or the county court or judge of such county, for an order enjoining the maintenance of such nuisance. Such petition shall state the facts upon which such application

is based. Upon the presentation of the petition the justice, judge or court shall grant an order requiring such person to appear before such justice, judge or court, or before a special term of the supreme court of the judicial district, on the day specified therein not more than ten days after the granting thereof, to show cause why such person should not be permanently enjoined from maintaining the nuisance, describing it. A copy of such petition and order shall be served upon the person, in the manner directed by such order not less than five days before the return day thereof. On the day specified in such order, the justice, judge or court before whom the same is returnable shall hear the proofs of the parties and may, if deemed necessary or proper, take testimony as to the allegations of the petition. If the judge, justice or court is satisfied that such person maintains a common nuisance as defined by this article and as alleged in the petition, an order shall be granted enjoining such person thereafter from maintaining such nuisance. It shall not be necessary for the court or judge to find that the property involved was being unlawfully used at the time of the hearing. On finding that the material allegations of the petition are true the court shall order that no intoxicating liquor shall be manufactured, sold, bartered or stored in the room, house, building, boat, vehicle, structure or place to which the proceeding relates, or any part thereof. The court or judge also may order that such room, house, building, structure, boat, vehicle, or place shall not be occupied or used for one year thereafter, or that it shall not be occupied or used during such period for other than dwelling purposes exclusively, or the court, in its discretion, may permit it to be occupied or used for any lawful purpose if the owner, lessee, tenant or occupant thereof shall give bond, with sufficient surety to be approved by the judge or court making the order, in the penal and liquidated sum of not less than five hundred dollars nor more than one thousand dollars payable to the people of the state and conditioned that intoxicating liquor will not thereafter be manufactured, sold, bartered, kept or otherwise disposed of therein or thereon and that he will pay all fines, costs and damages that may be assessed for any violation of the provisions of this article upon such property. A violation of the order made in such proceeding, after such service thereof or of notice of entry as the court or judge may direct, is a contempt of court, punishable as provided in the judiciary law. Costs upon the application for such injunction may be awarded in favor of and against the parties thereto in such sums as in the discretion of the justice, judge or court may seem proper. No bond shall be required to institute any proceeding under this section.

2 Any person who shall with intent to effect a sale of liquor, by himself, employee, servant or agent, for himself or any person, company or corporation, keep or carry around on his person, or in a vehicle or other conveyance whatever or leave at any place for another to secure any intoxicating liquor or who shall travel to solicit or solicit, or take or accept orders for the sale shipment or delivery of liquor in violation of the provisions of this article also may be enjoined, in a proceeding taken as provided in subdivision one of this section, from doing or continuing to do any of such acts or things. In a proceeding under this subdivision it shall not be necessary to show any intention on the part of the accused to continue such violations if the proceeding is brought within sixty days after they occurred

§ 1218 Penalties Any person violating any provision of this article for which a penalty has not been specifically provided herein, shall upon conviction for the first offense be punished by a fine of not more than five hundred dollars and upon conviction for a second offense shall be punished by a fine of not less than one hundred dollars nor more than one thousand dollars, or imprisonment for not more than ninety days, and for any subsequent offense by a fine of not less than five hundred dollars and imprisonment for not less than three months nor more than two years

§ 1219 No double jeopardy No prosecution for the violation of any provision of this article shall lie where the person or persons against whom the charge is made has or have been convicted or acquitted upon a charge embracing the same act or acts in a United States court

§ 2 This act shall take effect immediately

*Comment* Comment is invited from the members of the State Society to be sent to the Legislative Bureau, and if none are received in opposition to the bill it will be dropped

---

Senate Int No 114 (conc Assembly 221)  
—A bill introduced in the Senate by Senator Ernest E. Cole of Steuben County, concurrent Assembly Int No 221, introduced in the Assembly by Assemblyman John Boyle, Jr. of Suffolk County, would amend Chapter 187, Laws of 1924, by extending to March 15, 1925, time of commission on crippled children to report to Legislature

Referred to Finance Committee

January 28, 1925 Reported

No 114

Int 114

IN SENATE,

January 15, 1925

Introduced by Mr. Cole—read twice and ordered printed, and when printed to be committed to the Committee on Finance

#### AN ACT

To amend chapter one hundred and eighty-seven of the laws of nineteen hundred and twenty-four, entitled "An act to create a temporary commission to inquire into and report upon the number, distribution and condition of crippled children throughout the state, to recommend means more adequately to meet their needs and making an appropriation therefor," in relation to the time of making report

*The People of the State of New York, represented in Senate and Assembly do enact as follows:*

Section 1 Section five of chapter one hundred and eighty-seven of the laws of nineteen hundred and twenty-four, entitled "An act to create a temporary commission to inquire into and report upon the number, distribution and condition of crippled children throughout the state, to recommend means more adequately to meet their needs, and making an appropriation therefor," is hereby amended to read as follows

§ 5 The commission shall make a report of its proceedings, together with its recommendations, to the legislature on or before the fifteenth day of March [February], nineteen hundred and twenty-five, and may accompany its report with such proposed legislative measures to carry its recommendations into effect, as to the commission may seem proper

§ 2 This act shall take effect immediately

*Comment* It will be remembered that last year no comment was made upon this bill because it was thought that courtesy would be shown the medical profession in the appointment of an active practicing physician upon the commission, and yet when the commission was appointed no physician was placed thereon

Your Committee on Legislation would take the position that on such a commission a physician engaged in active practice should be appointed as it might be construed that the physicians of this State had been inactive in their desire and care of the crippled children of the State and had left it to lay people to recommend means more adequate to meet their needs, whereas past legislation will have shown that the medical men of this State have always been active in initiating and forwarding bills of like nature and have been invited to participate in such measures

Unless comment or request is received from the members of the Society the bill will be dropped

## THE NARCOTIC BILL.

Senate Int No 115 (conc Assembly Int 215)  
—A bill introduced in the Senate by Senator Morton J Kennedy of New York, concurrent Assembly Int 215, by Assemblyman Morris Weinfeld of New York, would add new article 22, and amend section 4-b, Public Health Law, and repeals section 1746, Penal Law, relative to habit forming drugs

Referred to Public Health Committees of both Houses

*Comment* Reference is made in relation to this bill, to page 402 of the State Society Journal of March 21, 1924, which bill now introduced is the same as was introduced last year, and after a conference with all concerned, was satisfactorily drawn in relation to its medical features

The bill this year is exactly the same as last year, being virtually word for word throughout, and has omitted the obnoxious features which the physicians fought against. Your Committee on Legislation would now take the stand, as it finally took last year, in favor of this bill, unless County Societies take action to the contrary

Senate Int No 116 (conc Assembly Int 216)  
—A bill introduced in the Senate by Senator Morton J Kennedy of New York, concurrent Assembly Int 216, by Assemblyman Morris Weinfeld of New York, would add new section 177, Insanity Law, requiring the licensing of private institutions for treatment of narcotic drug addiction

Referred to General Laws Committee of Senate, and to Judiciary Committee of Assembly

No 116

Int 116

IN SENATE,

January 15, 1925

Introduced by Mr Kennedy—read twice and ordered printed, and when printed to be committed to the Committee on General Laws

## AN ACT

To amend the insanity law, in relation to licensing private institutions for the treatment of narcotic drug addiction.

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Chapter thirty-two of the laws of nineteen hundred and nine, entitled "An act in relation to the insane, constituting chapter twenty-seven of the consolidated laws," is hereby amended by adding thereto a new section, to be section one hundred and seventy-seven, to read as follows

§ 177 Private institutions for the treatment of narcotic drug addiction No person, association or corporation shall establish or keep an institu-

tion for the care, custody or treatment for compensation or otherwise of any person for the habit of taking or using any narcotic drugs, including cocaine, opium, morphine, codeine, diacetyl morphine (heroin), cannabis indica, cannabis sativa, or any compound, manufacture, salt, derivative or preparation of any of them or any synthetic substitute of any of them identical in chemical composition, unless such institution holds a license for such purposes issued by the commission Every application for such a license shall be accompanied by a plan of the premises proposed to be occupied, describing the capacity of the buildings for the uses intended, the extent and location of grounds appurtenant thereto, and the number of patients proposed to be received therein, with such other information and in such form, as the commission may require The commission shall not grant any such license without first having made an examination of the premises proposed to be licensed, and being satisfied that they are substantially as described, and are otherwise fit and suitable for the purposes for which they are designed to be used, and that such license should be granted The commission may at any and all times, examine and ascertain how far a licensed institution is conducted in compliance with the license therefor, and after due notice to the institution and opportunity for it to be heard, the commission having made a record of the proceeding upon such hearing, may, if the interest of the inmates of the institution so demand, for just and reasonable cause then appearing and to be stated in its order, amend or revoke any such license by an order to take effect within such time after the service thereof upon the licensee, as the commission shall determine Any determination of the commission in respect to the revocation of a license shall be reviewable under certiorari proceedings by the supreme court or a justice therein instituted in the judicial district in which such institution is located Violation of the provisions of this section shall constitute a misdemeanor, punishable on conviction by a fine of not less than one hundred dollars and not more than five hundred dollars or by imprisonment for not less than sixty days or more than one year or by both such fine and imprisonment The commission shall have power and authority over all such institutions as provided in this chapter in relation to private institutions for the insane

§ 2 This act shall go into effect on the first day of January, nineteen hundred and twenty-six, except that applications for licenses may be made to the commission and the commission may make all necessary examinations and grant such licenses from the date on which this act becomes a law

*Comment* This bill in printed in full inasmuch as it has to do with the new matter and touches upon any person, association or corporation which establishes or keeps an institution for the care, custody or treatment, etc., of persons taking or using narcotic drugs known as habit forming, after such habit is formed

Attention of members of the State Society who may be proprietors, superintendents or members of boards of institutions of such nature, as well as lay boards of hospital committees, is called to the bill, though your Committee on Legislation is of the opinion that the bill is a good one and, taken in conjunction with the previous bill, as commented on, in relation to the habit forming drugs, should be accepted and helped in its passage by the medical profession

THE STATE DEPARTMENT OF EDUCATION AMENDING  
THE MEDICAL PRACTICE ACT

Senate Int No 211 (conc Assembly Int 307)  
—A bill introduced in the Senate by Senator John L. Karle of Queens County, concurrent Assembly Int No 307, introduced in the Assembly by Assemblyman Russell Dunmore of Oneida County, would amend sections 164, 169, 170, 173, 174 and repeal section 171, Public Health Law, relative to practice of medicine, by providing among other things for the registration and licensing of physicians

Referred to Public Health Committees of both Houses

*Comment* Now that the bill is in print, we would ask that comment, criticism and suggestions be forwarded to the Legislative Bureau, that we may have them on hand for reference

Senate Int No 263—A bill introduced in the Senate by Senator James A. Higgins of Kings County, would amend section 81, Insanity Law relative to qualifications of examiners in lunacy

Referred to General Laws Committee

No 266.

Int 263

IN SENATE,

January 23, 1925

Introduced by Mr. Higgins—read twice and ordered printed, and when printed to be committed to the Committee on General Laws

AN ACT\*

To amend the insanity law, in relation to qualifications of examiners in lunacy

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section eighty-one of chapter thirty-two of the laws of nineteen hundred and nine, entitled "An act in relation to the insane," con-

stituting chapter twenty-seven of the consolidated laws, as last amended by chapter six hundred and seventy-three of the laws of nineteen hundred and twenty-one, is hereby amended to read as follows

§ 81 Medical examiners in lunacy, certificates of lunacy The certificate of lunacy must show that such person is insane and must be made by two reputable physicians *who have filed with the commission a certified copy of the certificate of a judge of a court of record showing qualifications in accordance with law* The qualifications of medical examiners in lunacy *certified after date from which this act shall take effect shall be that he or she must be a reputable physician, graduate of an incorporated medical college, who has been in actual practice of his or her profession at least three years, and shall have at least two years actual experience in the care and treatment of the insane in an institution for the insane* [graduates of an incorporated medical college, who have been in the actual practice of their profession at least three years, and have filed with the commission a certified copy of the certificate of a judge of a court of record, showing such qualifications in accordance with forms prescribed by the commission]

Such physicians shall jointly make a final examination of the person alleged to be insane within ten days next before and inclusive of the date of the granting of the order The date of the certificate of lunacy shall be the date of such joint examination Such certificate of lunacy shall be in the form prescribed by the commission, and shall contain the facts and circumstances upon which the judgment of the physicians is based and show that the condition of the person examined is such as to require care and treatment in an institution for the care, custody and treatment of the insane

Neither of such physicians shall be a relative of the person applying for the order, or of the person alleged to be insane, or a manager, superintendent, proprietor, officer, stockholder, or have any pecuniary interest, directly or indirectly, or be an attending physician in the institution, to which it is proposed to commit such person

§ 2 This act shall take effect immediately

\* Matter in *italics* is new matter in brackets [ ] is old law to be omitted.

*Comment* Attention is called to the matter printed in caps which is the new portion of the bill and to the fact that hereafter should the bill become law no one can hold the position of medical examiner in lunacy unless he or she shall have had at least two years actual experience in the care and treatment of the insane in an institution for the insane

While this will limit sharply hereafter an examination in lunacy to those who follow such a specialty, it is to be surmised that the protection of the public will be the greater conserved

lation, as last year, feels that the Society should be in favor of such a measure, and unless comment or criticism is offered on the part of the members of the State Society, the bill will be dropped

Senate Int No 266—A bill introduced in the Senate by Senator James S Truman of Owego N Y, would amend subdivision 9, section 15, Workmen's Compensation Law, by providing for expenses for rehabilitating injured employees, not more than \$10 per week to be spent for maintenance

Referred to Labor and Industry Committee

*Comment* Unless comment or suggestion is received from the members of the Society in regard to the above mentioned bill it will be dropped

Senate Int No 278 (conc Assembly Int 414)—A bill introduced in the Senate by Senator George L Thompson of Kings Park, N Y, concurrent Assembly Int 414, introduced in the Assembly by Assemblyman Edwin W Wallace of Nassau County, would amend section 56 Criminal Code, by giving Special Sessions Courts jurisdiction in cases of wilful violation to comply with lawful order of local health board or officer, where penalty does not exceed \$50 nor imprisonment six months

Referred to Codes Committee of both houses

No 282

Int 278

IN SENATE,

January 26, 1925

Introduced by Mr Thompson—read twice and ordered printed, and when printed to be committed to the Committee on Codes

#### AN ACT

To amend the code of criminal procedure, in relation to jurisdiction of courts of special sessions

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section fifty-six of the code of criminal procedure is hereby amended by adding at the end a new subdivision, to be subdivision forty, to read as follows

40 For a wilful violation or refusal or omission to comply with any lawful order or regulation prescribed by any local board of health or local health officer where the penalty prescribed does not exceed fifty dollars nor the imprisonment six months

§ 2 This act shall take effect July first, nineteen hundred and twenty-five

*Comment* This bill is the same, word for word, as Senate Int No 455, noted on page 174 of the February 15, 1924, issue of the State Society Journal, and your Committee on Legis-

Senate Int No 282 (conc Assembly Int 413)—A bill introduced in the Senate by Senator George L Thompson of Kings Park, N Y, concurrent Assembly Int 413, by Assemblyman Edwin W Wallace of Nassau County, would amend section 21, Public Health Law, by empowering local health board to prescribe that a person wilfully violating or omitting to comply with any lawful order or regulation prescribed by it or a local health officer shall be guilty of a misdemeanor

Referred to Public Health Committees of both Houses

No 286

Int 282

IN SENATE,

January 26, 1925

Introduced by Mr Thompson—read twice and ordered printed, and when printed to be committed to the Committee on Public Health

#### AN ACT\*

To amend the public health law, in relation to violations of rules or orders of local boards of health

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section twenty-one of chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituted chapter forty-five of the consolidated laws, as last amended by chapter five hundred and fifty-nine of the laws of nineteen hundred and thirteen, is hereby amended to read as follows

§ 21 General powers and duties of local boards of health Every such local board of health shall meet at stated intervals to be fixed by it, in the municipality The presiding officer of every such board may call special meetings thereof when in his judgment the protection of the public health of the municipality requires it, and he shall call such meeting upon the petition of at least twenty-five residents thereof, of full age, setting forth the necessity of such meeting Every such local board, subject to the provisions of the public health law and of the sanitary code, shall prescribe the duties and powers of the local health officer, who shall be its chief executive officer, and direct him in the performance of his duties, and fix his compensation, which in case of health officers of cities, towns and villages, having a population of eight thousand or less, shall not be less than the equivalent of ten cents per annum per inhabitant of the city, town or



village according to the latest federal or state enumeration, and in cities, towns and villages having a population of more than eight thousand shall not be less than eight hundred dollars per annum. In addition to his compensation so fixed, the board of health must allow the actual and reasonable expenses of said health officer in the performance of his official duties and in going to, attending or returning from, the annual sanitary conference of health officers or equivalent meeting, held yearly within the state, and conferences called by the sanitary supervisor of the district, and whenever the services rendered by its health officer shall include the care of smallpox, the board of health shall allow, or whenever such services are extraordinary, by reason of infectious diseases, or otherwise, they may, in their discretion, allow to him such further sum in addition to said fixed compensation as shall be equal to the charges for consultation services in the locality, audited by the town board of a town, by the board of trustees of a village or by the proper auditing board of a city of the third class, which said expenses and said additional compensation shall be a charge upon and paid by the municipality as provided in section thirty-five of this chapter. Every such local board shall make and publish from time to time all such orders and regulations, not inconsistent with the provisions of the sanitary code, as it may deem necessary and proper for the preservation of life and health and the execution and enforcement of this chapter in the municipality. It shall make without publication thereon, such orders and regulations for the suppression of nuisances and concerning all other matters in its judgment detrimental to the public health in special or individual cases, not of general application, and serve copies thereof upon the owner or occupant of any premises whereon such nuisances or other matters may exist, or upon which may exist the cause of other nuisances to other premises or cause the same to be conspicuously posted thereon. The health officer may employ such persons as shall be necessary to enable him to carry into effect the orders and regulations of the board of health and the provisions of the public health law and of the sanitary code, and fix their compensation within the limits of the appropriation therefor. The board of health may issue subpoenas, compel the attendance of witnesses, administer oaths to witnesses and compel them to testify, and for such purposes it shall have the same powers as a justice of the peace of the state in a civil action of which he has jurisdiction. It may designate by resolution one of its members to sign and issue such subpoenas. No subpoena shall be served outside the jurisdiction of the board issuing it, and no witness shall be interrogated or compelled to testify upon matters not related to

the public health. It may issue warrants to any constable or policeman of the municipality to apprehend and remove such persons as cannot otherwise be subjected to its orders or regulations, and a warrant to the sheriff of the county to bring to its aid the power of the county whenever it shall be necessary to do so. Every warrant shall be forthwith executed by the officer to whom directed, who shall have the same powers and be subject to the same duties in the execution thereof, as if it had been duly issued out of a court of record of the state. Every such local board may prescribe and impose penalties for the violation of or failure to comply with any of its orders or regulations, not exceeding one hundred dollars for a single violation or failure, to be sued for and recovered by it in the name and for the benefit of the municipality, and may maintain actions in any court of competent jurisdiction to restrain by injunction such violations or otherwise to enforce such orders and regulations. *Every such local board of health may prescribe that a person who wilfully violates or refuses or omits to comply with any lawful order or regulation prescribed by it or a local health officer, shall be guilty of a misdemeanor punishable by a fine not exceeding fifty dollars or imprisonment not exceeding six months, and a court of special sessions in the territory over which such local board has jurisdiction shall have jurisdiction of such misdemeanor.*

§ 2 This act shall take effect July first, nineteen hundred and twenty-five

\* Matter in *italics* is new matter in brackets [ ] is old law to be omitted

*Comment* Unless there be amendments to this bill, it will be dropped

Senate Int No 283 (conc Assembly Int 399) —A bill introduced in the Senate by Senator J Griswold Webb of Clinton Corners, N Y., concurrent Assembly Int. 399, by Assemblyman Frank H Lattin of Orleans County, would amend section 12, County Law, by authorizing county supervisors to provide expenses for public health nurses, who shall work under the public health committee or board providing for appointment of advisory committee of citizens and relative to duties of nurses

Referred to Internal Affairs Committee of both Houses

*Comment* Your Committee on Legislation requests careful study of this bill by the Presidents and Comitia Minora of the County Societies throughout the State in relation to its provisions

Further comment will be forthcoming when we have heard from the individual members of the Society in regard to the measure

Senate Int No 302 (conc Assembly Int 748)  
—A bill introduced in the Senate by Senator Ernest E Cole of Bath, N Y, concurrent Assembly Int 748, by Assemblyman Irving F Rice of Cortland County, would amend sections 571, 571-a, 572, 575, Education Law, relative to medical inspection and health service in public schools

Referred to Public Education Committees of both Houses

*Comment* Will be made later

Senate Int No 308 (conc Assembly Int 386)  
—A bill introduced in the Senate by Senator James S Truman of Owego, N Y, concurrent Assembly Int 386, by Assemblyman Chas P Miller, of Genesee County, would add new article 4-a, Workmen's Compensation Law, relative to fibroid phthisis

Referred to Labor and Industry Committees of both Houses

*Comment* Unless criticism or request that this bill be carried in received from the members of the Society, the bill will be dropped

Senate Int No 349—A bill introduced in the Senate by Senator John L Karle of Queens County, would amend section 21, Public Health Law, relative to powers and duties of local health boards

Referred to Public Health Committee

No 354

Int 349

IN SENATE,

January 28, 1925

Introduced by Mr Karle—(by request)—read twice and ordered printed, and when printed to be committed to the Committee on Public Health

AN ACT

To amend the public health law, in relation to general powers and duties of local boards of health

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section twenty-one of chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," as last amended by chapter five hundred and fifty-nine of the laws of nineteen hundred and thirteen, is hereby amended to read as follows

§21 General powers and duties of local boards of health Every such board of health shall meet at stated intervals to be fixed by it, in the municipality The presiding officer of every such board may call special meetings thereof when in his judgment the protection of the

public health of the municipality requires it, and he shall call such meetings upon the petition of at least twenty-five residents thereof, of full age, setting forth the necessity of such meeting Every such local board, subject to the provisions of the public health law and of the sanitary code, shall prescribe the duties and powers of the local health officer, who shall be its chief executive officer, and direct him in the performance of his duties, and fix his compensation, which in case of health officers of cities, towns [and], villages and consolidated health districts, having a population of eight thousand or less, shall not be less than the equivalent of [ten] fifteen cents per annum per inhabitant of the city, town or village according to the latest federal or state enumeration, and in cities, towns [and], villages and consolidated health districts having a population of more than eight thousand shall not be less than [eight] twelve hundred dollars per annum In addition to his compensation so fixed, the board of health must allow the actual and reasonable expenses of said health officer in the performance of his official duties and in going to, attending and returning from, the annual sanitary conference of health officers, or equivalent meeting, held yearly within the state, and conference called by the district state health officer of the district, and whenever the services rendered by its health officer shall include the care of smallpox or taking specimens or cultures for diagnosis or release from isolation in cases of communicable disease, the board of health shall allow, or whenever such services are extraordinary, by reason of infectious diseases, or otherwise, they may in their discretion, allow to him such further sum in addition to said final compensation as shall be equal to the charges for consultation services in the locality, audited by the town board of a town, by the board of trustees of a village or by the proper auditing board of a city of the third class, which said expenses and said additional compensation shall be a charge upon and paid by the municipality as provided in section thirty-five of this chapter Every such local board shall make and publish from time to time all such orders and regulations, not inconsistent with the provisions of the sanitary code, as it may deem necessary and proper for the preservation of life and health and the execution and enforcement of this chapter in the municipality It shall make without publication thereof, such orders and regulations for the suppression of nuisances and concerning all other matters in its judgment detrimental to the public health in special or individual cases, not of general application, and serve copies thereof upon the owner or occupant of any premises whereon such nuisances or other matters may exist, or upon which may exist the cause of other nuisances to other premises, or cause the same to be conspicuously posted

thereon The health officer may employ such persons as shall be necessary to enable him to carry into effect the orders and regulations of the board of health and the provisions of the public health law and of the sanitary code, and fix their compensation within the limits of the appropriation therefor *The health officer, with the consent of the board of health, may appoint a competent physician to act as health officer during his temporary absence or incapacity on account of illness or other cause for a period not exceeding three months The health officer shall report immediately to the state department of health the name and address of the physician so appointed Such acting health officer, during the period for which he is appointed, shall have all of the rights, powers and duties imposed upon the health officer by the public health law and the sanitary code The board of health may allow such compensation as it deems reasonable covering such temporary service* The board of health may issue subpoenas, compel the attendance of witnesses, administer oaths to witnesses and compel them to testify, and for such purposes it shall have the same powers as a justice of the peace of the state in a civil action of which he has jurisdiction It may designate by resolution one of its members to sign and issue such subpoenas No subpoena shall be served outside the jurisdiction of the board issuing it, and no witness shall be interrogated or compelled to testify upon matters not related to the public health It may issue warrants to any constable or policeman of the municipality to apprehend and remove such persons as cannot otherwise be subjected to its orders or regulations, and a warrant to the sheriff of the county to bring to its aid the power of the county whenever it shall be necessary to do so Every warrant shall be forthwith executed by the officer to whom directed, who shall have the same powers and be subject to the same duties in the execution thereof, as if it has been duly issued out of a court of record of the state Every such local board may prescribe and impose penalties for the violation of or failure to comply with any of its orders or regulations, not exceeding one hundred dollars for a single violation or failure, to be sued for and recovered by it in the name and for the benefit of the municipality, and may maintain actions in any court of competent jurisdiction to restrain by injunction such violations, or otherwise to enforce such orders and regulations

§ 2 This act shall take effect immediately  
Senate, No 354 2

EXPLANATION—Matter in italics is new, matter in brackets [ ] is old law to be omitted

COMMENT Your Committee on Legislation is in favor of the purport of this bill, which will be dropped unless amendments be added thereto

Senate Int No 351 (conc Assembly Int 536)  
—A bill introduced in the Senate by Senator John L. Karle of Queens County, concurrent Assembly Int 536, by Assemblyman Frank H. Lattin of Orleans County, would amend section 311, Public Health Law, by permitting physicians to use vaccine virus to prevent smallpox, under certificate of approval by Health Commission

Referred to Public Health Committees of both Houses

No 356 Int 351  
IN SENATE,

January 28, 1925

Introduced by Mr. Karle—(by request)—read twice and ordered printed, and when printed to be committed to the Committee on Public Health

# AN ACT

To amend the public health, in relation to records and reports of vaccinations

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section three hundred and eleven of chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," as last amended by chapter twenty-five of the laws of nineteen hundred and twenty-four, is hereby amended to read as follows

§ 311 Vaccination how made, reports 1 No person shall perform vaccination for the prevention of smallpox who is not a regularly licensed physician under the laws of the state Vaccination shall be performed in such manner only as shall be prescribed by the state commissioner of health

2 No physician shall use vaccine virus for the prevention of smallpox unless such vaccine virus is produced under license issued by the secretary of the treasury of the United States [and is accompanied by] or under a certificate of approval issued by the state commissioner of health, and such vaccine virus shall then be used only within the period of time specified [in such approval] by the expiration date

3 Every physician performing a vaccination shall within ten days make a report to the local health officer upon a form furnished by the state commissioner of health setting forth the full name and age of the person vaccinated and, if such person is a minor, the name and address of his parents, the date of vaccination, the date of previous successful vaccination if possible, the name of the maker of the vaccine virus, the lot or batch number of such vaccine virus and whether upon re-examination after a proper

interval such vaccination was found to be successful or non-successful

4 Every local health officer shall retain in the files and records of his office every report of a vaccination reported to him under the provisions of the preceding paragraph and shall report once in each month to the state department of health the number of vaccinations reported to him during the preceding month, together with the number of those which were successful and the number unsuccessful. Such report shall be made in such manner as shall be prescribed by the state commissioner of health

§ 2 This act shall take effect immediately

EXPLANATION—Matter in *italics* is new matter in brackets [ ] is old law to be omitted

*Comment* This bill is favored by your Committee on Legislation, and unless there be amendments thereto we will not make any further comment thereon

Senate Int No 380 (conc Assembly Int 570)—A bill introduced in the Senate by Senator Daniel J Farrell of Kings County, concurrent Assembly Int 570, by Assemblyman Gerald F Dunne of Kings County, would amend section 13 Workmen's Compensation Law, relative to medical and surgical attendance of injured employees, by providing employee shall select physician

Referred to Labor and Industry Committee of both Houses

*Comment* This is the bill which many of the members of the medical profession have been desirous of seeing introduced and which your Committee in years past has been directed to work for

Unless there be opposition to such a bill from the members of the medical profession, your Committee will work upon the theory that the profession still desires it to try and have passed such an amendment

#### THE DRUGLESS PRACTITIONER BILL.

Senate Int No 473—A bill introduced in the Senate by Senator Leonard W H Gibbs of Erie County, would add new article 13-a, Public Health Law, relative to practice of all systems or sciences constructed or developed for treatment of disease and the removal of abnormality, injury or deformity of human beings except practice of medicine, osteopathy and Christian Science

Referred to Public Health Committee

*Comment* Is comment necessary on such a bill?

Int 473

February 3, 1925

IN SENATE,

Introduced by Mr Gibbs and referred to Public Health Committee.

#### AN ACT

To amend the public health law, in relation to practice of all systems, methods, or sciences constructed, formulated, or developed for the treatment of disease, and the removal of abnormality, injury or deformity of human beings, except the practice of medicine, osteopathy and Christian Science.

Section 1 Chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," is hereby amended by adding a new article, to be article thirteen-a, to read as follows

#### ARTICLE 13-A

##### Drugless Practice

- Section 285 Definitions
- 285-a Qualifications of practice
  - 285-b Board of examiners
  - 285-c Organization of board
  - 285-d Compensation of examiners
  - 285-e Application and fee for examination
  - 285-f Subjects of examination
  - 285-g Examinations
  - 285-h License after examination
  - 285-i License without examinations
  - 285-j Students of legalized school
  - 285-k Registration of license
  - 285-l Hearing and decision of charges
  - 285-m Limitation of license
  - 285-n Transfer of registration
  - 285-o Exceptions
  - 285-p Specific violations
  - 285-q Prohibitions
  - 285-r Recognition of license

§ 285 Definitions As used in this article  
1 "University" means University of the State of New York

2 "Regents" means Board of Regents of the University of the State of New York

3 "Board" means a board of examiners of drugless practitioners of the state of New York

4 "Examiner" means a member of a board of examiners of drugless practitioners of the State of New York

5 "Drugless methods" means the treatment of disease, the removal of abnormality, injury or deformity of human being by hand or mechanically without the use of drugs, osteopathy, surgery, or christian science

§ 285-a Qualifications to practice No person shall practice drugless methods unless licensed and registered as required by this article nor shall any person practice drugless methods who has ever been convicted of a felony

by any court, or whose authority to practice is suspended or revoked by the regents on recommendation of the State Board

§ 285-b Board of Examiners The State Board of Examiners of drugless practitioners is hereby created, to consist of five members who shall be appointed by the regents. The first board shall be selected from not less than fifteen names of drugless practitioners who shall have practiced in the state of New York for the past five years prior to the passing of this act and who shall be nominated by the society or societies of drugless practitioners incorporated under the laws of this State. The members of the first board shall be appointed for one, two, three, four and five years respectively and shall consist of persons of full age, residents of the State of New York, holding diplomas or degrees from legally incorporated schools or colleges of drugless methods. After the appointment of the first board, members shall be appointed from the list of regularly licensed and registered drugless practitioners and shall hold office for a term of five years and until their successors shall be appointed. The regents shall fill any vacancies, however occurring, during the term of any members thereof.

§ 285-c Organization of board very examiner shall receive a certificate of appointment from the regents and, before beginning his term of office, shall file with the secretary of state his constitutional oath of office. The board or any committee thereof, may take testimony and proofs concerning any matter within its jurisdiction. It shall elect proper officers and may subject to the regents' approval, make by-laws and rules not inconsistent with law, needed in performing its duties.

§ 285-d Compensation of examiners From the fees provided by this article, the board may pay all proper expenses, incurred by its provisions and each examiner shall receive a fee of ten dollars for each day and mileage while engaged in the performance of his official duties.

§ 285-e Application and fee for examination The board shall admit to examination any candidate who, not later than ten days before the date set for such examination, pays the fee of twenty-five dollars and submits to it satisfactory evidence verified by oath, if required that he or she,

1 Is more than twenty-one years of age  
2 Is of good moral character, as evidenced by the affidavit of four residents of the county in which said applicant resides

3 A citizen of the United States or has declared his or her intention of becoming such citizen

4 Has passed regents examinations aggregating at least seventy-two counts

5 Has graduated from a legally incorporated school or college of drugless methods giving not less than a three years' residence course consisting of two thousand sixty-minute hours, and graduated therefrom shall be deemed eligible for examination. Eighteen months after this act takes effect such graduation shall be from a school or college of drugless methods which shall give not less than four academic years of six months each, consisting of twenty-four hundred sixty-minute hours.

§ 285-f Subjects of examination Every member of the board shall submit to the regents as required, lists of questions covering the subjects of anatomy, physiology, pathology, toxicology, biology, histology, hygiene, physiological chemistry, sanitation according to drugless methods, bacteriology, symptomatology, dietetics and physical diagnosis. From these lists, the regents shall prepare question papers for all those subjects, which, at any examination, shall be the same for all candidates.

§ 285-g Examinations Examinations for license shall be held at least twice annually, and more often in the discretion of the regents and at such places as they shall direct, and shall be exclusively in writing and in English. Each examination shall be conducted by a regents examiner who shall not be a member of the drugless practitioner board of examiners. At the close of each examination the regent's examiner in charge shall deliver the question and answer papers to the board or its duly authorized committee, and such board shall, without unnecessary delay, examine and mark the papers and transmit to the regents an official report, signed by its president and secretary, stating the standing of each candidate in each branch and his general average. Such reports shall include the questions and answers and be filed in the public records of the university. To entitle the applicant to a license he must pass the examination with an average of at least seventy-five per centum. If a candidate fails in his examination he may, after not less than six months' further study, have a second examination without fee.

§ 285-h License after examination On receiving from the State Board an official report that the candidate has successfully passed the examination, and is recommended for license the regents shall issue to him a license to practice drugless methods. Each license shall be issued by the university under seal and shall be signed by each acting member of the board of drugless practitioner examiners, and shall be numbered, and shall state that the licensee has given satisfactory evidence of fitness as to age, moral character, education and other matters required by law, and that, after full examination, he or she has been licensed to practice.

§ 285-1 License without examination Any person twenty-one years of age, and who is of good moral character, as evidenced by affidavit of four reputable residents of the county in which he reside, and who, for at least two years prior to the passage of this act, has practiced drugless methods exclusively, and has a diploma from a legalized incorporated school or college of drugless methods, may, within one month after this act goes into effect, without examination and upon payment of the sum of twenty-five dollars to the board, and upon such further evidence as the board may require, receive from the board a certificate, which, when presented to the regents, shall entitle such person to a license to practice drugless methods as though such examination had been tried and successfully passed and been certified to the regents

§ 285-j Students of legalized school Students who are enrolled for a two-year course prior to the passing of this act, upon completion of such two year course in legalized incorporated school of drugless methods shall be eligible for the examination

§ 285-k Registration of license very license to practice drugless methods shall, before the licensee begins practice thereunder be registered in a book to be known as the "drugless practitioner register," which shall be provided and kept in the office of the clerk of the county where such practice is to be carried on, with name, residence, place and date of birth, source, number and date, of license An affidavit of the above facts and that he or she is the person named in such license, and had, before receiving the same, complied with all requirements of law and the rules of the university in connection with the conferment thereof and that no fraud, misrepresentation or mistake in any material regard was employed by anyone or incurred in order that such license might be conferred shall be filed with such clerk at the time of such registration Every license shall before registering, be exhibited to the county clerk, who, in case it is under seal by the regents, shall endorse or stamp thereon the date and his name preceded by the words "registered as authority to practice drugless methods in the clerk's office \* \* \* county" The clerk shall thereupon give to every drugless practitioner so registered a transcript of the entries in the register, with a certificate under seal that he has filed the prescribed affidavit. The licensee shall pay the county clerk a total fee of one dollar for such registration, affidavit and certificate

§ 285-l Hearing and decision of charges If any practitioner of drugless methods be charged under oath before the board with unprofessional or immoral conduct, or with gross ignorance, or inefficiency in his profession, the board shall notify him to appear before it at an appointed time and place, with counsel if he so desires, to

answer said charges, furnishing to him a copy thereof Upon the report of the board that the accused has been guilty of unprofessional or immoral conduct, or that he is grossly ignorant or inefficient in his profession, the regents may suspend the person so charged from practice for a limited season, or may revoke his license Upon the revocation of any license, the fact shall be noted upon the records of the regents and the license shall be marked as cancelled, of the date of its revocation Upon presentation of a certificate of such cancellation to the clerk of any county wherein the licensee may be registered, said clerk shall note the date of the cancellation on the register of drugless practitioner and cancel the registration A conviction of felony shall forfeit a license to practice drugless methods, and upon presentation to the regents or a county clerk by any public officer or officer of drugless method society of a certified copy of a court record of license and clerk's register, and the license and registration shall be marked "cancelled" Any person who after convicted of felony shall practice drugless methods in this state, shall be subject to all the penalties prescribed for the unlicensed practice of drugless methods, providing that if such conviction be subsequently reserved upon appeal and the accused acquitted or discharged, his license shall become again operative from the date of such acquittal or discharge

§ 285-m Limitation of license Every duly licensed and registered drugless practitioner shall be entitled to practice only that method or methods which his diploma or diplomas shall designate, and shall at all times have posted and exposed in a conspicuous place in his or her office his or her license and certificate of registration, nor shall he use any other title or degree except the one his or her diploma calls for

§ 285-n Transfer of registration A practicing drugless practitioner having registered a lawful authority to practice in one county, and removing such a practice or part thereof to another county, or regularly engaging in practice or conducting an office in another county, shall show, or send by registered mail, to the clerk of such other county, his or her certificate of registration The clerk of such other county, on payment of a fee of one dollar (\$1) thereof, shall stamp or indorse upon such certificate the date and his name, preceded by the words "Registered also in \_\_\_\_\_ County," and return the certificate to the applicant

§ 285-o Exceptions This article shall not be construed to effect doctors of medicine, osteopaths or others legally entitled to practice their particular profession or business, turkish baths, their managers and operators, or persons giving gratuitous services in cases of emergency, or any drugless practitioner practicing in one county and

duly registered therein and called to attend isolated cases in another county, but not residing or habitually practicing therein

§ 285-p Specific violations Every person who shall practice drugless methods within this State without lawful registration, or in violation of the provisions of this act, shall forfeit to the county wherein such person shall so practice, or in which any violation of the provisions of this act is committed, fifty dollars (\$50) for every day of such unlawful practice, and the district attorney may bring an action in the name of such county for the collection of such penalties, and the expense incurred in such prosecution, which shall be paid into the county treasury Any person who shall practice drugless methods under a false or assumed name, or who shall falsely impersonate another practitioner of a like or different name, shall be guilty of a felony, and any person guilty of violating any of the other provisions of this article, or who shall buy, sell or fraudulently obtain any drugless method diploma, license or record of registration, or who shall aid, abet or knowingly assist in such buying, selling or fraudulently obtaining, or who shall practice drugless methods under the cover of a diploma or license illegally obtained or signed or issued unlawfully under fraudulent misrepresentation, or who, after conviction of a felony shall attempt to practice drugless methods, and any person who shall, without having been authorized to do so legally, append a drugless practitioner title to his or her name, or shall assume or advertise that he or she is lawful practitioner of drugless methods, shall be guilty of a misdemeanor and, on conviction thereof, shall be punished by a fine of not less than two hundred and fifty dollars or imprisonment of six months for the first offence, and on conviction of a subsequent offense by a fine of not less than five hundred dollars or imprisonment for not less than a year, or both fine and imprisonment

§ 285-q Prohibitions All licensed drugless

practitioners are hereby forbidden to administer drugs or practice surgery or obstetrics

§ 285-r Recognition of license Licensed drugless practitioners shall have the right to practice in public and private hospitals and other institutions in the State, when requested to do so by a patient or his or her natural or lawful guardian or representative or a member of his or her family All state, county and municipal officers of this State shall recognize all licensed drugless practitioners in the practice of drugless methods the same as licensed physicians are recognized in the practice of medicine.

§ 2 This act shall take effect immediately

---

Senate Int No 522 (conc Assembly Int 620)  
—A bill introduced in the Senate by Senator James S Truman of Owego, N Y, concurrent Assembly Int 620, by Assemblyman Chas P Miller of Genesee County, would amend section 2828, Workmen's Compensation Law, by providing that bar of statute of limitations shall be deemed to have been waived unless objections to failure to file claim within one year is raised on first hearing at which all parties in interest are present

Referred to Labor and Industry Committees of both Houses

*Comment* This bill will be dropped unless request is received to carry it

---

Senate Int No 530 (conc Assembly Int 756)  
—A bill introduced by the Joint Committee on Pollution of Waters, would add new section 343-d, Public Health Law, providing for cleanliness in shellfish industry and for medical examination of workers

Referred to Public Health Committee

*Comment* None at present

## IN ASSEMBLY

Assembly Int No 120—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would add new section 213, Labor Law, requiring employers to furnish nursing and first aid service in factories, mercantile and other establishments

Referred to Labor and Industry Committee

*Comment* No further comment at present

---

Assembly Int No 123—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would add new subdivision 10-a,

section 360, Tax Law, by permitting deduction from income for tax purposes of all expenses paid during the year for medical, surgical or dental services

Referred to Taxation and Retrenchment Committee

*Comment* No comment is necessary on this bill, it is presumed that the medical profession would favor such an amendment

Assembly Int No 127—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would amend sections 570, 571, Education Law, by providing that boards of edu-

cation and trustees shall appoint physicians and dentists and may employ nurses for service in schools

Referred to Public Education Committee

*Comment* Members of the Society can refer to page 85 of the February 1, 1924, issue of the Journal in regard to the comment then written relative to the similar bill introduced by Mr. Reich last year and again the year before in which the obnoxious part was opposed by the medical profession giving over to the authorities throughout the State the privilege through law of *providing* treatment for disease or physical defects of school children thus adding one more agency in the already complex provisions of the State for the care of its so-called wards

As last year, physicians can have no objection to the employment by the educational authorities of whomsoever they will for the inspection of school children and thus protect others from infectious or contagious diseases, or in case of ignorance of parents, aid the school in advising that physical defects be remedied

It, however, must always be recognized that the advice must be according to present day construction of thought, as the possibility is open of over-enthusiastic and semi-educated persons in authority suggesting that treatment of certain types be instituted which has long ago been proven to be of faddist nature and of no value whatsoever

This can readily be appreciated in the poor and unscientific suggestion that a child with Potts disease be recommended for manipulation of the spine which has long ago been proven to be the most injurious type of treatment for such a condition and is directly at variance with present day science

Assembly Int No 167—A bill introduced in the Assembly by Assemblyman Joseph Gavagan of New York County, would amend sections 40, 115, Workmen's Compensation Law, relative to compensation and time limit in case of occupational diseases

Referred to Labor and Industry Committee

*Comment* Unless comment or request is received from the members of the Society this bill will be dropped

Assembly Int No 182—A bill introduced in the Assembly by Assemblyman John Meegan of Erie County, would amend subdivision 6, section 15, Workmen's Compensation Law, by providing compensation for disability shall not exceed \$30 per week, instead of \$20 as at present

Referred to Labor and Industry Committee

*Comment* Unless comment or request is received from the members of the Society this bill will be dropped

Assembly Int No 184—A bill introduced in the Assembly by Assemblyman F. A. Miller of Kings County, would amend section 118, Workmen's Compensation Law, by authorizing physical examinations and practical tests of claimants to determine loss of use and proportionate loss of use of a member, result and test to be part of the record

Referred to Labor and Industry Committee

*Comment* None as yet

#### THE CHIROPRACTIC BILL.

Assembly Int No 185—A bill introduced in the Assembly by Assemblyman William Nicoll of Schenectady County, would define and regulate the practice of chiropractic

Referred to Public Health Committee.

Assembly Committee on Public Health, Room 310, The Capitol Messrs Lattin of Orleans, Bartholomew of Washington, Esmond of Saratoga, Austin of Monroe, Lyon of Cayuga, Loomis of Delaware, Van Cleef of Seneca, Thomas of Rensselaer, Bernhardt of Erie, Shepherd of Kings, Berg of Bronx, Kinsley of Bronx, Bungard of Kings

Assembly Int No 191—A bill introduced in the Assembly by Assemblyman Samuel Rosenman of New York County, would amend section 21, Workmen's Compensation Law, by providing in proceeding to enforce a claim it shall be presumed that an accidental injury, if proven, arose out of and in course of employment

Referred to Labor and Industry Committee

*Comment* Unless Comment or request is received from the members of the Society this bill will be dropped

Assembly Int No 201—A bill introduced in the Assembly by Assemblyman Frederick L. Hackenberg of New York County, would amend section 3, Workmen's Compensation Law, by providing for compensation for disabilities or death resulting from poisoning by benzene or by chlorine or iodine derivatives or petroleum products, etc

Referred to Labor and Industry Committee

*Comment* The attention of the members is called to this bill, inasmuch as it may affect employees of professional men, of hospitals, laboratories and the like where many of the substances mentioned in the bill are used in such institutions or in the offices of physicians



Assembly Int No 202—A bill introduced in the Assembly by Assemblyman William Hart of Richmond County, would amend section 3, Workmen's Compensation Law, by providing for compensation in case of poisoning by gasoline or other volatile petroleum products

Referred to Labor and Industry Committee

*Comment* Unless Comment or request is received from the members of the Society this bill will be dropped

Assembly Int No 203—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would amend section 3, Workmen's Compensation Law, by providing for compensation in case of infection or inflammation of skin on contact surfaces, due to oils, cutting compound or lubricants or due to dust, liquids, fumes, gasses or vapors

Referred to Labor and Industry Committee

*Comment* Same comment is offered as that on Assembly Int 201, Unless request is received from the members of the Society the bill will be dropped

Assembly Int No 204—A bill introduced in the Assembly by Assemblyman Michael Reilly of Kings County, would amend section 3, Workmen's Compensation Law, by providing for compensation in case of diseases due to inhaling silica dust

Referred to Labor and Industry Committee

*Comment* None, the bill will be dropped

Assembly Int No 214—A bill introduced in the Assembly by Assemblyman Lewis G Stapley of Livingston County, would amend section 107, State Charities Law, by authorizing investigations by superintendent or officer designated by him, and authorizing an arrangement for use of laboratory service of hospital

Referred to Judiciary Committee

*Comment* None, the bill will be dropped

No 214

Int. 214

IN ASSEMBLY,

January 15, 1925

Introduced by Mr Stapley—read once and referred to the Committee on Judiciary

AN ACT

To amend the state charities law in relation to the duties of the superintendent

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section one hundred and seven of chapter fifty-seven of the laws of nineteen hundred and nine, entitled "An act relating to state charities, constituting chapter fifty-five of the consolidated laws," as last amended by chapter forty of the laws of nineteen hundred and four-

teen, is hereby amended by adding two new subdivisions, to be subdivisions twelve and thirteen, to read as follows

12 The superintendent, or other officer designated by him, shall, in any investigation into the treatment and care of patients and the conduct, performance or neglect of duty of officers or employees, be authorized to subpoena witnesses, compel their attendance, administer oaths to witnesses, examine witnesses under oath and require the production of any books or papers deemed relevant or material to the inquiry or investigation The attendance of the witness and the giving of testimony or production of a book or paper by him may be compelled under the provisions of sections four hundred and six, four hundred and seven, and four hundred and eight of the civil practice act

13 The superintendent may enter into an arrangement with proper municipal or county officials or others under which the laboratory service of the hospital may be made available to municipalities or counties or parts thereof adjacent to the hospital, when in his judgment such an arrangement will be in the interests of public health and not prejudicial to the interests of the institution or its work He may receive moneys to be applied to extension of laboratory service or in consideration thereof and expend the same in accordance with the terms of the arrangement entered into as aforesaid, subject to the rules of procedure to be established by the board of managers

§ 2 This act shall take effect immediately

#### THE NARCOTIC BILL.

Assembly Int No 215 (conc Senate Int 115)  
—See concurrent Senate Int No 115 for digest and comment

Assembly Int No 229—A bill introduced in the Assembly by Assemblyman A Spencer Feld of New York County, would add new section 579-b Education Law, providing for county supervisors to supervise education of children with retarded mental development

Referred to Public Education Committee

Int 229

IN ASSEMBLY,

January 19, 1925

Introduced by Mr Feld—read once and referred to the Committee on Education

AN ACT\*

\* Matter in *italics* is new matter in brackets [ ] is old law to be omitted

To amend the education law, in relation to the supervision of the education of children with retarded mental development.

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Article twenty-b of chapter twenty-one of the laws of nineteen hundred and nine,

entitled "An act relating to education, constituting chapter sixteen of the consolidated laws, such chapter having been amended by chapter one hundred and forty of the laws of nineteen hundred and ten and such article added by chapter five hundred and fifty-three of the laws of nineteen hundred and seventeen, is hereby amended by adding a new section, to follow section five hundred and seventy-nine-a, to be section five hundred and seventy-nine-b, to read as follows

§ 579-b *County supervisors* In every county of the state there shall be a county supervisor to supervise the education of children with retarded mental development as defined by this article In counties within the city of New York there shall be such additional supervisors as may be necessary and shall be determined by the board of estimate and apportionment The salaries of such supervisors shall be a joint charge against the cities, union free school districts and school districts within the county, but the state shall apportion to such city or district, in the same manner as teachers' quotas are apportioned thereto, an amount equal to one-half of the salary paid to each such supervisor and charged against such city or district The amount of the salary to be paid to supervisors shall be determined by the legislative authority of the county No person shall be a supervisor unless he be a duly licensed physician with at least five years' experience in the treatment of mental disorders and diseases The children mentioned in this article shall be given special courses of mental training under the general direction and supervision of the supervisor Such children shall be required to attend such special courses until they are eighteen years of age

§ 2 This act shall take effect immediately

*Comment* Your Committee on Legislation believes that this bill as drawn appears to be an eminently sane bill and that it should receive the support of the Society

Assembly Int No 233—A bill introduced in the Assembly by Assemblyman Paul T Kameron of New York County, would amend section 28, Workmen's Compensation Law, by authorizing industrial board to permit claim for compensation to be filed within two years after accident or death

Referred to Labor and Industry Committee  
*Comment* None, the bill will be dropped

Assembly Int No 236 (conc Senate Int 228)  
—See concurrent Senate Int 228 for printed bill and comment

Assembly Int No 237 (conc Senate Int 231)  
—See concurrent Senate Int 231 for digest and comment

Assembly Int No 301—A bill introduced in the Assembly by Assemblyman Frank H Lattin of Orleans County, would amend section 13, Workmen's Compensation Law, by permitting injured employees at employer's expense, to engage medical or other attendance

Referred to Labor and Industry Committee.

*Comment* This bill is somewhat similar to Assembly Int 570, and is that which your Society in large measure has been asking in relation to the Workmen's Compensation Law County Chairmen are requested to forward their approval to the Labor and Industry Committee

Assembly Int No 302—See February 6th Journal for digest This bill will be dropped

#### THE STATE DEPARTMENT OF EDUCATION BILL AMENDING THE MEDICAL PRACTICE ACT

Assembly Int No 307 (conc Senate Int 211)  
—See concurrent Senate Int 211 for digest and comment

Assembly Int. 384—A bill introduced in the Assembly by Assemblyman Samuel Mandelbaum of New York County, would add new section 1097-a, Greater New York Charter, requiring board to furnish free eyeglasses to school children unable to pay therefor

Referred to Cities Committee

*Comment* This is a local bill and will be dropped

Assembly Int No 386 (conc Senate Int 308)  
—See concurrent Senate Int 308 for digest and comment

Assembly Int No 399 (conc Senate Int 283)  
—See concurrent Senate Int 283 for digest and comment

Assembly Int No 414 (conc Senate Int 278)  
—See concurrent Senate Int 278 for digest and comment

No 415

Int 414

IN ASSEMBLY,

January 26, 1925

Introduced by Mr Wallace—read once and referred to the Committee on Codes

AN ACT

To amend the code of criminal procedure in relation to jurisdiction of courts of special sessions

*The People of the State of New York represented in Senate and Assembly do enact as follows*

EXPLANATION—Matter in italics is new matter in brackets [ ] is old law to be omitted.

Section 1 Section fifty-six of the code of criminal procedure is hereby amended by adding

at the end a new subdivision, to be subdivision forty, to read as follows

40 For a wilful violation or refusal or omission to comply with any lawful order or regulation prescribed by any local board of health or local health officer where the penalty prescribed does not exceed fifty dollars nor the imprisonment six months

§ 2 This act shall take effect July first, nineteen hundred and twenty-five.

Assembly Int No 422—A bill introduced in the Assembly by Assemblyman Samuel Rosenman of New York County, would amend section 352, Civil Practice Act, by providing physicians and nurses may disclose professional information as witnesses in action to annul marriages on ground of fraud

Referred to Codes Committee

*Comment* This is an attempt to break down Section 352 of the Civil Practice Act relative to confidential communications between patient and physician, and inasmuch as there already exists on the statute books sufficient laws which if enforced and lived up to by the parties about to enter into marital relations, sufficiently cover the ground whereby the physicians need not be dragged in as a party to either of the complainant or the defendant

Assembly Committee on Codes, Room 344, The Capitol Messrs Esmond of Saratoga, Robinson of Tompkins, Hutt of Erie, Gedney of Rockland, Wallace of Nassau, Skinner of Schenectady, Sargent of Onondaga, Pammenter of Monroe, Galgano of New York, Schoffel of Bronx, Rosenman of New York

Assembly Int No 434—A bill introduced in the Assembly by Assemblyman Jerome C Ambro of Kings County, would amend section 355, Prison Law, by providing for removal to hospitals of prisoners confined either for civil or criminal cause, when they require immediate medical or surgical treatment

Referred to Penal Institutions Committee

No. 436.

Int 434

IN ASSEMBLY,

January 27, 1925

Introduced by Mr Ambro—read once and referred to the Committee on Penal Institutions

AN ACT

To amend the prison law in relation to removal of sick prisoners from jail

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section three hundred and fifty-five of chapter forty-seven of the laws of nineteen hundred and nine, entitled "An act relating to prisons, constituting chapter forty-three of the consolidated laws," is hereby amended to read as follows

§ 355 Removal of sick prisoners from jail If the physician to a jail, or, in case of a vacancy, a physician acting as such, and the warden, or jailer, certify in writing, that a prisoner confined in the jail, *either in a civil cause or upon a criminal charge*, is in such a state of bodily health that [his life will be endangered unless he is] *he requires immediate medical or surgical treatment and that in their opinion he should be removed to a hospital for treatment*, the county judge, or, in the city and county of New York, one of the justices of the supreme court, must, upon application, make an order, directing the removal of the prisoner to a hospital within the county designated by the judge, or, if there is none, to such nearest hospital as the judge directs, that the prisoner be kept in the custody of the chief officer of the hospital until he has sufficiently recovered from his illness, to be safely returned to the jail, that the chief officer of the hospital then notify the warden or jailer, and that the latter thereupon resume custody of the prisoner

§ 2 This act shall take effect immediately

*Comment* This is an eminently good bill for the care and protection of human life in relation to an individual when incarcerated, and your Committee on Legislation feels that it should be supported, and unless there be objections heard it will forward its approval to the introducer of the bill and to the committee in which it rests

The bill will be dropped pending any changes

Assembly Int No 527 (conc Senate Int 29)  
—See concurrent Senate Int 29 for digest and comment

Assembly Int No 536 (conc. Senate Int 351)  
—See concurrent Senate Int 351 for digest and comment

Assembly Int No 570 (conc Senate Int 380)  
—See concurrent Senate Int 380 for digest and comment



# State Department of Health



## LOOK AT THE LABEL

The attention of the Department has recently been called to a case in which the attending physician administered 28,000 units of tetanus antitoxin, using six different bottles, under the impression that he was using diphtheria antitoxin. Fortunately, the patient did not have diphtheria, as first suspected.

If the initial diagnosis had been correct, a child's death might readily have occurred as a result of the neglect to administer diphtheria antitoxin due to failure to read the labels on the bottles.

## TETANUS—1923

During 1923 there was recorded for the State, exclusive of New York City, a total of 47 deaths attributed to tetanus. In four of these deaths the cause was undetermined, but for the remainder the causes noted were as follows:

Unknown	4
Pistol wound	1
Blank cartridge wounds	6
Gunpowder burn	1
Wound of hand caused by a fire-cracker	1
Dart thrown causing injury below left eye	1
Roller-skating, fell on sidewalk—abrasion on knee	1
Tetanus neonatorum	3
Abscessed teeth (five extracted)	1
Lacerated scalp	1
Fell on stub or piece of wood injuring hand	1
Fracture—hit with clam shell	1
Fractured arm—fall	1
Fractured arm—fall, swing	1
Abrasion	1
Crushed foot, tree fell on it	1
Crushed wound of toes	1
Wound hand—fell on fly wheel motorboat engine	1
Post-diphtheritic paralysis-uremia	1
Incised wound of toe—cut with axe	1
Septic parotitis	1
Punctured wound of foot—rusty nail	3
Fall from roof—fractured wrist	1
Fall—injuring skull	1
Fall from coal trestle—fractured wrist	1
Stone thrown by another—infected wound, forehead	1
Blister on heel from shoe	1
Sliver penetrating leg	1
Vaccination (cowpox)	1
Kicked by horse	1

Fall from horse	1
Hypodermic injection by unknown quack	1
Syphilitic ulcers—arms and hands	1
Following thyroidectomy—4 weeks previous	1
Electric burns	1

Of these deaths, 5 occurred under five years of age, 23 or practically 50 per cent, between the ages of five and nineteen, 15 between twenty and sixty, and 4 over sixty years. Their incidence was between the months of March and December inclusive, none occurring in January or February, and 38 between June 1 and October 3. The highest monthly total was reached in July, the month of the glorious Fourth, the next highest being in October, which claimed nine deaths. There were 39 deaths of males and 8 of females.

## PROMPT IMMUNIZATION PREVENTS OUTBREAKS

The health officer, who, by prompt action, prevents an epidemic from starting is to be commended far more than he who quells an outbreak, but the former gets far less publicity.

Two instances of prompt action which probably prevented serious outbreaks of diphtheria and typhoid fever in at least two families in the town of Skaneateles were recently found in a report made by the health officer of that municipality, Dr. Milton E. Gregg, to the Division of Communicable Diseases.

Called to attend members of an Italian family, he found diphtheria of the throat present in a boy, and a case of nasal diphtheria in another child who had recently been brought by his mother, the housekeeper, from the city of Fulton. Antitoxin was administered to the patients and the other members of the household, as well as to children of neighboring families.

A case of typhoid fever developed in another family, the patient being a young man who had recently returned from a visit to Cincinnati, Ohio. The health officer succeeded in having all the other members of this family vaccinated with State typhoid vaccine. Had this not been done others in the family probably would have contracted the disease, as the patient had a severe diarrhea, and the home conditions were such that it would have been very difficult to keep the disease from spreading.

As events turned out, no further cases of either disease developed.

# NEWS NOTES

## PRE-CLINICAL SIGNS OF DISEASES OF THE SKIN

By HOWARD FOX, M D,

NEW YORK CITY

Abstract of the Eighth Lecture in the Symposium on Periodic Health Examinations, given in the New York Academy of Medicine on January 15, 1925, under the auspices of the Medical Society of the County of New York, and illustrated with lantern slides

There are practically no pre-clinical signs in the vast majority of skin diseases. They appear as a rule without warning from either the clinical or laboratory standpoint.

Two symptoms might however be mentioned which occasionally precede the outbreak of cutaneous lesions, namely pain and itching. Strictly speaking even these are not pre-clinical. Herpes zoster in a certain proportion of cases may be preceded by neuralgic pain before the appearance of the characteristic vesicles or even the slightest amount of redness. Itching or a sensation of burning may accompany a number of inflammatory diseases, but is rarely present before the outbreak of the eruption. In the disease known as pruritus with lichenification (lichen simplex) the lesions may be preceded for a variable time by severe itching. Pruritus may of course be present without ever producing any visible evidences of scratching and constitute a disease—*sui generis*.

In presenting the dermatological aspect of periodic health examination I would like to touch upon three phases of the subject which seem to be pertinent.

- 1 The significance of the so-called precancerous dermatoses and of scars

- 2 Some of the serious diseases whose early recognition is all important

- 3 The relation of certain diseases of the skin to internal disorders, often of a more serious nature

A large number of cutaneous affections have been incriminated as a possible source of malignancy. In this category belong the pigmented nevi, concerning the importance of which opinions seem to differ. There can be no doubt that when a malignant process begins in a pigmented mole (generally a melano-carcinoma) it is most serious. When metastases have occurred, there is no disease which is more certainly fatal. Fortunately it is a very rare one. When the almost universal occurrence of small pigmented moles is considered, the chances of malignancy arising from such lesions is exceedingly small. The type of pigmented mole which is most dangerous is the flat, bluish black one. The vast majority

of pigmented nevi can be safely left alone. When in rare instances they show signs of activity, they should receive immediate attention and be vigorously destroyed (cautery, electro-coagulation, etc.) When pigmented moles are situated in locations such as the bearded region where they are liable to frequent traumatism, they should be destroyed.

Among other cutaneous lesions which may be the starting point of malignant disease should be mentioned xeroderma pigmentosum, chronic radiodermatitis, senile, seborrheic and arsenical keratoses, leucoplakia, ulcers, scars, fistulae, lupus vulgaris, inveterate psoriasis, Paget's disease of the nipple, and Bowen's precancerous dermatosis. While any one of the above affections may serve as the origin of cancer, this is certainly not the ordinary sequence in the vast majority of cases.

The disease which best merits the appellation of precancerous is probably xeroderma pigmentosum. This appears first in childhood, chiefly on the exposed parts of the body, and bears a close resemblance to the changes produced by excessive irradiation from the roentgen ray or radium. It appears to be a form of sensitization to actinic rays and is eventually fatal as a rule from the formation of prickle cell epithelioma. The termination of severe cases of chronic radiodermatitis is well known even by the laity. Leucoplakia is by no means an invariable forerunner of cancer especially where smoking and other forms of irritation are avoided and unskillful or half way methods of treatment are not employed. While cancer may develop upon a lupus vulgaris, for instance, this does not happen except on very rare occasions. The same may be said of the majority of the so-called precancerous affections.

Scars of various types will be noted in the course of periodic examinations, though their significance is not always understood. The so-called spontaneous keloid is often seen upon the chest and is a well known racial peculiarity of the negro. It differs from the hypertrophic scar, which does not extend beyond the confines of the original injury. The scars of burns and tuberculosis are keloidal, banded, and deforming, in con-

trast to those of syphilis which are soft, pliable and small in comparison with the amount of ulceration or infiltration which preceded them. The scars of nodular (late) syphilides with their grouping in circles or portions of circles are often as characteristic as the original lesions which caused them. Scars of herpes zoster, variola, acne varioliformis and self-inflicted wounds (malingerers) are generally characteristic.

There are certain serious affections of the skin whose early recognition is of the greatest importance. At this time a cure may be obtained, while if allowed to progress this may become impossible. Lupus vulgaris when appearing at the outset as a small group of apple jelly nodules upon the cheek, especially in young individuals, can be excised or vigorously treated by other means. When the disease has progressed, and especially when it has invaded the mucous membrane, a cure is often hopeless.

Leprosy is a disease which should be recognized early not only for the sake of others (in communities where the disease is endemic) but for the patient's sake. Even with the modern method of using ethyl esters of chaulmoogra oil, very few lepers, in my opinion, are ever cured. In the earliest stages however, such an event is possible. Any yellowish-brown macules which are more or less definitely anaesthetic, especially in persons from a leprosy region, should arouse the suspicion of this dreaded disease.

Cutaneous cancer occurs most frequently on the face where it is of the relatively benign type, which practically never metastasizes. On the extremities and genitals and about the orifices it

is often a much more serious problem. While cancer of the skin may assume many forms, the most characteristic symptom is the presence of a semi-translucent waxy border. Absence of pain and a tendency to bleed easily are also noted in this disease.

For the early recognition of syphilis, it is fortunate that in most cases (at least in males) there is a definite initial lesion. That this may be a very insignificant ulceration without the classic induration is unfortunately true. The expression "typical Hunterian chancre" is misleading in that it causes many to overlook small lesions of the genitals which should awaken at least a suspicion of syphilis. It seems necessary to frequently caution against the practice of cauterizing genital sores until at least repeated dark field examinations have been made.

Various eruptions of the skin are simply signs of internal disorders or constitute a single symptom of a general disease. Rosacea is almost invariably a sign of gastro-intestinal disturbance, and the same is true of acute urticaria. Lupus erythematosus is probably due to focal sepsis, in some cases of a tuberculous nature. Eczema, furunculosis, pigmentation, and xanthoma may all be caused by diabetes. In rare instances keratoses of the feet may be due to gonococcal infection. The rare condition known as acanthosis nigricans is an indication of internal malignancy. The dermatitis of pellagra is simply one of the symptoms of a serious disease.

While certain skin diseases are purely local conditions, others should be looked upon as danger signs suggesting a more serious underlying condition.

## TOMPKINS COUNTY MEDICAL SOCIETY

The January meeting of the Tompkins County Medical Society was held in the parlors of the Board of Commerce, Ithaca, N. Y., Tuesday evening, the 27th, 1925. President John W. Judd in the chair.

The minutes of the December meeting were read and approved.

1925—President Judd announced the following standing committees for Legislative: Luzerne Coville, M. A. Dumond, Minor McDaniels. Public Health: L. T. Genung, William A. Smith, J. H. VanMarter.

Since our last meeting the Society has met with a great loss in the death of our fellow member, Dr. Roscoe C. Wilson of Ithaca.

A fitting memorial was presented by the Committee on Resolutions and read while the members stood with bowed heads. The memorial was

directed spread upon the minutes and a copy sent to the bereaved family.

Dr. Luzerne Coville was by motion designated as the representative of the Society in the Board of Commerce of Ithaca with voting power.

It was moved and carried that the Annual Banquet be held in March.

Hon. Charles E. Treman of the Ithaca Trust Company then addressed the meeting upon "Investments." Among other things, Mr. Treman said: "This is the age of specialists, not alone in medicine but in many other fields. The person who has money to invest and has not made a study of investments, should get the advice of his banker, (specialist) and follow it. Remember there is no such thing as security, safety and 3½% a month. The safer the investment the lower the income. The person who develops the habit of systematic saving and investing in safe bonds

will be the most likely to have a steady income

Three things should always be looked after closely before investing First, safety of principal, Second, satisfactory income, Third, salability There is a vast difference between investing and speculating Make your investments first until you have secured a satisfactory income Then if you have any surplus funds that you can afford to lose, if things should go that way, you may be justified in speculating Remember that if you buy stocks, you become a partner in the business which is managed by others If you buy bonds, you have what amounts to a mortgage

Mr J F Hickey, merchant and business man, then addressed the meeting on "Business Methods for Doctors of Medicine" After complimenting the medical profession upon its high ideals as shown in its code of ethics, Mr Hickey expressed his belief that Medical Colleges should include in their curriculum a short business course He stated that from his observation there

were as many physicians who are successful in a business way as there are merchants The one outstanding point of failure with both is that of collection of accounts Almost every one dislikes to force collections It is necessary, however, that collections be made in order to protect one's home, family and business Mr Hickey made special mention of collection problems of the Hospital (of which he is a trustee), and suggested the members of the society might be able to help in their solution

Hon J T Newman then addressed us on "Wills and Estates," giving rather detailed instructions as to what should go in a will to properly safeguard the interests of the estate and the beneficiaries

After each address the subject was opened for discussion and many questions were asked and much information gained

The meeting was then adjourned, a light lunch was served, and a social hour enjoyed

## CHILD WELFARE CLINICS IN YATES COUNTY

Early in January I received a request from Dr Florence McKay, Director of the Division of Maternity, Infancy and Child Hygiene, asking me to present the matter of Children's Health Consultations to the various County Medical Societies in my district and secure from societies a list of designated members to conduct these consultations every six months, and offering a modest honorarium (about \$15.00 a day) for part payment, the community to add to it as it sees fit

The society seemed to be interested in the proposition and on motion, the following Children's Health Consultation Committee was appointed to act with the President Dr G Howard Leader, Dr John A Hatch, Dr Charles E Doubleday

The following physicians were designated to conduct consultations in the various districts

Village or Town	Examiners	Location of Clinic
Dundee Village and Barrington Township	Dr McDowell	Dundee
Benton Township	Dr Maloney	
	Dr Welker	Belona
Italy Township	Dr Ward	
	Dr Chaffee	Italy Hollow
	Dr Foster	
Jerusalem Township	Dr Costello	Branchport
	Dr Halstead	

Township of Potter	Dr Halstead	Potter
	Dr Chaffee	
Rushville Village	Dr Halstead	Rushville
	Dr Chaffee	
Milo Township	Dr Hatch	Second Milo
	Dr Foster	
Starkey Township	Dr Maloney	Lakemont
	Dr Wright	
Torrey Township	Dr Welker	Dresden
	Dr Ward	

This list is only tentative, as some of the physicians designated were not at the meeting and may decline to serve In that event, the Children's Health Consultation Committee will select others to act as consultants

It is planned to devote two weeks in May and two weeks in October for holding these consultations Miss Nellie Z Mahar, the County Nurse, will make all preliminary arrangements for these clinics Additional nursing service will be furnished by the State Department of Health Miss Mahar will do the follow-up work

At the annual meeting of the Society, the Children's Health Consultation Committee will make a report of the work done throughout the County, and make such recommendations as it sees fit for the future conduct of these consultations

B WAKEMAN, M D,  
District State Health Officer

trast to those of syphilis which are soft, pliable and small in comparison with the amount of ulceration or infiltration which preceded them. The scars of nodular (late) syphilides with their grouping in circles or portions of circles are often as characteristic as the original lesions which caused them. Scars of herpes zoster, variola, acne varioliformis and self-inflicted wounds (malingering) are generally characteristic.

There are certain serious affections of the skin whose early recognition is of the greatest importance. At this time a cure may be obtained, while if allowed to progress this may become impossible. Lupus vulgaris when appearing at the outset as a small group of apple jelly nodules upon the cheek, especially in young individuals, can be excised or vigorously treated by other means. When the disease has progressed, and especially when it has invaded the mucous membrane, a cure is often hopeless.

Leprosy is a disease which should be recognized early not only for the sake of others (in communities where the disease is endemic) but for the patient's sake. Even with the modern method of using ethyl esters of chaulmoogra oil, very few lepers, in my opinion, are ever cured. In the earliest stages however, such an event is possible. Any yellowish-brown macules which are more or less definitely anaesthetic, especially in persons from a leprosy region, should arouse the suspicion of this dreaded disease.

Cutaneous cancer occurs most frequently on the face where it is of the relatively benign type, which practically never metastasizes. On the extremities and genitals and about the orifices it

is often a much more serious problem. While cancer of the skin may assume many forms, the most characteristic symptom is the presence of a semi-translucent waxy border. Absence of pain and a tendency to bleed easily are also noted in this disease.

For the early recognition of syphilis, it is fortunate that in most cases (at least in males) there is a definite initial lesion. That this may be a very insignificant ulceration without the classic induration is unfortunately true. The expression "typical Hunterian chancre" is misleading in that it causes many to overlook small lesions of the genitals which should awaken at least a suspicion of syphilis. It seems necessary to frequently caution against the practice of cauterizing genital sores until at least repeated dark field examinations have been made.

Various eruptions of the skin are simply signs of internal disorders or constitute a single symptom of a general disease. Rosacea is almost invariably a sign of gastro-intestinal disturbance, and the same is true of acute urticaria. Lupus erythematosus is probably due to focal sepsis, in some cases of a tuberculous nature. Eczema, furunculosis, pigmentation, and xanthoma may all be caused by diabetes. In rare instances keratosis of the feet may be due to gonococcal infection. The rare condition known as acanthosis nigricans is an indication of internal malignancy. The dermatitis of pellagra is simply one of the symptoms of a serious disease.

While certain skin diseases are purely local conditions, others should be looked upon as danger signs suggesting a more serious underlying condition.

## TOMPKINS COUNTY MEDICAL SOCIETY.

The January meeting of the Tompkins County Medical Society was held in the parlors of the Board of Commerce, Ithaca, N. Y., Tuesday evening, the 27th, 1925. President John W. Judd in the chair.

The minutes of the December meeting were read and approved.

1925—President Judd announced the following standing committees for Legislative: Luzerne Coville, M. A. Dumond, Minor McDaniels. Public Health: L. T. Genung, William A. Smith, J. H. VanMarter.

Since our last meeting the Society has met with a great loss in the death of our fellow member, Dr. Roscoe C. Wilson of Ithaca.

A fitting memorial was presented by the Committee on Resolutions and read while the members stood with bowed heads. The memorial was

directed spread upon the minutes and a copy sent to the bereaved family.

Dr. Luzerne Coville was by motion designated as the representative of the Society in the Board of Commerce of Ithaca with voting power.

It was moved and carried that the Annual Banquet be held in March.

Hon. Charles E. Treman of the Ithaca Trust Company then addressed the meeting upon "Investments." Among other things, Mr. Treman said: "This is the age of specialists, not alone in medicine but in many other fields. The person who has money to invest and has not made a study of investments, should get the advice of his banker, (specialist) and follow it. Remember there is no such thing as security, safety and 3% a month. The safer the investment the lower the income. The person who develops the habit of systematic saving and investing in safe bonds



who recently died at the age of 91, after a long lifetime spent in the general practice of medicine. The account says

"They were called family doctors. And when one was sick or 'run down' or discouraged about things, there was a mighty lot of comfort in calling on the old doctor, in having him come to the house, and just sit around and ask about the folks, and, if there were children in the family, he gave their ears a tweak, asked them how's school, and did they like coasting, and how were all the dolls, and what did Santa Claus bring them for Christmas. Small talk. No talk for a specialist."

As a matter of fact, the best consulting specialists show exactly these traits which are supposed to be the distinguishing marks of the old family doctor, and they are far more kind and considerate than the gruff old family physician usually was.

The editor then goes on to describe the journey of the old doctor through the snow and darkness and continues

"And he would wipe some of the melted snow from his beard (that was before doctors knew that beards carried germs) and ask

"Well, how's the little boy today?" and laugh

"Then he would sit down beside the bed and feel our pulse. How nice and cool his fingers felt. 'Let me see your tongue.' Then he would use the spoon handle to depress the back of the tongue, and he would peer into the throat. 'Say "ah".' And we'd say 'ah' and look at the big eyes of the doctor, and we liked what we saw there.

"Then the doctor would open his worn black case and leave a few pills and put something in a tumbler of water and then he would go away. And we would just feel as safe as if we had a guaranty that everything would be all right."

But the trouble was that everything was not always all right. The virulent attack of diphtheria with no membrane in sight, the stomach ache and vomiting which meant intestinal obstruction and immediate operation—in such cases as these the old doctor was not a life saver.

And then too modern physicians have to undergo as many hardships as their predecessors. The principal difference is that while formerly some member of the stricken family first braved the storms and cold and darkness to call the doctor, and thus guaranteed the real need of the doctor's services, now the call goes over the telephone and the doctor makes the journey alone while the stricken family stay at home and build a roaring fire to thaw out the frozen doctor when he arrives.

The *Troy Times*, January 27, contains the following headlines

"Indication of presence of typhoid germs in the City of Troy's water supply

"Startling announcement made of Board of Contract meeting. Chlorinating machine purchased and will be operated this week."

The account then describes the purchase of two chlorinating machines at a cost of \$2,300 as an emergency measure, and the commendation of the water commissioner "for his prompt work in the situation." The account then goes on to say

"It was then brought out that Troy is one of only a few cities in the state which does not either filter or chlorinate the water.

"Isn't it a fact that Troy's water supply has been regarded as among the best in the state?" inquired the Mayor.

"The source has," replied the City Engineer, "but any big watershed is liable at any time to contamination."

"The engineer further advanced the information that unless the city authorities acted promptly in the matter, the Interstate Commerce Commission would take action at the instigation of the railroads, who take their water from this city to be used for the tanks on the train. In fact, it was brought out that the Boston and Maine Railroad had already ordered that no more water be taken from Troy."

The main point of interest to medical men is that Troy has taken effective steps to safeguard its water supply.

The *Schenectady Union*, January 27, carries an appeal to the people to avail themselves of periodic health examinations. It quotes Health Officer Collins as saying

"There occurred in Schenectady during the past two years 119 sudden deaths, I mean by that, persons who died suddenly while at their work, on the street, or found dead in bed, etc., without medical attendance. It is safe to say that if a large majority of these cases had a periodic health examination made, these sudden deaths might have been prevented or at least life prolonged.

"Such examinations can be had and be well done in the office of your family physician. There is no reason why any conscientious physician cannot make a thorough physical examination and render effective advice to his patient. A good time for these examinations would be on the birthday of the individual, and if this rule was once established and regularly carried out, I am sure in many instances life might be prolonged."

Such news items as these will do much to popularize the demand for the examinations.



# THE DAILY PRESS



We have received word of several meetings of Medical Societies by means of clippings from the daily press

The *Liberty Register*, January 15, contains an account of a meeting of the Sullivan County Medical Society held on January 14 in Liberty. The President of the Society, Dr Charles S Rayevsky, stated that the Society was planning to take an active part in the solution of health problems of Sullivan County in the future.

Dr F W Sears of Syracuse described the periodic examinations as they were being planned in Syracuse, and the plan will be sponsored by the Sullivan County Medical Society.

In our medical survey of Sullivan County printed in the *Journal* last December, we called attention to the opportunities which the medical men of Sullivan County had to assist in solving the peculiar problems of that county. We are gratified to read that the physicians are taking active steps to solve their own problems.

The *Poughkeepsie Star* of January 15, contains a very brief account of the annual meeting of the Dutchess-Putnam Medical Society which was attended by fifty members.

The *Salamanca Inquirer*, January 9, contains a short account of the annual meeting of the Cattaraugus County Medical Society on January 6, in Salamanca, but this account, like the preceding one, gave only the bare facts of the meeting. The daily newspapers are always glad to comment on the activities of the medical societies, if the civic work of the society is told to the reporters.

The daily newspapers do not often carry accounts of the meetings of medical societies, and the only reason is probably that the physicians do not give the news to the papers. We wish that the Secretary of every County Medical Society would send an account of every meeting to the local newspapers of the County, and to the editors of the dailies which circulate in the county.

The *Kingston Leader*, January 14, contains the following encouraging news regarding the activities of the physicians of a sister city:

"The Medical Society of the city of Amsterdam is setting an example for other medical organizations by taking an active interest in

the work of the local health department. Dr Schiller, health officer, with the approval of the mayor, has indicated his intention to appoint an advisory council made up of members of the society, suggesting that it meet monthly for conferences with him regarding his work. The suggestion that a monthly meeting of the society be devoted to discussion of civic affairs is being considered."

The daily papers throughout the land have carried stories of an epidemic of diphtheria in Nome, and of the heroic journey of six hundred miles by relays of drivers of dog sleds, in order to bring antitoxin to the stricken people. The *New York Sun*, February 4, says:

"The story of the daring of Leonard Sepalla, who ran the serum on the first long lap of the relay and crossed Norton Sound in an unbroken swirl of wind driven snow and ice, was told for the first time today.

"The ice in the sound was heaving—breaking up and drifting out to sea—before he started the race. Ignoring this warning, which meant that his life was in peril from forces over which his strength and endurance could have no control, the musher set out.

"His race behind his twenty dogs was made by this danger one where the need of speed was trebly great. He must race to reach the next musher in the relay for the relief of Nome, he must race against the blizzard which threatened himself and his dogs with death from exposure, he must race against the danger that the ice would break up beneath him, bringing his own death and the destruction of the precious serum.

"He might have avoided the last danger by taking a longer route around the bay. That would have lost time, when time at Nome meant life. He took the chance on the ice. He won through, saved many hours and perhaps many lives.

"Sepalla is expected in Nome today. His daughter, Sigried, is one of those ill with the disease."

All the front page news stories of the epidemic, published daily for over a week, extolled the virtues of diphtheria antitoxin, and commended the sled drivers and their dogs by whose united heroism the life-saving serums was carried to the people of Nome.

The *Hudson Star*, January 10, contained a tribute to the late Dr John J Glover of Hudson.

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 6

NEW YORK, N Y

FEBRUARY 20, 1925

## MEDICINE AND PSYCHOLOGY\*

By HERMAN G MATZINGER, M.D.,

BUFFALO, N Y

FOR a long time the feeling has been growing among thinking and observing people that there is something wrong with higher education. It has not alone become a chief topic among educators but has spread to the intelligent public. Magazine articles and books are appearing in bewildering numbers offering studies, critiques and suggestions. All manner of new experiments are being tried in the hope of finding some solution or, at least, some suggestion of a workable remedy. There have developed two groups of investigators, one concerning itself with the curriculum and methods of teaching, the other with the mental equipment and make-up of the student. The latter has been very busy during the recent past, and is deeply engrossed in developing tests which shall determine who is fit for higher education as it is offered now, while the former is still busy and has been for a long time with determining what subjects are essential and how they shall be grouped and taught. Today we find that this investigation is no longer confined to colleges and universities, but has spread to and involved professional and public schools as well. If we inquire for the cause for this widespread unrest, we soon discover that the principal reason is to be found in the fact that education, as it is today administered, does not prepare the student for life, as it professes to do, in spite of enormous expenditure of time, money and effort. In other words the practical results are disappointing not alone to the educator and the educated, but also to the intelligent public who pays the bills and who offers its sons and daughters in the hope of making them more useful and more successful in the pursuit of happiness than they otherwise might be. You will agree that true happiness results only from useful, creative work—accomplishment in any line so long as it is not

destructive to or does not interfere with the natural rights of others. An opportunity to work is the secret of happiness. Without it we must needs be unhappy no matter what our station in life or how much education we may have. It is at least a debatable question whether higher education fulfills its mission in this respect. There can be no question as to the value of higher education in the perpetuation of knowledge and in the advancement of both knowledge and science, but it is far from being an established fact that it, in any material way, enhances the average individual's prospects for usefulness and therefore for happiness. There are many unsuccessful people who believe that lack of education is the chief cause of their failure and many who believe that they are successful in spite of it, just as there are many who will readily admit that much of the time spent in getting as much education as possible not only delayed them in getting to work, but tended to scatter effort and interest.

Almost everyone who has been for a long time interested and occupied in the teaching of medicine is more than certain that there is also much that is wrong in the courses as they are offered today. In spite of most marvelous advance in the so-called medical sciences, it is generally acknowledged that the proportion of really good physicians graduated is, at best, no larger than in earlier days. We recognize, of course, that in some measure this is due to the fact that many undertake the study of medicine who are unfitted for the practice of the healing art, but this was as true in past years as it is now, the principal difference which is noteworthy being that in the development of the technical and scientific departments of medicine there are now openings for many trained specialists, whose work though valuable and necessary, can not be called practicing medicine. The phenomenal development of this side of medicine has, of course,

\* Read at the Annual Meeting of the Medical Society of the State of New York, at Rochester April 22, 1924



## BOOKS RECEIVED



Acknowledgment of all books received will be made in this column and this will be deemed by us a full equivalent to those sending them. A selection from these columns will be made for review, as dictated by their merits, or in the interest of our readers.

**INFECTION, IMMUNITY AND INFLAMMATION** A Study of the Phenomena of Hypersensitiveness and Tolerance, and Their Relationship to the Clinical Study, Prophylaxis, and Treatment of Disease By FRASER B GURD, B.A., M.D., C.M., F.A.C.S., Montreal The C V Mosby Company, St. Louis 1924 Price \$5 00

**AN AFRICAN HOLIDAY** By RICHARD L. SUTTON, M.D., LL.D., Fellow of the Royal Geographical Society of Great Britain With 102 Original Illustrations The C V Mosby Company, St. Louis, 1924 Price \$2.25

**OPERATIVE SURGERY** By J. SHELTON HORSLEY, M.D., F.A.C.S. Attending Surgeon, St. Elizabeth's Hospital, Richmond, Va. With 666 Original Illustrations Second Edition The C V Mosby Company, St. Louis, 1924 Price \$12 50

**THE DIAGNOSIS OF CHILDREN'S DISEASES, WITH SPECIAL ATTENTION TO THE DISEASES OF INFANCY** By Professor Dr. E. FEER, Director of the University Children's Clinic, Zurich, Switzerland Translated by CARL AHRENDT SCHERER, M.D., F.A.C.P. J. B. Lippincott Company, Philadelphia Price \$5 00

**FRACTURES AND DISLOCATIONS, IMMEDIATE MANAGEMENT, AFTER-CARE, AND CONVALESCENT TREATMENT WITH SPECIAL REFERENCE TO THE CONSERVATION AND RESTORATION OF FUNCTION** By PHILIP D. WILSON, A.B., M.D., F.A.C.S., and WILLIAM A. COCHRANE, M.B., Ch.B., F.R.C.S. Edin. 978 Illustrations J. B. Lippincott Company, Philadelphia. Price \$10 00

**THE CRIPPLED HAND AND ARM** By CARL BECK, M.D. 302 Illustrations J. B. Lippincott Company, Philadelphia. Price \$7 00

**METHODS AND PROBLEMS OF MEDICAL EDUCATION** (Second Series), Division of Medical Education, The Rockefeller Foundation, New York, 1924

**MANUAL FOR DIABETICS** By GLADYS L. BOYD, M.D., and MARION D. STALSMITH Introduction by F. G. BANTING, M.D. 12 mo. Cloth, 101 pages Price \$1.50 net Funk & Wagnalls Company, Publishers

**THE EFFECTS OF INANITION AND MALNUTRITION UPON GROWTH AND STRUCTURE** By C. M. JACKSON, M.S., M.D., LL.D., Professor and Director of the Department of Anatomy, University of Minnesota. 117 Illustrations P. Blakiston's Son & Co., Philadelphia. Price \$8 00



## BOOK REVIEWS



**ANGINA PECTORIS** By SIR JAMES MACKENZIE, M.D., LL.D. Large Octavo of 253 pages, illustrated London, Henry Frowde & Holder & Stoughton, New York, Oxford University Press, 1923 Cloth, \$9 00 (Oxford Medical Publication)

In this work Mackenzie gives his theory and complex of symptoms, and his ideas as to the cause of heart pain, in detail. The origin is from the changes in the heart muscle. The nature of reflexes, and the relation of the sympathetic nerves of the heart to cerebro-spinal sensory nerves, is described in full, so as to associate definite ideas concerning the distribution of pain sensations, in Angina Pectoris. All of the essential matter and notes are enumerated from Mackenzie's own personal records and observations. Methods are given for further heart investigation, so that a better prognosis can be known, better treatment instituted and heart failure prevented. In the last quarter of the book are 160 Case histories, taken from the author's work which give actual notes concerning the progress and study of heart pain subjects.

A T M

**CHRONIC INTESTINAL STASIS (ARBUTHNOT LANE'S DISEASE)** A Radiological Study By ALFRED C. JORDAN, M.D. Large octavo of 230 pages with 314 illustrations New York, Oxford University Press 1923 Cloth \$7 50 (Oxford Medical Publications)

This monograph of over 200 pages deserves a better title than it has received. The beautiful radiographic reproductions which it contains cover the X-ray diagnosis of nearly all the gastrointestinal diseases which are recognizable by this method of diagnosis. The

author voices Lane's opinion that practically all human ills, from cancer of the rectum to pyorrhea, are due to intestinal stasis, and the latter can be cured by a Curtis belt and suitable dietetic and hygienic measures or by colectomy. It seems too bad that a radiographer of Jordan's ability should waste such beautiful X-ray material to illustrate a subject which today has no legitimate standing in medicine. If the text be entirely disregarded, a study of the illustrations would be well worth while.

A

**FEDERAL INCOME TAXES, PRINCIPLES AND PRACTICE**, by E. E. ROSSMOORE, B.S., Certified Public Accountant (New York) D. Appleton and Co., New York and London, 1924

No taxpayer is in greater need of clear and authoritative information than the physician and such a work as the one here considered provides just such material.

Just as many medical textbooks are divided into Principles and Practice so this treatise is similarly divided.

Those medical students and practitioners who like the case report method of teaching medicine will feel right at home in the presentation of 467 actual problems with their complete solutions. The need for such treatises is in that "while good citizenship requires that a man render unto Cæsar the things which are Cæsar's, it is essential that he keep intelligently and adequately informed so that he may determine his own liability, protect his own rights and be prepared to render competent judgment when the questions of taxation come up for national discussion."

WM. HENRY DONNELLY

the knowledge of structure there soon came the various sciences which deal with organic functions and which collectively are known as physiology. From these come special sciences dealing with abnormal function with the attendant tissue alterations called pathology, bacteriology, immunology and pharmacology. All these have today reached a truly astonishing degree of perfection that commands admiration, and yet there is something vital lacking, namely, the understanding of the behavior of the body as a whole, as an organism.

The practice of medicine depends on a thorough and intimate knowledge of life processes as a whole as well as of separate organs because they are inter-related and inter-active and together determine what we call human behavior. So it seems plain that psychology is rightly a part of physiology and should constitute a further development of that science with a view of explaining conduct in general and bridging the chasm between medicine and psychiatry.

Psychology is therefore a logical extension of the science of physiology and should be taught as such in a thoroughgoing course in medicine. The study of human behavior is the study of the human mind and one needs but be reminded of the prevalence of mental disorders and diseases to realize the importance of this extension of the science of physiology in its bearing on treatment as well as prophylaxis. How can we longer afford to neglect to incorporate so important a matter in the teaching of medicine? Even the layman is aware of its importance and is eager to discover the elements of behavior and to see a formulation of laws to describe and explain the complex phenomena of life which constitute mind. Many of them are much more able and better trained in measuring human action and experience than the average physician.

Very few physicians who are thoroughly conversant with and daily make complicated biological and chemical tests can apply the simplest mental tests. Indeed few of them know their significance. Some of them have had a premedical acquaintance with conventional psychology as a department of philosophy but do not realize that psychology is rapidly divorcing itself from this field of speculative inquiry and has entered the domain of the natural sciences.

A large amount of material obtained by careful observation of the various phenomena of mental life and experience has been recorded and scientifically studied and analyzed. Out of this has come first genetic psychology which concerns itself with the historic development of behavior and behaviorism which

attempts to formulate laws of conduct. It has been suggested that together these two lines of investigation be called psychobiology, and that since they concern themselves with instinctive and voluntary habit reactions they belong to physiology and should be taught as such in the curriculum of every good school of medicine. The neglect of such instruction and the passive attitude exhibited by those who standardize medical training has opened the way for the development of the many spurious sects and cults who, with half truths and fragmentary knowledge, draw attention to their advanced position and insight and undertake the treatment and correction of many disorders which are manifestly entirely medical. One can hardly over-estimate the number of mild psychoses and borderline conditions that sorely need medical study and management to say nothing of the psychoses proper and the psychoneuroses. You know only too well how indifferent physicians are about them, and when the matter of defect comes up with delinquency and conduct disorders which are anti-social or even criminal there are few who can apply or suggest anything better than the most archaic medical or legal treatment. Mental disorders and conduct disorders in general are so numerous that their cost to the taxpayers is enormous. The second largest single item of expense our state has is the care of the insane, and if you add to this the amount of police, court and prison cost connected with juvenile delinquency and criminality, it would dumfound you. Materially increasing this is the cost of the backward and retarded if not defective school child who clogs the educational machine and who through ill advised and poor treatment also becomes an unnecessary burden and an extra cost to the community.

A normal body will function normally and show normal behavior or mind in any normal situation in life. Any departure from such conduct or evidence of mind is due to temporary or permanent disorder of function of the body as a whole. This again may be the remote effect of some originally more circumscribed disorder or defect. The reason for the lack of intelligent and scientific medical treatment of these conditions lies in the obvious fact that no course in physiology includes more than the careful study of separate organ and tissue functions, and ignores entirely the conduct of the body as a whole, as an organism. Moreover, neither genetic psychology or behaviorism are included in the preparation for courses in neuropsychiatry or psychiatry.

It must be admitted that this new science of behavioristic psychology is hardly well enough developed at the present time to become a

tended to magnify its importance in such a way that medical education and the practice of medicine have become so scientific and so specialized that interest in the individual patient is almost become negligible. Together these developments have determined unfortunate situations affecting the schools, the graduates and the public. Schools of medicine have been classified and standardized on a basis of numbers of square feet of floor space devoted to laboratory work and the amount of original research work done in a given space of time. Naturally the student becomes more and more impressed with the importance of the laboratory in not only making diagnoses, but in the scientific treatment of disease. It is small wonder then that he refuses to practice in smaller towns and rural communities, and remains where laboratories are handy and his diagnosis can be confirmed or made for him before he undertakes treatment.

Discoveries in science in any department quickly become public property and the people demand that they receive the benefit of them especially when health and life are at stake. In the interest of the thus neglected extra-urban sick the state offers to supply these facilities for the physician who will practice among them and the way is opened for state medicine and state control of physicians. Magnification of the scientific side of medicine does another thing which is deplorable in that it determines specialism in practice, because the conscientious student will soon decide that he can not master all of so complex and scientific a subject and will therefore elect to devote himself to a smaller field in which he may become as proficient as he chooses and not only take a higher position among his colleagues, but be free from the danger of malpractice suits.

The very worst consequence of this materialistic trend in medical education is a direct result of centering interest on localized organic tissue change as a necessary cause of disease manifestations and serious modification of function of organs. It is this which has made the autopsy and the specimen so much more important and interesting than a recovery, and it is this which has made us lose sight of the all important fact that the human being is an organism and must be studied and treated as such. Failure here is the secret of the appeal which the cults make to so many otherwise intelligent people who are unwilling to believe that they are mere machines with interchangeable parts.

The earliest protest to this conception of life was made a long time ago when man assumed that he was created in the image of God. However egotistic this conception may be, it

nevertheless gave proof of the fact that man early observed that he was "fearfully and wonderfully made," that he is not a mere automaton and that he has unique faculties and possibilities which are not entirely subject to the laws of matter. There has come a recrudescence of this feeling in our day which is alienating the faith of thinking people in medicine as it is practiced today. All the great and wonderful achievements of preventive medicine and other notable scientific discoveries in the nature of disease processes are accepted and properly evaluated, but in spite of all this there is a manifest tendency toward a feeling that something is lacking. The intimate individual human needs in illness and other troubles are not met satisfactorily and as a natural result we observe with much concern a leaning towards the cults who have something to offer other than scientific clinical study, strict regimen and medicine. We need not try to persuade ourselves that they have much to offer, least of all should we ignore them in the hope that their influence will soon pass and do no harm. Investigation will show that they are supplying a demand which they carefully but empirically meet and develop while we ignore it because it does not interest us. What are we going to do about it?

The most powerful determiners of human activity are the instincts and the emotions—hereditary and unlearned reactions—which no laboratory can as yet measure, whose influence, for example, on metabolism through the endocrine system is only beginning to be appreciated and whose relation to human conduct in health and in disease offers an interesting and profitable field of investigation. The practitioner in medicine whose chief object is to maintain and restore health should be well grounded in the principles of human action and experience. This he can obtain through psychology, which is the science of behavior and experience. It is safe to say that the average physician is as ignorant of the body activities through which human experience gains expression, in other words, of mind, as were the physicians of a thousand or more years ago, of the structure and functions of the organs of the body and life processes in general.

The history of the development of medicine shows that there was a constant desire to understand human behavior. In the quest for a scientific basis for the practice of the art of medicine it first became necessary to know the structure of the body and gross anatomy was developed. This was followed by histology, cytology, embryology and, finally, by pathological anatomy. With the growth of

tions, local infection and internal secretions, could never have discovered"

Psycho-therapy is a re-education and much of the difficulty or ease of treatment depends largely on the individuality of the patient, especially his intelligence more than upon anything else. For this reason we should always consider the individual and his environment to that extreme degree recognized by the competent internist.

The treatment should in the first place be directed toward the nature of the disorder, and, secondly, on the personal equation, the individuality of the patient. As in all other therapeutic measures, we should consider the patient as an individual and his environment. This includes a careful history and most thorough physical and neurological examination. During the history taking, the all-important relation between physician and patient is established and care should be had at all times to establish that confidence which is necessary. If this confidence is built up from the beginning of the re-educational process, by the physician demonstrating his honesty of purpose and truthfulness, much will be gained. The patient should be told the truth always, and at the onset, should be advised that the symptoms present are those of a disease complex, an exaggeration and not imaginary or unnecessary and selfish indulgences. The truth is otherwise and the patient should be made to feel at the earliest possible moment that his difficulty is not imaginary.

Treatment is re-educational, a readjustment, mental, physical and moral as to the needs of life and an insight through which there may not be a recurrence.

Where possible, the environment should be changed and the patient's life should be systemized and made as regular as possible, giving as many new "contacts" as can be used. These latter can be increased as time goes on. Readjustment to full usefulness must be made the primary goal, not mere immediate comfort. Whether the headache of resentful disappointment, or the indigestion of anger, or the palpitation of fear, the situation should be treated by always leading the patient to a consideration of the condition at fault as more important than the symptoms. In this way,

symptoms may be made the most helpful object lessons, illustrating and clinching the more theoretical re-education.

He should be given that definite knowledge of his condition which we call "insight," and through which he may avoid a recurrence and when necessary, be removed temporarily from his ordinary home environment to one which is as free as possible from distractions, but at the same time gives opportunities for normal and not invalid life. His life should be as regular as possible, so that he gets not only the advantage of good habits, but gets some helpful discipline in doing things, because they are to be done, and not because he does or does not feel like doing them. A regime is of the greatest help in divorcing action from feeling, and work, play and rest should be properly divided and arranged. Rest induced if necessary, is a factor always to be carefully considered, as is work and play, and each properly measured for the individual. Diet is important, for we find many of these patients who are under or over-fed. Hydrotherapy is helpful, as are carefully graduated exercises.

That confidence gained at the first interview is all important and any antagonism generated should first be broken down, and his confidence, hope and determination to get well encouraged at all times. His readjustment to his environment by advice and encouragement, and a knowledge of his own so-called normal limitations. At all times no bizarre or ultra-scientific explanations should be given, but plain, lucid instructions, remembering at all times our object—to give useful applicable knowledge to the patient from which he shall derive full power of normal adaptation. We should at all times remember the role played by the simple organic functions and any disturbance adjusted by medical means if necessary. Remembering the part played by the endocrine system, whether cause or effect, our attention should be directed toward the correction of any possible imbalance. In short, our object is a physical as well as mental readjustment. In this connection may I stress the necessity and importance of mental hygiene, and ask your support of the work being carried on by the National and State Committees on Mental Hygiene.

distinct subject in the curriculum of a medical course, but it must also be granted that it has very important medical relations which make it imperative to acquaint the student with them. In the school which I serve we are now giving in the second year a 30-hour didactic course in what for lack of a better name we call medical psychology and which is intended to prepare the student for the fourth year course in psychiatry. But the subject has a much broader application and deserves elaboration. The present needs could be well met by including psychology in the premedical

course and extending it later in the course on physiology as psychobiology, which in turn could be correlated with neurology, psychopathology and psychiatry. In this way the graduate in medicine would not only be prepared to care properly for the mass of patients who now are allowed to flounder about among the cults, but also to be of material help in the social disorders of the community which he serves. Finally, it would hasten the day when there will be developed a science of mental hygiene which will become the last word in preventive medicine.

## PSYCHO THERAPY \*

By G. KIRBY COLLIER, M.D., F.A.C.S.

ROCHESTER, N. Y.

**S**INCE the dawn of medicine, psycho-therapy has been used by the medical practitioner, but only of late years has this been placed upon any semblance of a scientific basis. Although using psycho-therapeutic methods unconsciously, many have scoffed at its usage, and it has, in a measure, fallen into the hands of the charlatan and quack who has used it unintelligently, many times with very favorable results and more often with severe harm to the patient. As a result of this, much of the literature upon this subject has fallen into lay hands, and in those unprepared for such, has given rise to many faulty conceptions of abnormal psychology.

Much of the popular literature has dwelt upon the sex feature, limiting this aspect to that narrow sphere, understood by the layman, and not to the broad sex idea which is inclusive of most or all of that which goes into the formation of life. Unfortunately this sex idea is also prevalent among many physicians and due to their repugnance of this feature, they have held aloof and criticized any of the various methods of approach.

That we might have a proper conception of our patient and to be able to treat him intelligently, it is necessary that we have some understanding of normal psychology and its pathology. We must be able to recognize the fact that there is a pathology, psychic as well as somatic, and that we are liable to psychic injuries, to the same degree as physical, when our defenses are lowered. We must recognize that many of our concepts are faulty and that many of these are never righted, that our so-called self-analytic mechanism is not always

100 per cent perfect and that it is not always retroactive. We must recognize that all adults meet the psychological crisis in life, the larger number reacting normally, a few breaking down mentally. All at some time suffer grief, emotional stress, illness, infection and varying mental conflicts, and a few react with symptoms of a psychosis of varying degrees. Many have alcoholic infection, but only a few develop paresis. Alcohol was formerly a common beverage, used excessively by many but only a few reacted by showing mental symptoms commonly associated with alcohol, and so it is with all the many incidents and accidents of life that befall the individual. From the modern psychiatric standpoint, as well as that of the internist, each patient becomes a distinctly individual unit, differing from all others in hereditary characteristics, physical and psychological development, environmental influences and mental trends with a personality that reacts independently to disease, mental conflicts and all the assorted experiences of life in its various stages. As has been so aptly expressed by Dr. Adolf Meyer, in advising of the approach to the study of a mental case: "After studying in each patient all the non-mental disorders, such as infections, intoxications, and the like, we can now attack the problems of life which can be understood only in terms of plain and intelligible human relations and activities, and thus we have learned to meet on concrete ground the real essence of mind and soul, the plain and intelligible human activities and relations to self and others. There are in the life records of our patients certain ever-returning evidences and situations which a psychiatry of exclusive brain speculation, auto-intoxica-

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester, N. Y., April 23, 1924.



tions, local infection and internal secretions, could never have discovered"

Psycho-therapy is a re-education and much of the difficulty or ease of treatment depends largely on the individuality of the patient, especially his intelligence more than upon anything else. For this reason we should always consider the individual and his environment to that extreme degree recognized by the competent internist.

The treatment should in the first place be directed toward the nature of the disorder, and, secondly, on the personal equation, the individuality of the patient. As in all other therapeutic measures, we should consider the patient as an individual and his environment. This includes a careful history and most thorough physical and neurological examination. During the history taking, the all-important relation between physician and patient is established and care should be had at all times to establish that confidence which is necessary. If this confidence is built up from the beginning of the re-educational process, by the physician demonstrating his honesty of purpose and truthfulness, much will be gained. The patient should be told the truth always, and at the onset, should be advised that the symptoms present are those of a disease complex, an exaggeration and not imaginary or unnecessary and selfish indulgences. The truth is otherwise and the patient should be made to feel at the earliest possible moment that his difficulty is not imaginary.

Treatment is re-educational, a readjustment, mental, physical and moral as to the needs of life and an insight through which there may not be a recurrence.

Where possible, the environment should be changed and the patient's life should be systemized and made as regular as possible, giving as many new "contacts" as can be used. These latter can be increased as time goes on. Readjustment to full usefulness must be made the primary goal, not mere immediate comfort. Whether the headache of resentful disappointment, or the indigestion of anger, or the palpitation of fear, the situation should be treated by always leading the patient to a consideration of the condition at fault as more important than the symptoms. In this way,

symptoms may be made the most helpful object lessons, illustrating and clinching the more theoretical re-education.

He should be given that definite knowledge of his condition which we call "insight," and through which he may avoid a recurrence and when necessary, be removed temporarily from his ordinary home environment to one which is as free as possible from distractions, but at the same time gives opportunities for normal and not invalid life. His life should be as regular as possible, so that he gets not only the advantage of good habits, but gets some helpful discipline in doing things, because they are to be done, and not because he does or does not feel like doing them. A regime is of the greatest help in divorcing action from feeling, and work, play and rest should be properly divided and arranged. Rest induced if necessary, is a factor always to be carefully considered, as is work and play, and each properly measured for the individual. Diet is important, for we find many of these patients who are under or over-fed. Hydrotherapy is helpful, as are carefully graduated exercises.

That confidence gained at the first interview is all important and any antagonism generated should first be broken down, and his confidence, hope and determination to get well encouraged at all times. His readjustment to his environment by advice and encouragement, and a knowledge of his own so-called normal limitations. At all times no bizarre or ultra-scientific explanations should be given, but plain, lucid instructions, remembering at all times our object—to give useful applicable knowledge to the patient from which he shall derive full power of normal adaptation. We should at all times remember the role played by the simple organic functions and any disturbance adjusted by medical means if necessary. Remembering the part played by the endocrine system, whether cause or effect, our attention should be directed toward the correction of any possible imbalance. In short, our object is a physical as well as mental readjustment. In this connection may I stress the necessity and importance of mental hygiene, and ask your support of the work being carried on by the National and State Committees on Mental Hygiene.

## EDUCATING AND PLACING OUT MENTAL DEFECTIVES\*

By O H COBB, M D,

SYRACUSE, N Y

**S**EVENTY-THREE years have passed since New York State, inspired by the success of Eduard Seguin, in France, undertook the education of mental defectives. Seguin, in 1837, at his private school in Paris, and later as Director of the School of Idiots, at the Bicetre, developed his Physiological Method of Education. He demonstrated that sluggish intellectual functions could be aroused by energetic oft-repeated stimuli to the brain through all sensory pathways and by calisthenics to correct deformities and improve the health, posture and movements. Maintaining that the idiot could learn by doing he gave special attention to developing the functions of the hand. He emphasized the importance of attractive, cheerful surroundings, intelligent, kindly teachers and attendants, formation of habits of right living and industry, imitation of teacher and playmates, creation of new interests and desires, and the use of the awakened faculties to express and satisfy them. Seguin's methods with little modification are still used in the institutions for training the lower grades, and form the foundation of all our work with mental defectives.

Our ideas regarding the problem have undergone evolution with the passing years. In the beginning it was considered only as a matter of education. It was hoped that most of the children, even of the lowest grade, taken at an early age, could be so improved as to be self-supporting in a favorable environment. Later came the recognition of insuperable natural limitations of many and the need of custodial care for their protection from a misunderstanding and often hostile world. The early years of this century brought a realization of the gravity of mental deficiency as a social problem. In 1909 the French psychologists, Binet and Simon, published their tests for intelligence, which were soon adapted to the American child and popularized by Goddard. The widespread application of these tests to inmates of reformatories and penal institutions led to the overemphasis of the peril of mental deficiency to the community and the demand for the permanent segregation of all mental defectives. Of late years the policy has been to accumulate information by establishing contact with all defectives at an early age through mental clinics, aided by the schools and other social agencies, provide special classes where possible,

and parole or colonize the most promising cases from the institution.

State mental clinics under the supervision of the State Commission for Mental Defectives and the State Hospital Commission are now available in nearly all the larger centers throughout the State. By medical treatment, advice to parents, improvement of environment, or placement in special or manual training classes, combined with follow up work by the referring agency, many problem children are adequately cared for. Where environment cannot be adjusted, no special classes are available or delinquent tendencies are developing, the child is committed to an institution. Idiots and many imbeciles require permanent custodial care.

State schools for mental defectives are located at Syracuse, Newark, Rome, Thiells (near Haverstraw), and Napanoch. Syracuse accepts only morons of school age, Newark, women of child-bearing age, Napanoch, male delinquents over sixteen, Letchworth Village and Rome, all types. A department of the Bedford Reformatory for Women is devoted to female delinquents over sixteen. New York City maintains at Randalls Island an institution for 2,000. It is estimated that 10,000 beds are needed in the State Schools, or 4,000 more than present capacity.

Admission to an institution is upon commitment by the county superintendent of the poor (in some cities by the commissioner of charities) or by a court of record, or children's court, after certification by two qualified physicians (or a physician and psychologist). It is desirable that all cases should be considered and recommended by a mental clinic.

The institution school, adequately equipped, provides light, airy rooms for grade, manual and industrial training, an amusement hall with moving picture and stage equipment, and a gymnasium. The staff of trained teachers should be sufficient for classes not exceeding twenty-five. Not alone the school proper, but the entire institution is planned for the development of good habits and industry, for the training of mental defectives proceeds from reveille to taps. Kitchens, dining-rooms, laundry, store-rooms, sewing-rooms, shops, garden, bakery and colonies all contribute to the cause. An atmosphere of cheerful activity pervades all departments.

On admission the routine includes a thorough physical examination, with treatment where indicated, psychometric tests and

\* Read at the Annual Meeting of the Medical Society of the State of New York, at Rochester N Y April 22, 1924

psychiatric admission note. Later the head teacher examines for school achievements, tests for possibilities in reading, writing, spelling and numbers, and places the child in his class. The history contains all available information regarding the child, including results of staff meeting and periodic routine examinations with special emphasis on personality traits.

Our objective is to train the idiot for self-help, the imbecile for simple tasks under supervision, and the moron for self-support in the community in a favorable environment.

The state syllabus is followed from kindergarten to fifth grade. The younger or duller pupils receive sensory and motor training, according to Seguin's methods. Kindergarten work is modified to suit the special needs and prepare a foundation for manual training. Special attention is given to time telling, the calendar, money and model store, self-expression is encouraged by retelling and dramatization of stories, group plays and more elaborate productions from time to time. Nature Study in all the grades is pursued with interest. The child usually grades according to mental age, though often retarded by mental sluggishness or laziness.

Music stimulates memory and improves speech. All sing in classes, choirs or glee club, a few learn piano and assist in kindergarten, physical training classes and Sunday school. A band and orchestra, playing difficult music at sight, call forth consistent hard work.

In physical training the aim is to improve health, posture and gait by marching, exercises, apparatus work and dances supplemented by indoor and outdoor games, hikes and a summer camp. Drill makes a boy orderly and alert. Boxing, which all boys love, improves moral conditions.

Manual training, which occupies half the school day, offers individual instruction and a wide range of choice in work, pattern and color scheme. It is one of the most effective means of developing a child's brain, stirs ambition and improves many conduct problems. Even destructive low grade children instead of tearing their clothes learn to tear up mattress ticks for carpet rags and unravel burlap bags for weaving. In the girls' manual classes an unlimited variety of hand work is available, and the boys repair shoes and furniture, and make tables, desks, toys, mattresses, brushes, brooms, toweling and mats. The older girls take a more serious part in the work of the institution. The boys are assigned as apprentices to the mechanics or baker, or learn farming at one of the colonies.

The first essential in our work is a cheerful, receptive attitude on the part of the children.

To this end attention is given to amusement. There are weekly dances and movies, monthly plays by the children in costume, and a spring festival with folk and æsthetic dances. The holidays are suitably observed, and Christmas and Fourth of July celebrated with pomp and circumstance. Hundreds of children attend the circus and county and state fairs. So far as possible discipline is maintained by rewards rather than punishments. For a month's good conduct and work a child receives a star button that means a special treat, such as a trip to the down-town movies or a picnic. A boys' court with full array of legal talent and the appearance of authority, but closely supervised, deals with the cut-ups. An offender may be sentenced to menial tasks for a week, but suspended and commuted sentences are the rule. Good conduct leads to appointment as an officer in the boys' battalion with membership in the officers' club, a separate table and other privileges. Regular religious instruction is given.

For successful work mental defectives must be treated as individuals not as a class. They have in common limited intelligence, but differ markedly in personality. A child may be obstinate, stubborn, resentful of correction, uncleanly, not able to concentrate on anything, lazy, emotionally unstable, given to sex tendencies or irregularities, generally opposed to institution rules and customs, or subject to periodic episodes. Temperament may be influenced by epileptic or schizophrenic tendencies. These qualities singly or in combinations interfere with progress and parole. Criminal or sex experience before admission is a detriment. The good qualities of these children, too numerous to mention, endear them to their teachers.

In considering a child for parole intellectual capacity is of less importance than personality. In general, under present industrial conditions, a moron without marked personality defect is considered capable of self support in a favorable environment.

There are two methods of social rehabilitation: colonization and parole. Colonies afford an intermediate step between closely supervised institution life and the comparative freedom of parole. In colonies, girls either work by the day in homes or with their supervisor in a near-by mill. Boys are employed on neighboring farms or elsewhere, while preparing for parole. In girls' colonies and in boys', where outside work rather than training is emphasized, a definite weekly amount is given for spending money and bank account, the balance of earnings going into the colony maintenance fund.

Parole is either to a home found by the

social worker or where conditions are favorable to the child's own family. In inferior families there is a tendency to conduct misdeeds and marriage of girls. Our experience has been that few boys marry. The social worker places girls at \$2 to \$10 per week in homes where they receive careful supervision and ample opportunities for safe recreation. Most boys are located on farms at wages varying with the season and their ability. Monthly conduct and financial reports are required, occasional visits made, and a monthly paper or mimeographed letter sent to all. Visits to the school and special entertainments serve to maintain cordial relations. All paroles are required to open savings bank accounts and may withdraw for any legitimate

purpose, not otherwise. Many have a balance of several hundred dollars. The term of parole is indefinite, that is, until a child is permanently provided for.

Colonization is largely a New York State development. Direct parole is in use in institutions throughout the country. Under favorable conditions colonization and parole may safely provide for at least a quarter of the institution population. The arguments in favor of parole and colonization are that they provide accommodation for hundreds who otherwise would receive no care, lessen the heavy burden upon the State for construction and maintenance, and afford social rehabilitation to many under the most favorable conditions.

## RELIEF MEASURES DURING LABOR.\*

By H W SCHOENECK, M D,

SYRACUSE, N Y

**T**HERE is no more commendable effort put forth by the obstetrician to-day than that which aims to ease the suffering of child-birth—unless it is the conservation of human life.

To accomplish these results to a far greater extent than ever before, realized, is no small task. But to incorporate in this endeavor, a desire to secure to these lives saved a bodily fitness ample to function to its best advantage, places upon the obstetrician a responsibility which is ponderous indeed.

Progressive obstetrics cannot countenance ease of delivery, however humane it may be, if it places either human life or bodily fitness in jeopardy.

The public, it is true, is clamoring for anything which makes for a painless birth. It stipulates, however, that the procedure must be without danger to mother and babe.

The press and popular magazines, within the past few years, have given much space to so-called painless child-birth.

Their exposition is made colorful and attractive, the disadvantages and dangers made to appear infinitesimal and not worthy of consideration. During the same period of time, medical literature has been copiously supplied with contributions on the subject of making labor easy and less painful. To the medical man, painless child-birth through the birth canal is something to be hoped for, but as yet unattainable.

The painless child-birth of the lay press has had its day, it has taken its toll—and the public,

pretty generally, is satisfied that it entertained a fancy, not a reality.

Will the claims made by the advocates of prophylactic version—prophylactic forceps—modified twilight sleep, as to safety and nearness of approach to a painless birth, stand the test of time and unbiased examination?

It is not fair to the men who employ these various methods to accuse them of bad faith, even though some of these measures in part or as a whole, throw into the discard some of our most cherished and long established rules of procedure for the care of the woman in labor—they may be in the right—if so, the failure to reduce the maternal and infant mortality and morbidity must be laid at the door of conservatism—if wrong, the burden of labors end results is upon them.

The results obtained by many operators, from experience with all three methods, should help to clear away the uncertainty which overshadows the question of their safety and effectiveness.

It would seem that the merits of any one of these over the other, when compared with spontaneous labor, should be reflected by a comparative analysis of their maternal morbidity, fetal and maternal mortality—incidence of lacerations and anatomical end results.

Such an analysis is made and presented for your consideration.

The records of 435 consecutive births in the hospital are used for this purpose. They were private patients, the majority had been seen early in pregnancy and had received prenatal super-

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester N Y April 23, 1924

vision, the others were patients referred because of some unusual condition complicating pregnancy or labor

#### MORBIDITY

36 versions were performed, 30 in multipara, 6 in primipara

The technic of Potter with which you are familiar, was followed

The result sought in 16 multipara was solely to avoid the second stage of labor

There was no disproportion in any of these cases—heads were well engaged and delivery would have eventually terminated spontaneously

These 16 cases included

3 flat pelvises with moderate degree of contraction

The second baby in five twin births

5 R O P—3 L O A

Of the remaining versions in multipara, 14 in number, the indications were as follows

1—To correct a presentation impossible of delivery

1 chin posterior—1 shoulder presentation

2—To avoid dissipation of the vital strength of mother or child

2 cases of heart disease—1 thyroid—2 eclamptics—1 pre-eclamptic—1 accidental hemorrhage—1 placenta previa—1 cord presentation

There were also

3 cases in which head failed to engage because of a pendulous abdomen

Version in primipara numbered 6

1 transverse—2 marginal placenta previas—1 eclamptic—1 second baby in a twin pregnancy—1 occiput posterior which rotated into the hollow of the sacrum

Bag insertion preceded version in the first four cases

Most men will concede the justification for version in labors complicated by an abruptio placenta—placenta previa—presentation of cord or its prolapsus—pendulous abdomen not due to an insuperable disproportion

For in these cases version offers the safest method of delivery as well as the least painful

The justification for version in the cases complicated by diseases of heart—thyroid—pre-eclamptic or eclamptic toxemia and the 16 cases mentioned before is subject, it would seem, to the determination of its relative safety compared with other methods of procedure

It will be noted that version was not done in primipara as often as in multipara. In explanation of this it is necessary to remark that my experience with breech extraction in primipara has impressed me with the difficulty frequently met with in resuscitating babes born in this way. This was attributed to the prolonged interference

with the fetal circulation, resulting from an endeavor to accomplish a slow expulsion through a pelvis, the soft parts of which were not easily relaxed

The futility of overcoming this bad feature by rapid extraction manifested itself early, for this alternative is prone to result in the development of extended arms—nuchal hitch and deep laceration of the perineum, complications which increase rather than decrease risks

Preliminary ironing out of the perineum, a procedure which is supposed to eradicate the danger of an inelastic pelvic floor, did not seem to wholly overcome it

This reluctance to do version in primipara was furthered, in that the dangers to the babe were out of proportion to the relief obtained by the mother—as version is only a second stage procedure and little relief is afforded her in the first stage

I was not adversely influenced by the fear of tears, for I believed in a properly performed version these would be no greater than in a spontaneous delivery

It was in multipara that I believed version afforded a safe labor as well as the easiest labor possible

For in multipara we find the soft tissues offering little resistance and if the necessity arises, a rapid extraction can be done

Then too, the relief obtained by the mother in version in some multipara is far superior to that offered by the general anesthetic. Scopolamine and morphine administration is contra-indicated in the great majority of multipara because of the rapidity of labor

The fear of infection I never could quite be rid of, despite favorable statistics, so that a meticulous technic was scrupulously adhered to

Despite these precautions, the morbidity rate for multiparous version was 18 per cent—a rise in temperature of 100 or more on 2 days between the 2—14 was considered morbid

Two well-defined cases of puerperal endometritis developed—convalescence was very much retarded. The reason for temperature in the other cases could not be determined

The morbidity of the six primiparous versions was 80 per cent—this tremendously high figure is explained by the use of bags and other manipulations antecedent to version in these complicated cases

The 18 per cent morbidity is relatively high when compared with the rate for spontaneous deliveries in primipara which was 5 per cent and in multipara 37 per cent. This latter figure included a phlebitis in a bag case, and 2 cases in which a rise of temperature of 100 occurred for 3 days without clinical evidence of infection. These 2 cases had been packed for post-partum hemorrhage

Excluding these three complicated cases, the

morbidity of spontaneous delivery is slightly over 1 per cent

Low forceps or prophylactic forceps deliveries gave in multipara 4.8 per cent—in primipara 9 per cent

In breech deliveries in multipara the morbidity was nil

The morbidity of prophylactic version in multipara was exceeded only by the rate for breech deliveries in primipara which was 25 per cent and high forceps in primipara of 33.1-3 per cent

The reason for the high rate in forceps other than low in primipara is similar to that expressed in explanation of the 80 per cent morbidity in version in primipara (i.e., factors other than the procedure itself entered into the production of fever)

There were 8 dry labors—cervix was manually dilated five times—bags were inserted in two eclampsics and three pre-eclampsics

The rate of 25 per cent for breech deliveries in primipara finds its expression perhaps in the frequency with which both feet were brought down and extraction begun as soon as the cervix was completely dilated—a procedure necessitating invasion of the uterine cavity

The question of whether low forceps in themselves are a frequent source of morbidity is answered by these figures

In 64 low forceps (27 primipara—37 multipara) without cervical or perineal tears only two showed a morbidity—approximately 3 per cent

It is remarkable here, that of the four well-defined cases of puerperal infection in the whole series, two occurred in uncomplicated version—one in a bag insertion and one in a cesarean section

The explanation for the high morbidity of prophylactic version, inasmuch as no tears of cervix or perineum occurred, undoubtedly lies in the transference of pathogenic organisms from the vulva and vagina into the uterus

The raw surface created here by the separation of the membranes preparatory to the rupture of the amniotic sac affords a nidus for the growth and noxious activities of germ life

#### LACERATIONS

The frequency with which lacerations occurred in these various procedures observed, was as follows

In multipara cervical lacerations were equally rare in version—low forceps and normal deliveries

Secondary repairs held well, as did primary trachelorrhaphies. Only once did a tear occur in the latter type of operation. The laceration in a subsequent delivery instead of tearing along the line of suture showed a central tear in the posterior lip

Perineal lacerations were more frequent.

Breech deliveries gave no tears—version 3.1 per cent—spontaneous deliveries 9 per cent—forceps 20 per cent

Secondary perineorrhaphies, primary repairs of second degree lacerations and deep episiotomies invariably tore along the line of scar

Efforts used to prevent cervical and perineal tears in primipara and multipara were as follows

Pituitrin was not used unless complete dilation of cervix had occurred and then very seldom. Efforts to test dilatability of external os by separating fingers was avoided in primipara as well as in multipara, as this is a pernicious habit and results in a slight tear which extends usually, as labor progresses

In spontaneous deliveries the anesthetic was pushed to the surgical degree only when the brow could be reached through the perineum and recession of the head prevented—further extension of head was under control from then on—patient being deeply under and unable to call in to play forceful contractions of abdominal muscles. In version and forceps deliveries ironing out of perineum was practiced

The superiority of prophylactic version and breech extraction in preserving the tissues of the pelvic floor as shown by these figures, is dependent upon the gradual dilation of soft parts, by an unhurried expulsion of the fetal body with its smallest diameter first, reaching the largest by graduation

Version and breech extraction should, in primipara, for reasons above given, show a smaller percentage of lacerations than normal or forceps delivery

The records do not show this to have occurred

Version had 100 per cent of perineal tears—cervical tears occurred in 80 per cent

These are, however, not suitable cases for purposes of comparison as they were, in many instances, complicated by bag insertion

The Breech deliveries have not this drawback however, and since extraction here in most cases is similar to what occurs in extraction after version, these may stand for version and may be used for comparison with normal and forceps deliveries

In 62 spontaneous deliveries in primipara 48 per cent perineal tears and 44 per cent cervical tears were found

In 127 low forceps perineal tears were 64 per cent—cervical 42 per cent

In breech extraction 64 per cent perineal tears—cervix lacerated in 90 per cent

The striking part here is that spontaneous labor with respect to tears has the advantage over the other two procedures with version and extraction placed third

Inasmuch as tears of the soft parts are prone to increase morbidity, the full importance of the above comparison is obvious

The effect of lacerations on morbidity is shown by the following figures

In spontaneous labors in multipara with 9% tears, the morbidity was 17—In primipara the percentage of morbidity jumps to 5%, as the percentage of tears reach 48.5% in perineum—45% cervical

This would seem to indicate that tears, even though taken care of immediately after labor showing no breakdown subsequently in themselves increases morbidity

This question naturally arises, is not morbidity more frequent in cervical repairs than where cervix is left unrepaired? The figures obtained show unrepaired cervixes to give 12%—repaired 17%

#### THE ANATOMIC END RESULTS

The anatomic end results of all primipara numbering 230 cases delivered spontaneously, by forceps, or version was much better than expected

Forceps and version in twins accounted for a bilateral laceration of cervix, retroversion and moderate degree of prolapse

In three high forceps—one resulted in a relaxed vagina and cystocele, the second a cervical tear, prolapse, retroversion—the third, prolapsus and retroversion

Two normal cases of spontaneous labor without tears presented in one—vaginal relaxation and prolapse—in the other, prolapse, bilateral cervical tear

Twenty-eight lacerated cervixes were found—three trachelorrhaphies failed to heal out of 57

Twenty-five lacerations were left unrepaired purposely to determine whether or not they would heal spontaneously, and this was found not to occur

The final results as to integrity of birth canal depends, it would seem, not on whether spontaneous delivery occurred or whether forceps were applied or version done, but upon these factors

1 The avoidance of pituitrin or operative measures to deliver child with cervix not fully dilated This not only tears cervix but stretches and lacerates the connective tissue supports of uterus and bladder

2 Failure to employ episiotomy in those cases where undue stretching of soft parts or tears of same is imminent

3 Failure to pull down cervix into view in all cases and to repair if lacerated

4 The failure to appreciate the frequency with which lacerations are overlooked if examination is superficial For cervix tear without much blood loss and many pelvic floors are badly torn without tearing of the skin

#### FETAL MORTALITY

Twenty fetal deaths occurred in the 435 cases—a mortality of 4.5 per cent of this number

Seven were intra-uterine deaths—two from neglected prolapse cord—one a complete separation of a normally situated placenta at eight months—one fibroid completely obstructing the birth canal (seen for the first time after two days in labor—one true knot in the cord—one death, cause unknown—one death at five months, spontaneous delivery at the sixth month

There were five non-viable fetuses

One Placenta membranacea—one pre-eclamptic—one ablatio placenta—one toxic goitre—one marginal placenta

Pregnancy was interrupted in these five cases in the interest of the mother

Nine viable fetuses included

One fetus born of an eclamptic mother—died seven hours after a spontaneous birth

One medium forceps—mother had convulsions during extraction.

One spontaneous birth—mother died of influenza-pneumonia

Three still-born deaths followed high forceps

One still-born breech extraction in contracted pelvis

One hemorrhage of new-born—three days post-partum

One prophylactic version in multipara

If the seven intra-uterine deaths and five deaths in non-viable fetuses may be subtracted, the mortality would be 1.8 per cent

It is worthy of note that there were no deaths in uncomplicated spontaneous or low forceps deliveries

One death occurred in a prophylactic version in a multipara

The 100 per cent perfect results in spontaneous deliveries is attributed to the application of low forceps, and the use of episiotomy in many instances to hurry delivery when head was on the perineum and progress was at a stand-still

Then, too such procedures as induction of labor—cesarian section and version, saved many babes who would have been lost if birth had been left to natural forces

The death from prophylactic version could have been avoided by prophylactic forceps or spontaneous delivery

The same may be said for two deaths which occurred in a series of 24 versions not included in this report

All were ideal cases for version—a multiparous birth canal—head engageable—therefore no disproportion—yet complications resulted and three lives were lost

The first death occurred under these circumstances, a large baby—when version was completed, the cord prolapsed—no pulsation—no effort on part of patient to deliver baby was successful—traction was made—some difficulty with after-coming head—still-birth

Second case showed cord tightly stripped between thighs, the approximation of gluteal folds interfered with its detection in utero—the cord was cut when at vulva, babe inspired several times, patient was exhorted to bear down but the depth of anesthesia was such that no assistance from was forth-coming. Traction was made with pressure on fundus, a nuchal hitch and extraction of the other arm resulted

The time necessary to overcome this complication was evidently sufficient to cause death of babe

In the third case, a large baby—no progress from half-hearted efforts of the mother—traction equally inefficient—pressure made on fundus at time umbilicus was in sight—extraction of arms and fetal head resulted, efforts to correct complications exceeded time limit—fracture of clavicle and still-birth resulted

#### MATERNAL MORTALITY

The maternal mortality was 68 per cent

One patient died during the puerperium of broncho-pneumonia following a cesarian section. One of influenza-pneumonia at the time of delivery. One following cesarian section for liver type of toxemia

#### SUMMARY

It is evident in summarizing these findings, that

Normal labor unattended by unmistakable signs of maternal exhaustion or interference with fetal circulation, if allowed to progress to completion of second stage, is the least hazardous of the measures under consideration

The Maternal morbidity is less than prophylactic forceps or version. Lacerations of birth canal are lessened in incidence and degree. The maternal and fetal mortality is nil

It must be emphasized that this favorable outcome in spontaneous labors is only possible when the failures incident to a delivery left to nature are understood and overcome by preventive measures

To mention only a few of these preventive measures

- 1 Rigid asepsis both ante and post-partum
- 2 Regulation of expulsive efforts in precipitate labors to guard against deep laceration of birth canal
- 3 Protection of perineum and vaginal outlet by deep anesthesia and ritgens maneuver when head is emerging

4 An occasional episiotomy to guard against undue injury and permanent loss of integrity of pelvic supporting tissues

5 Repair of all lacerations, cervical and perineal, immediately after labor

Nature must be assisted here in these cases most favorable for her as well as under circumstances when her powers are unquestionably impotent

The procedure standing second to spontaneous labor is prophylactic forceps or low forceps

It takes this position because of its absence of fetal mortality and its low maternal morbidity

The procedure which gave the highest fetal mortality and maternal morbidity was prophylactic version

#### DISCUSSION

Does this depreciation of routine prophylactic version and forceps necessarily consign the woman in normal labor to an ordeal of suffering and a subsequent abnormal convalescence—I do not believe it does

For the administration of anesthetics, at the time of uterine contractions, early in the second stage of labor, gives much relief

The anesthetic of choice is gas oxygen

Its administration is more agreeable to the patient as is also its after effects

Nausea and vomiting is extremely rare

It is superior to chloroform, ether or anesthol, in that analgesia is obtained with greater rapidity and without interference with the force of uterine contractions

Therefore a greater degree of relief is obtained with less risk of prolonging labor or interfering with nature's method of avoiding post-partum hemorrhage

Combined with ethylene or ether when head is emerging, it curbs undue expulsive force

The one striking disadvantage in this method is the necessity for having, for hours at a time, an anesthetist of experience in attendance

This is prohibitive for financial reasons to the great mass of the public

Self-administration, a make-shift tried early in practice, was not without its failures and complications and the same may be said of the practice of allowing the inexperienced interne or doctor to give this type of anesthesia

Given, however, by an expert, the results are ideal in that while labor is not shortened nor made as free from pain as in the other two procedures, the relief is enough to make labor more comfortable and convalescence more rapid than where the anesthetic is only used at a time when the caput is in sight

In some multipara even before complete dilation of cervix has taken place, if membranes are ruptured, labor is completed with such rapidity under anesthesia that in order to avoid delivering



in bed, this procedure is done only in the labor room

Surely there is no call for prophylactic version or forceps here

We hear much of the suffering attendant upon posterior positions. In multipara, in the great majority of instances, rotation is not retarded.

Occasionally delivery is prolonged by slow rotation or the occiput rotates into the hollow of the sacrum.

In the former case analgesia during contractions and a bit of patience is necessary, in the latter event version or manual correction and forceps is indicated.

Interference in all cases in multipara either to prevent abnormal rotation or prolongation of labor with consequent suffering is unwarranted as well as dangerous.

Thirty-four per cent of the cases in this report were occiput posterior positions—94 per cent of them rotated spontaneously—six needed manual correction and forceps.

Why subject 100 individuals to operative measures for the sake of avoiding abnormal rotation which is likely to occur but six times out of a hundred.

The relief of the primipara is not so easy of attainment with anesthetics, as with version or scopolamine and morphine administration followed by forceps.

Scopolamine and morphine administration in the first stage of labor with morphine  $\frac{1}{4}$  gr and scop 1-150 as an initial dose in primipara, is far superior to all other procedures in the relief it gives, not only during this stage, but in the second stage also. As the head is emerging it must be supplemented by other anesthetics.

The advantages of scopolamine and morphine used as a first stage procedure other than its safety and marked relief is the gentleness and rapidity with which the cervical tissues are thinned out and complete dilation effected.

It curbs also the forceful expulsive efforts of patient where head is on the perineum making unnecessary the early perineotomy practised as a preventive measure against stretching—distraction and laceration of pelvic soft parts.

Its disadvantages are these:

1. Asphyxia or obligopnea in the new-born occurs in about 15 per cent of cases—it is not troublesome however, and babes respond readily to oxygen and intermittent compression of the chest wall.

2. The attendance of the obstetrician is necessary from the start of the administration to the birth of the child—if the maximum effectiveness of its use is desired.

3. Repeated dosage cannot be given according to rule. This will depend upon rapidity of progress of first stage and the response of patient to drugs.

Very occasionally errors in judgment as to how

long an interval will elapse from the first dosage to delivery occur. This should be at least four hours. Two things will happen, labor is stopped or unduly prolonged or babe is born before the drugs have been eliminated.

In neither instance is any particular harm done—the first is disturbing to one's equanimity—the second sometimes gives an asphyxiated baby which always responds well to treatment and suffers no ill effects afterwards.

One must, in order to avoid these errors, be willing to spend the time necessary to determine by frequent rectal examination, progression in thinning out of cervical tissues—in dilation of external os and in depth of descent and from this determine when morphine and scopolamine should be started and when scopolamine should be repeated if at all.

A fourth disadvantage is prolongation of second stage of labor. This does not occur as a rule if one starts dosage only when labor is well under way and discontinues scopolamine when cervical dilation is completed.

#### CONCLUSIONS

In concluding this paper, I am not unmindful or unappreciative of the personal benefits received from the work of Potter and De Lee. Version and breech extraction, from the teaching of the former, has been simplified and made less productive of untoward results than formerly.

The early perineotomy of De Lee with the application of low forceps in individuals under modified twilight sleep administration undoubtedly saves many fetal lives and avoids maternal birth canal injuries.

But at the same time one cannot, in the light of this analysis of results obtained, subscribe to the routine use of either the one or the other.

Nor can one honestly state that the hazards of these procedures should be treated lightly, for in so doing, men less experienced in matters obstetrical, would feel warranted in employing these measures indiscriminately, to the end that in version a tremendous fetal mortality and maternal morbidity would follow—in forceps and perineotomy, many pelvic floors would be destroyed.

This is certain—for the general practitioner their routine use would spell disaster.

For my own guidance, I am convinced that for these procedures to be effective in reducing the deaths and injuries incident to child-birth there must be:

- First. Discrimination in their application so as to meet the needs of the individual case.

- Second. The procedure must be performed under a rigid aseptic technic in hospital surroundings where conveniences and facilities are such that any emergency which may arise can be met, with promptness and precision.

# NERVOUS AND MENTAL STATES, FOLLOWING INJURIES TO THE HEAD\*

By DAVID EDWARD HOAG, M.D.,

NEW YORK CITY

THE physician is frequently meeting with cases showing what we are pleased to term a psycho-neurotic syndrome. In the experience of the writer, practically all head injury cases have following in their wake either nervous or mental symptoms, in varying degrees of intensity. It generally becomes the lot of those of us specializing in nervous and mental diseases, to manage and treat this very distressing condition, which in many cases extends over a long period of time. To obtain the benefit we hope and desire is many times most baffling indeed. In fact, the slow progress toward recovery that these cases make, and the ultimate gloomy prognosis that we often feel obliged to make, has led the writer to attempt an appeal to the surgeon, he with the first-hand knowledge of the injury, he whose province it becomes to direct and manage the treatment of these patients, in the first few weeks following the initial injury.

Is there anything that the surgeon can do, or may have observed, that may shorten the period of disability, or hasten the convalescence? May the neurologist, if he sees the case early enough, stay or drive away the neurotic or mental picture, that is in most cases so intractable?

The contributions to the literature on this subject consist so largely of varying opinions and theories that our lack of knowledge seems but the more manifest. We know that after many head injuries varying in degree from fracture of the skull to a comparatively light blow, may show a psycho-neurotic syndrome, may develop a definite psychosis, may present a picture of vague indefinite pains, that these patients are slow to respond to any form of treatment, and that this state may persist independent of compensation being a feature or not, and either in the presence or absence of litigation.

Is it the patient's conception of the situation and his attitude of mind toward that situation, that develops the emotion which determines his reaction? Is there a so-called inadequate personality type of individual, whose apperception is faulty, who cannot see things as they are, and who cannot be persuaded to accept them as others see them, nor to view them in the verifying light of experience, wisdom and judgment? Is this picture too strongly drawn, and does it do the victim of head injury an injustice? May there be an

actual pathologic condition? Has an aedema that is more or less permanent been produced? Has there been produced a molecular change, a complete cellular upset, that does not readjust itself? May there have been a motivation created by the sudden advent of accident into the life of the individual, with the uncertain outlook into the future? May not the influence and example of environment have something to do with the situation that develops? May not sometimes the unguarded attitude or statements of well-meaning but misguided friends or relatives, or even it may be of medical attendants or nurses, have a deterrent influence upon recovery?

With this perhaps rather lengthy questionnaire in mind, let us proceed to review just what are the prominent characteristics of the syndrome referred to. First of all in reviewing the literature, it seems to be a fair consensus of opinion that subjective complaints are present in eighty per cent of head injuries; eight per cent show decidedly psychotic symptoms, while only ten per cent show no subjective complaint. The most prominent subjective complaints are headache and vertigo, continuing for a very long time after all evidence of injury has disappeared. These symptoms being accentuated when patients are on elevated structures, or when they are in a stooping position, the headache being described as a band about the head. Less common complaints are tremors, weakness, in somnia, nausea, cardiac palpitation, inability to concentrate and to use memory as before, or to stand the stress and strain of exertion.

Not being able to confirm these subjective complaints by any physical examination, which might indicate an organic lesion leads to controversy among observers. Some of them insist that the individual is a malingerer because there can be found no confirmatory physical signs, while others believe that the headache and dizziness, and therefore inability to resume work, is attributable to the original injury to the head. One has to diagnose between a post-traumatic functional neurosis, and wilful simulation. One of the most comprehensive reports on this subject is by Lewy, who states that from the large material at his command he is of the opinion that simulation in toto is rare, but that exaggeration of existing symptoms is often encountered.

In cases where the headache and vertigo is supplemented by unsteady gait with nausea

\* Read at the Annual Meeting of the Medical Society of the State of New York, at Rochester, N. Y., April 22, 1924.

and vomiting, and a tendency to fall to one side, there is far more definite proof of real injury to brain, cerebellar in character. It is a matter of more or less common observation that syphilitics and alcoholics may have developing after head injury the various typical organic or functional syndromes so commonly following in the wake of over-indulgence in alcohol and syphilis, although the injury to head may have been but slight. It would appear that these symptoms lying dormant, as it were, became precipitated into activity by the injury. Epileptic attacks are oftentimes traceable to a head injury, as is well known, although it may have been months or even years since the injury. It has been thought that the possibility of not being able to recognize the so-called fissure fracture, because of the lack of external evidence, and presenting no immediate disability was responsible for the development of a neurosis. These cases often give no history of unconsciousness at time of injury, but weeks or months afterward the psycho-neurotic syndrome may appear. It would seem that thorough stereoscopic radiographic examination should never be omitted in injuries of the head however slight, even though showing no symptoms whatsoever.

Concussion of the brain, so often a sequel of trauma to the head, and with its customary history of loss of consciousness, of but short duration, virtually becomes a compression, if accompanied by intra-cranial hemorrhage, and would present practically the same need for operative measures as if it were due to depressed bone fragment. The latter condition is usually accompanied by small contracted pupils, slow pulse, restlessness of the patient, and a paralysis of some focal nerve center due to the compression. If the patient survives the injury or the acute manifestations, he may suffer from the same sequellae as in cerebral concussion, and in addition he is exposed to more post-traumatic defects in consequence of the cortical irritation and thickening of the meninges which later may develop into a pachymeningitis, and are accountable for the epileptiform attack, or paralysis which often occurs after these injuries. In a consideration of the definite mental states following head injury, that are genuinely psychotic in character, and may with safety be labeled as such, the complex presented is usually either that of dementia precox, or the manic-depressive type, and but rarely a general paresis. Again this leads to controversy, and one can but venture the hypothesis that individuals having an inherited neurological defect, and who may receive an injury to the head, are at least potential candidates, in which a psychosis may develop, and that the head injury must be re-

garded as a contributing or precipitating factor. Although cases are exceedingly infrequent, I have records of a few showing a definite syndrome of general paresis, and two cases of tabes dorsalis, in which the history of syphilis was negative, together with negative serologic findings in blood and spinal fluid, but who did give a history of trauma to the head. I am fully aware that this is not the orthodox belief relative to the causation of general paresis or tabes dorsalis, nor is it my own belief that these diseases can proceed from any other than a specific cause, but I merely cite these cases as worthy at least of consideration. Lewy summarizes by saying that an injury to skull in a person having suffered from syphilis, or who has been addicted to alcohol in excess, may be the precipitating factor in the development of a psychosis.

Frazier and Ingham, in their splendid work on the traumatic neuroses imply their firm belief as to ultimate recovery from the subjective symptoms of head injury, if judiciously managed. Coming from high authority this is a much more optimistic view than is shared by most of us, I am sure. Dana speculates as to whether there might not be an underworld school for those having had head injuries, and who desire permanent disability compensation. Cushing has reported his physiologic investigations, and I believe outlines a particular surgical technique for all head injuries. Sharpe hints at too frequent surgical intervention as a source of high mortality in head injuries, without due regard to shock or edema. Away back in 1889 it was Oppenheim who first used the term traumatic neurosis, which term is presumed to embrace all of the psycho-neurotic syndromes which follow shock or accident. It was also Oppenheim who asserted with good reasoning that these terms referred to a specific disease with molecular physical changes in the brain. This has not been generally accepted and but few are in harmony with this point of view. As late as 1915, however, he re-affirmed his views that after trauma there is a definite reaction on physiological functioning, which may be either physical or mechanical—either of which may have the same effect on the nervous system. This may occur without hemorrhage, inflammation or degeneration, being merely a displacement of molecules, a tearing apart of associated functioning parts like the removal of a link in a chain. He states that although this condition is not microscopically demonstrable, and does not represent definite alteration of tissue, nevertheless in every case it produces a condition of inhibitions to motor impulses. These observations resulting largely from experiences with the war neuroses, repre-

sent a brilliant though not of necessity a convincing attempt on the part of Oppenheim, to isolate a syndrome peculiar to the traumatic neuroses

Wilson, an aurist of England, ventures on a hypothesis which presents the same line of reasoning. He believes that the symptom picture following physical trauma to the head, including deafness, unsteady equilibrium, with vertigo and a narrowing of the field of vision, is explained that as a result of trauma to the head there is structural discontinuity of the nerves at the synapses—that there is a spread of nerve impulses into adjacent pathways and that in the case of the function of hearing the auditory impulse no longer reaching its goal, deafness results. Such a dissolution may occur at any or all synapses. His method of reasoning although conjectural, may be applied to many of other the symptoms of the traumatic neuroses, such as functional loss of vision, functional paralysis, et cet. Mayer, of Pittsburgh explains the psychoneuroses, starting with the assumption that an acute stoppage of cerebral activity may result after trauma which need not be structural in origin, but is of such a degree that the individual cannot readjust himself to it. This disordered situation brings emotional reactions and its motor responses. If the brain adjusts itself the emotions subside gradually, if not, the attempt to do so increases the emotional reaction—the body vainly tries to secure an adjustment, the glandular secretions work overtime. From this over-stimulation serious damage may result. An ideogenous factor now stepping into play establishes a vicious circle. According to Sherrington, such a draining of energy is probably similar in result to the over-activity of cells which in diaschisis produces a physiologic stoppage of function. This is transient if the cells can replace energetic substances—permanent if they become damaged, or if the synaptic connections cannot become re-established. One may go through the literature ad libitum, and find various converging and again diverging opinions as to the status of the subjective complaints following injury to the head. The question is asked, and very properly, too, as to how much is due to injury and how much to predisposition.

The late Pearce Bailey, in his classic monograph on the war neuroses, implicates motive as an outstanding cause of neurosis, as well as an incentive to cure. In the first instance a neurosis develops, as it were, automatically—the soldier believing that due to this he may receive his discharge. On the other hand, the experience has been that if it is made to appear that he will not be discharged while suffering from a neurosis, a long step at least has been

made toward recovery. It is believed that the great success of the French Army with their cases of neuroses, is due to the fact that the neuroses are not pensionable and that no soldiers are discharged for such causes. It would appear that the real cause of many of the subjective complaints which follow head injury do not depend so much upon extent of the injury or violence, as upon its subjunctive reflection upon the mind of the person injured. There are several factors in this development, one of these being an inherent predisposition easily magnified into motive, for which the individual may have been groping for years. On the other hand, it would seem that there must be at least a fairly definite causative mechanism to account for a symptom picture so universal and uniform. In the few cases that escape the long train of subjective symptoms may there have become established, what we may please to call a psychopathologic defense reaction.

The tremendous industrial and transportation enterprises of the present day will give rise to an ever-increasing number of these cases, demanding proper understanding and classification whether the alleged injury is psychical or physical is for us to determine—and shall we search for motive? Our professional relations become of great importance where litigation is entered upon for the sake of securing indemnity. Indemnity sought for material injury such as loss of eye, or arm, or leg, broken skull or spinal column, with definite objective symptoms is legitimate, but one must stand appalled today, at the wholesale litigation based upon alleged or actual injury, where the physical evidence is slight or absent, yet where serious and permanent damage to the mind, health and body are claimed. Railroads and corporations pay large sums annually to complainants of this class. This very situation places upon the medical profession a tremendous responsibility, whether serving as physician to claimant, or as an expert, so-called, in court, where the justice and extent of the claim is to be determined.

In conclusion permit me to say that it is not only my belief, but the belief of others, that although there may be a certain number of genuine legitimate cases of real definite head injury, where the victim presents a set of psycho-neurotic complaints that are beyond his control, still there are a far greater number of cases of neuroses—so-called—that are born and nurtured in the days following accident, engendered by pique, spite, anger, or revenge—led on by the golden dreams of avarice and a liberal jury verdict—an amount often out of all proportion to the thrift and earning capacity of the individual, as shown by his pre-

vious mode of life. The physician often becomes unconsciously and unwittingly—never premeditatedly I am sure—an accomplice to this end. Many of the populace seem to regard corporations as their natural prey, and have no scruples about mulcting said corporations out of huge sums. I am not venturing on any insecure hypothesis, as to the causes of these apparent states of mind as related—but am relating them only as I have observed them, with the hope of finding interpretation elsewhere. The vagaries of the human mind form an intensely interesting and fascinating study. It is the province of the physician to seek a physical cause for mental ills but we should in no case neglect the moral side, and be on the alert for motive, for we are in a

sense the moral as well as the physical guardians of the people.

#### BIBLIOGRAPHY

- Pearce Bailey. *War Neuroses*, *Jour A M A*, September, 1920  
Harvey Cushing. *New York Medical Journal*, Feb 7, 1917  
Dana. Difficulties in Diagnosis, *Archives Neurol & Psychiat*, Nov., 1920  
William Sharpe. Diagnosis and Treatment Brain Injuries, Lippincott & Co, 1920  
Raphael Lewy. Bulletin No 3, State Department of Labor, 1923  
Mayer. *Journal, A M A*, Sept. 22, 1917  
Oppenheim. *Neurol Central*, 1915, 34-514  
Wilson. *British Medical Journal* 1917, page 353  
Frazier and Ingham. *Archives Neurol & Psychiatry*, Jan., 1920  
Hoag. *Transactions, Society Medical Jurisprudence*, Oct. 11, 1920

#### Deaths

BARNES, JOHN A, Troy, Albany Medical College, 1898, Fellow American Medical Association, Member State Society. Died January 4, 1925

CRONIN, JOHN J, New York City, College of Physicians and Surgeons of New York, 1893, Member State Society, Alumni Association of Roosevelt Hospital. Died January 30, 1925

DE BERMINGHAM, JOSE MARIE, New York City, New York University, 1896, Member State Society. Died February 13, 1925

GRIFFIN, NELSON H, Cairo, College of Physicians and Surgeons of New York, 1875, Member State Society. Died December 25, 1924

JENNINGS, DEAN WARDELL, Catskill, Albany Medical College, 1907, Member State Society, Assistant Physician Benedictine Hospital, Kingston. Died January 25, 1925

KUTSCHUCK-WEBSTER, VLADIMIR, Brooklyn, University of Kharkoff, Russia, 1894, Member State Society. Died February 6, 1925

O'CONNELL, T JOSEPH, Rochester, University and Bellevue Medical College, 1902, Member

State Society, Rochester Academy of Medicine, Rochester Pathological Society, Alumni Association St. Vincent's Hospital, Oculist and Aurist State Industrial School, Surgeon Homeopathic Hospital and Dispensary. Died January 11, 1925

SILLECK, WALTER MANDEVILLE, New York City, College of Physicians and Surgeons of New York, 1908, Fellow American Medical Association, Fellow American College of Surgeons, New York Academy of Medicine, Member State Society, Alumni Association St. Luke's Hospital, Associate Visiting Surgeon Post-Graduate Hospital, Assistant Surgeon Harlem Hospital. Died February 15, 1925

THOMPSON, AMOS WALTER, Saratoga Springs, New York University, 1887, Fellow American Medical Association, Member State Society, Gynecologist Saratoga Hospital. Died January 7, 1925

WILSON, ROSCOE C, Ithaca, Long Island College Hospital, 1901, Fellow American Medical Association, American Academy of Ophthalmology and Oto-Laryngology, Member State Society. Died January 18, 1925

sent a brilliant though not of necessity a convincing attempt on the part of Oppenheim, to isolate a syndrome peculiar to the traumatic neuroses.

Wilson, an aurist of England, ventures on a hypothesis which presents the same line of reasoning. He believes that the symptom picture following physical trauma to the head, including deafness, unsteady equilibrium, with vertigo and a narrowing of the field of vision, is explained that as a result of trauma to the head there is structural discontinuity of the nerves at the synapses: that there is a spread of nerve impulses into adjacent pathways. and that in the case of the function of hearing the auditory impulse no longer reaching its goal, deafness results. Such a dissolution may occur at any or all synapses. His method of reasoning although conjectural, may be applied to many of other the symptoms of the traumatic neuroses, such as functional loss of vision, functional paralysis, et cet. Mayer, of Pittsburgh explains the psychoneuroses, starting with the assumption that an acute stoppage of cerebral activity may result after trauma which need not be structural in origin, but is of such a degree that the individual cannot readjust himself to it. This disordered situation brings emotional reactions and its motor responses. If the brain adjusts itself the emotions subside gradually; if not, the attempt to do so increases the emotional reaction the body vainly tries to secure an adjustment, the glandular secretions work overtime. From this over-stimulation serious damage may result. An ideogenous factor now stepping into play establishes a vicious circle. According to Sherrington, such a draining of energy is probably similar in result to the over-activity of cells which in diaschisis produces a physiologic stoppage of function. This is transient if the cells can replace energetic substances: permanent if they become damaged, or if the synaptic connections cannot become re-established. One may go through the literature ad libitum, and find various converging and again diverging opinions as to the status of the subjective complaints following injury to the head. The question is asked, and very properly, too, as to how much is due to injury and how much to predisposition.

The late Pearce Bailey, in his classic monograph on the war neuroses, implicates motive as an outstanding cause of neurosis, as well as an incentive to cure. In the first instance a neurosis develops, as it were, automatically—the soldier believing that due to this he may receive his discharge. On the other hand, the experience has been that if it is made to appear that he will not be discharged while suffering from a neurosis, a long step at least has been

made toward recovery. It is believed that the great success of the French Army with their cases of neuroses, is due to the fact that the neuroses are not pensionable and that no soldiers are discharged for such causes. It would appear that the real cause of many of the subjective complaints which follow head injury do not depend so much upon extent of the injury or violence, as upon its subjunctive reflection upon the mind of the person injured. There are several factors in this development, one of these being an inherent predisposition easily magnified into motive, for which the individual may have been groping for years. On the other hand, it would seem that there must be at least a fairly definite causative mechanism to account for a symptom picture so universal and uniform. In the few cases that escape the long train of subjective symptoms may there have become established, what we may please to call a psychopathologic defense reaction.

The tremendous industrial and transportation enterprises of the present day will give rise to an ever-increasing number of these cases, demanding proper understanding and classification whether the alleged injury is psychical or physical is for us to determine—and shall we search for motive? Our professional relations become of great importance where litigation is entered upon for the sake of securing indemnity. Indemnity sought for material injury such as loss of eye, or arm, or leg, broken skull or spinal column, with definite objective symptoms is legitimate, but one must stand appalled today, at the wholesale litigation based upon alleged or actual injury, where the physical evidence is slight or absent, yet where serious and permanent damage to the mind, health and body are claimed. Railroads and corporations pay large sums annually to complainants of this class. This very situation places upon the medical profession a tremendous responsibility, whether serving as physician to claimant, or as an expert, so-called, in court, where the justice and extent of the claim is to be determined.

In conclusion permit me to say that it is not only my belief, but the belief of others, that although there may be a certain number of genuine legitimate cases of real definite head injury, where the victim presents a set of psycho-neurotic complaints that are beyond his control, still there are a far greater number of cases of neuroses—so-called—that are born and nurtured in the days following accident, engendered by pique, spite, anger, or revenge—led on by the golden dreams of avarice and a liberal jury verdict—an amount often out of all proportion to the thrift and earning capacity of the individual, as shown by his pre-

other states. It may be described as consisting of three groups whose influence start from a center and spread in ever widening circles to every part of the State.

At the center in Albany is Dr. James N. Vander Veer, Chairman of the Legislative Committee of the Medical Society of the State of New York. He has an office force of three persons. Each day he receives the proof sheets of the records of the Senate and Assembly on every bill, and on every Saturday afternoon he receives the printed digest of the action on all bills. He personally goes over these bills and makes a digest of them and places it in the mail on Sunday night as copy for the fifteen pages more or less which are printed in the JOURNAL. He also has 200 copies mimeographed and sent at once to the Chairmen of County Legislative Committees.

Dr. Vander Veer does all this for the good of the cause and without the hope of fee or reward. He is the central man-spring which makes the whole medical legislative system go.

Next to Dr. Vander Veer there is the circle of sixty Chairmen of the Legislative Committees of the County Medical Societies. They too are busy for they must get in touch with their members of the Legislature, and influence them regarding medical bills. Theirs is the responsibility of reaching the legislators directly.

The next circle consists of the ten thousand members of the County Medical Societies. They will get their knowledge from the JOURNAL, and directions for work from the County Chairmen. Their duty is to do occasional details of work as they are asked, such as calling on legislators and writing letters and sending telegrams.

Last year the County Chairmen were called together in Albany for a conference with Dr. Vander Veer on the day of the hearing on the principal medical bills. A similar conference is called on March fourth, on the day of a legislative hearing on the Medical Practice bill, the two bills on chiropractic, and the drugless therapy bill.

The legislative system of the Medical Society of the State of New York may be compared to a radio system. At the central station is the broadcaster, Dr. Vander Veer. Circles of influence from him reach the detecting and amplifying chairmen in every county. Snatches of the broadcasted material are picked up by circles of listening members and by them are put to practice. It is not to be expected that every member shall listen in to every program that is broadcasted, but he is expected to cooperate when the opportunity comes.

F O

---

## THE PHYSICIAN IN MEDICAL BILLS

The number of bills introduced into the present Legislature affecting medical matters is larger than usual. Many seem to be inspired by welfare organizations who do not recognize the prominent part which practicing physicians must take in the application of the proposed laws. Too often the laws are drawn without reference to the family physician. This is illustrated by Senate Bill Int. No. 283, Assembly Int. 399, which was printed on page 175 of the February 6th issue of this JOURNAL. This bill permits a Board of Supervisors to appoint public health nurses who shall be *directed* by a committee of the Board, and *supervised* by the State Commissioner of Health. The nurses may work in public schools under the direction of the school authorities and under the provision of the State Education Law.

Here at once is a mixed-up condition in which three separate laws are authorized to direct the distracted nurse who tries to serve three masters, and one can readily picture the attitude of the physicians who must work with the nurses and know not who is responsible for their assignments. The obvious method of avoiding serious conflict of authority is to place the direction of the nurses under one law, be it County Law, Public Health Law, or the Educational Law. The

closing paragraph provides that the Board of Supervisors *may* appoint an advisory committee of citizens of whom at least one shall be a physician, and at least one a woman. The number on the committee is not mentioned, and only one need be a physician and his fitness for the position is not mentioned. One can imagine the type of physician which the average political Board of Supervisors would appoint. It would seem that provision should be made by which the organized body of physicians in the county, that is, the County Medical Society, should have a voice in the appointment of the medical member of the advisory committee to the extent of at least the nominating of the member. It would also seem that the appointment of an advisory committee should be mandatory and that physicians should form the majority of the committee.

This law and dozens of similar ones, have been introduced into the Legislature by the leaders of organizations who are fully aware of the existence of the Medical Society of the State of New York, and of the willingness of its officers to give advice to anyone who seeks light on any subject in which physicians are involved. Under present conditions the only course open to the State Medical Society is to oppose the bill in its present form.

F O



# EDITORIALS



The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication.

*Editor-in-Chief*—NATHAN B VAN ETEN, M D,  
New York  
*Associate Editor*—ORRIN SAGE WIGHTMAN, M D,  
New York  
*Executive Editor*—FRANK OVERTON, M D  
Patchogue

### COMMITTEE ON PUBLICATION

E ELIOT HARRIS, M D, *Chairman* New York  
ORRIN SAGE WIGHTMAN, M D New York  
EDWARD LIVINGSTON HUNT, M D New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

*President*—OWEN E. JONES, M D Rochester  
*First Vice President*—GEORGE A. LEITNER, M D Piermont  
*Second Vice President*—LUZERNE COVILLE, M D Ithaca  
*Speaker*—E. ELIOT HARRIS, M D New York  
*Vice-Speaker*—GEORGE M FISHER, M D Utica  
*Secretary*—EDWARD LIVINGSTON HUNT, M D New York  
*Assistant Secretary*—WILBUR WARD, M D New York  
*Treasurer*—CHARLES GORDON HEYD, M D New York

### CHAIRMAN, STANDING COMMITTEES

*Arrangements*—FREDERICK H FLAHERTY, M D Syracuse  
*Public Health and Medical Education*,  
JOSHUA M VAN COTT, M D, Brooklyn  
*Scientific Work*—ANDREW MACFARLANE, M D Albany  
*Medical Economics*—HENRY LYLE WINTER, M D Cornwall  
*Legislation*—JAMES N VANDER VEER, M D Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex President and the Councilors of the District Branches.

*First District*—EDWARD C. RUSHMORE, M D Tuxedo Park  
*Second District*—FRANK H LASHER, M D Brooklyn  
*Third District*—ARTHUR J BEDELL, M D Albany  
*Fourth District*—CHARLES C TREMBLEY, M D Saranac Lake  
*Fifth District*—NELSON O BROOKS, M D Oneida  
*Sixth District*—GEORGE H FOX, M D Binghamton  
*Seventh District*—WILLIAM I DEAN, M D Rochester  
*Eighth District*—HARRY R. TRICK, M D Buffalo

### COUNSEL

GEORGE W WHITESIDE, Esq., 27 William St New York  
Telephone, Broad 1744

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St New York

### EXECUTIVE OFFICER

JOSEPH S LAWRENCE, M D 51 Chapel Street, Albany

### SECTION OFFICERS

*Medicine*  
*Chairman*—ROBERT L. LEVY, M D New York  
*Secretary*—L. WHITTINGTON GORHAM, M D Albany  
*Surgery*  
*Chairman*—MARSHALL CLINTON, M D Buffalo  
*Secretary*—EDWARD S VAN DUYN, M D Syracuse  
*Obstetrics and Gynecology*  
*Chairman*—HAROLD C. BAILEY, M D New York  
*Secretary*—NATHAN P SEARS, M D Syracuse  
*Pediatrics*  
*Chairman*—JOSEPH C. PALMER, M D Syracuse  
*Vice-Chairman*—ROGER H DENNETT, M D New York  
*Secretary*—ARTHUR W BENSON, M D Troy  
*Eye Ear Nose and Throat*  
*Chairman*—ARTHUR G BENNETT, M D Buffalo  
*Secretary*—EUGENE E HINMAN, M D Albany  
*Public Health Hygiene and Sanitation*  
*Chairman*—PAUL B BROOKS, M D Albany  
*Secretary*—ARTHUR D JACQUES, M D Lynbrook  
*Neurology and Psychiatry*  
*Chairman*—EUGENE N BOUREAU, M D Syracuse  
*Secretary*—CLARENCE O CHENEY, M D Utica

## MEDICAL LEGISLATION

The present session of the Legislature has been one of uncertainty and hurry, especially in medical bills. The editors of the JOURNAL and the Chairman of the Legislative Committee have so far been able to do little more than to publish the medical bills which have been introduced, but during the remainder of the legislative sessions we hope to be able to print comments on the individual bills and to give the members of the Medical Society of the State of New York an intelligent idea of their nature.

Our members may also be asked to visit their legislators and give them information regarding the bills. There will be need of promptness in complying with these requests. Most bills are introduced by groups that are backed by money

and selfish interests and their promoters have often avoided publicity and education. Their method is usually to introduce a bill and to get a number of interested voters to write letters in its support. Physicians usually form the only group in opposition to the hasty legislation and they act only from civic motives, and are dignified and deliberate in their actions. Yet a single letter from a physician often has more weight than a score from laymen, for the physicians have the respect and confidence of the community.

If you are asked to write a letter, or send a telegram, please do so at once.

The machinery by which the physicians of New York State keep track of legislation is the most complete of all the States, and is copied by ten





# LEGAL



By GEORGE W. WHITESIDE, Esq.  
Counsel, Medical Society of the State of New York

## MARCH FOURTH AT ALBANY

The joint committee on Public Health of the Senate and Assembly announce a hearing in the assembly chamber upon the Karle-Dunmore bills sponsored by Dr. Downing and the Regents, which are similar to the bills of last year supported by the State Society. At the same time a hearing on three chiropractic bills introduced by Senator Gibbs and Assemblymen Esmond and Nicoll respectively will be held.

The Karle-Dunmore measures have a serious purpose and are designed to protect educational standards of medical licensure and the practice of medicine from the destructive influences of unethical and unlawful practice. These bills seek to protect the title of "Doctor" from promiscuous use by quacks and to create law-enforcement machinery of state-wide operation. The standards of medical licensure which the Karle-Dunmore bills seek to protect are subjected to destructive attack by the three chiropractic bills, each of which contains the essential vice of similar bills that have been introduced during the last ten years of wholesale license of untried, untested and uneducated men without examination.

It should be kept in mind that the purpose of medical licensing laws is to protect the health of the community by providing safeguards against the practice of healing by those not qualified, and not to create a favored class or arbitrarily confer privileges upon a few to the exclusion of the many. The benefit conferred upon the licensee is but incidental to the program of state control and of regulating a vocation affected with a public interest. The grant of license to the individual is for the purpose of forbidding others who are unqualified from doing damage to the public health. When the legislature seeks to grant licenses to practice healing for the purpose of protecting the public against the practice of the unqualified, it cannot, in doing so, arbitrarily and without reference to skill, learning or fitness, grant licenses to certain uneducated exempted classes. Proper protection to the public in the practice of the healing art can be had only by keeping out the unscientific, uninformed and ignorant, and basing licensure, that presupposes mental ability, upon strict educational qualifications. The selfish interest of the licensee cannot be urged against a program of state control of licensure.

The chiropractors, in their bills seek selfish interest at the expense of the public health, because

they demand license without test of fitness. On March 4th at the hearing the chiropractors will stage a farce that properly should be entitled "How to be a Licensed Doctor without Examination or Education." They believe in much noise as evidenced by their slogan "He Who Bloweth Not His Own Horn, for Him no Horn shall be Blown."

The first act of this comedy is enacted in the bill of Mr. Nicoll in which, under the guise of an attempt "to define and regulate the practice of chiropractic," licenses are granted to upwards of a thousand chiropractors now practicing, without any test or examination, and thereafter educational barriers are to be raised against future competition by knock-out educational tests. In this act is presented likewise a new member of the present Board of Medical Examiners in the person of a chiropractor.

The second act of Mr. Gibbs concerns itself with "The Practice of all Systems, Methods or Sciences Constructed, Formulated or Developed for the Treatment of Disease, the Removal of Abnormality, Injury, or Deformity of Human Beings, except the Practice of Medicine, Osteopathy and Christian Science." "Drugless Methods" is introduced in this act as a means of "treatment of disease, the removal of abnormality, injury, or deformity of human beings by hand or mechanically without the use of drugs, osteopathy, surgery or Christian Science." In this act any person over twenty-one years of age who has four friends who swear he is good, and who has violated the Medical Practice Act for two years and holds a diploma—earned or bought seems immaterial—according to the reading of the text—and pays the state \$25, gets a license to practice. Those who come on the scene later seeking licenses have difficult educational hurdles to get over before they are licensed, but that is helpful to those who have already helped themselves to licenses without examination. The balance of the act consists of a progression of "regulations" in dainty legal costumes, but the real purpose of the regulations is but poorly disguised and is readily recognized.

The third act is by Mr. Esmond. Here the chiropractor is specifically exempted from the operation of the proposed Karle-Dunmore Medical Practice Act and thus is saved by a few lines from the jaws of sudden professional death. He is then taken in charge by Mr. Esmond, and sec-

## PHYSICIAN CAN AID LEGISLATOR

My dear Doctor Have you written to the Senator and Assemblyman who represent you at Albany, advising them as to how you wish they should represent you when the various medical bills—particularly the medical practice act, the chiropractic bill and the drugless therapy bill—come up for consideration? If you have not done so, don't you think it would be only fair to them that you should give them this information at once?

A joint hearing on these three medical bills has been announced for 2 P M on Wednesday, March the 4th It is important, therefore, if you wish your opinion on these bills be given the opportunity of carrying its influence, that you communicate it immediately to your members of the Senate and Assembly, and to both Committees on Public Health You may argue that your legislative representatives are familiar with your opinion on these questions, but that is hardly fair unless you have discussed the matter with them since the bills were presented which are now before the two bodies, because these bills are not exact duplicates of the ones that were introduced last year

Do you ever think that perhaps legislative men arrive at decisions to act by a course of reasoning not very different from that employed by the physician in his conduct with a patient? The physician is always very careful to inform himself about the history of the complaint that the patient makes at the time of the visit Now the legislative man, after his fashion, does what he can, likewise, to inform himself concerning the history of the legislation that is proposed and also the history of its progress, particularly noting the evidences of opposition and approval that have collected during that period of time from the introduction of the bill to its final reading Therefore, every person interested in legislation should make it a point to see that there is history of the character he desires developing along with the bill as it progresses

Today while discussing with an Assemblyman the medical practice act, and attempting to clarify for him that portion of the bill wherein qualifications of a practitioner are stated, making a point of assuring him that those qualifications were not drawn up for the express purpose of excluding chiropractors, but were constructive in character and were intended to raise the standard of the physicians among themselves, his mail was

handed him It consisted of one letter which he passed to me to read after he had looked it over It was from a woman of his district, who said that she had heard there was a bill before the legislature which would license chiropractors, and she hoped that he would support that bill because she was convinced they did good work, saying that they had cured her He told me that he had received, in the last week or ten days, many such letters from people of his district This may seem like a small matter, but it has its effect, and when that effect is multiplied a sufficient number of times without a counter effect, it is apt to produce an opinion or conviction which will result in action The men of the legislature cannot be expected to be familiar with every question that comes up in the form of a bill or resolution demanding their action, nor can they be expected to withhold their vote simply because they are not thoroughly versed with the matter under debate They usually do whatever they can to inform themselves upon the bills, and particularly upon those which appear to them to be the most important, so as to be able to give an intelligent opinion or explanation for whatever action they take when a decision is demanded, but those experienced with legislation know that great aid can be given the Senators and Assemblymen, without either having asked for it, by having their constituents write short letters, giving in a few words the reasons why they think they would have their representatives make certain decisions

Your Legislative Committee is doing its utmost to see that every member of the two Committees on Public Health, and as many other legislative men as possible, are informed as to the desire of the medical profession concerning the disposition of the bills mentioned above, but the most powerful appeals that can be made to any member of the legislature are those which come from the persons in his district by whose ballot he now holds his position and whose support he hopes to deserve in the future

Will you, then, act upon our suggestion and between now and March 4th do what lies within your power to have your representative correctly informed concerning your wishes and those of your friends, as to their action in connection with these medical bills?

J S L



# LEGISLATION



By JAMES N VANDER VEER, M.D.  
Chairman, Committee on Legislation.

## SPECIAL NOTICE TO COUNTY LEGISLATIVE CHAIRMEN

Joint Conference of Legislative Chairmen of County Medical Societies, with the Officers of the Medical Society of the State of New York, and the Advisory Committee on Legislation, will be held on Wednesday, March 4, 1925, at 9 30 A M, at The Hotel Ten Eyck, Albany, N Y Registration with presentation of credentials not later than 9 A M

## INDEX OF LEGISLATIVE BILLS DISCUSSED IN THIS JOURNAL

B—Bill printed  
D—Digest  
C—Comment.

Senate Int. No	Assembly Int. No	Law	Subject	Page and Date	
115	215	Public Health	THE NARCOTIC BILL	B 80	Jan 23
				C. 270	Feb 20
116	216	Insanity	Licensing Institutions for Drug Addicts	B 84	Jan 23
				C. 270	Feb 20
211	307	Public Health	THE MEDICAL PRACTICE ACT	B 123	Jan 30
				C 270	Feb 20
228	236	State Charities	Inspection of Children's Institutions	D 130	Jan 30
263		Insanity	Qualifications of Examiners	B 174	Feb 6
				C 271	Feb 20
283	399	County	Expenses of Public Health Nurses	B 175	Feb 6
				C. 271	Feb 20
302	748	Education	Health Service in Schools	B 176	Feb 6
380	570	Workmen's Comp	Injured Employee to Select His Physician	B 177	Feb 6
				C. 272	Feb 20
473		Public Health	Drugless Therapy	B 232	Feb 13
				C 272	Feb 20
530	756	Public Health	Medical Examination of Workmen in Shellfish Industry	D 272	Feb 20
	120	Labor	First Aid in Factories	B 85	Jan 23
	127	Education	Health Service in Schools	B 86	Jan 23
	184	Workmen's Comp	Examinations of the Injured	D 87	Jan. 23
				C. 272	Feb 20
	185		A CHIROPRACTIC BILL	B 87	Jan. 23
				C 277	Feb 20
	229	Education	Mentally Deficient Children	D 131	Jan 30
594	301	Workmen's Comp	Medical Attendance	B 183	Feb 6
				C 273	Feb 20
	422	Civil Practice	Professional Secrets	B 186	Feb 6
				C. 278	Feb 20
586	850	Education Law	Inspection School Children	B 272	Feb 20
632	802	Public Health	Pharmacies	B 273	Feb 20
647	184	Workmen's Comp	Examination After Injury	C. 275	Feb 20
671	868	Penal Law	Crippled Children	B 288	Feb 20
681	986	State Charities	Dissecting Material	C 275	Feb 20
693	950	Public Health	Foreign Medical Degrees	B 276	Feb 20
701	716	Public Health	Revocation of License	B 276	Feb 20
	649	Public Health	A CHIROPRACTIC BILL	B 278	Feb 20
	908	Penal Law	Wood Alcohol	B 294	Feb 20
	925	Public Health	Reciprocity in Licensures	B 294	Feb 20
716	909	Public Health	Rural Hygiene	C 277	Feb 20
	973	Public Health	State Institutions Study Malignant Disease	C. 295	Feb 20

tion by section is put together under the label "chiropractic" and crowned with a license halo. At this point a procession of over a thousand chiropractors bearing similar crowns proceeds across the stage of present-day life, having been presented with their crowns by Mr Esmond without any test as far as the Regents of the State are informed.

At this point it is anticipated that the curtain would have to be lowered for a few moments to indicate a return to sanity in order that the joint committee, having been regaled with the ludicrous, might seriously consider a constructive program presented by the Senate act of Mr Karle and the companion Assembly act of Mr Dunmore. It would be expected that by this time the legislators would have had enough of

the comedy to be ready to consider the serious. Dr Augustus S Downing, a veteran warrior against quackery and the defender of standards of professional education at this point takes the center of the stage, followed by the State Commissioner of Health and the representatives of the State Medical Society and other guardians of law and order, constitutional government and honest legislation. The performance before the joint committee will end and there will be one outstanding question.

Do the people want the farce as presented in the three vaudeville chiropractic acts, or do they want intelligent legislation designed to protect the health and well-being of the citizens of this State?

### CLAIMED WRONG DIAGNOSIS AND IMPROPER ADVICE

A man of about 46 years of age called upon a physician specializing in neurology, complaining of pain in the right calf and thigh and in the lumbar region. After examination, the physician made a diagnosis of myositis of gluteus maximus muscle. He also suspected that the patient's condition might be due to the condition of his teeth, and referred him to a dentist. It appears that the patient went to a dentist, who took X-rays of his mouth and reported to the physician that the same showed pyorrhea pockets around the upper right bicuspid and second molar, that the bridge attached to these teeth was causing considerable irritation to the surrounding tissues, the first and second bicuspid had imperfect canal fillings and showed apical infection, and that the bridge was also causing irritation to the tissues underneath it. There was likewise a probability of a left antrum congestion, and the bridge attached to the lower right molar was a cause of irritation to the tissues. There was also an impacted right molar on the lower left side. The dentist had made a clinical diagnosis that the bridges in the patient's mouth were unsanitary and causing a great deal of disturbance to the surrounding tissues and that there were pyorrhea pockets present. He advised the removal of all the bridges and treatment for the pyorrhea and the removal of the impacted molar. About six weeks thereafter, the patient called upon the physician, at which time the physician made a lumbar puncture and advised that the patient permit the dentist to do the work that he deemed necessary.

The patient was not again seen by the physician until a month later, when he stated that he was feeling better, but complained of pain in the right thigh. An injection of 5 cc of 50 per cent solution of alcohol was administered. This

was the last that the physician saw of this patient. After the patient's second visit to the physician, he returned to the dentist, who continued to treat him for several months, during which time he extracted the impacted lower left third molar, removed three bridges, extracted the lower left bicuspid, scaled off deposits from the other teeth and put the patient's mouth in a good, healthy condition.

About a year thereafter, this patient instituted an action against the physician and also instituted a separate action against the dentist, charging that he had gone to the defendant physician to treat him for a certain malady from which he was suffering and that the physician on his first examination stated that the plaintiff's nerves were out of order, that thereafter the physician took a spinal fluid test and advised the plaintiff to have his mouth X-rayed and to undergo the treatment advised by the dentist after X-ray and examination of his mouth, that the defendant, in his treatment of the plaintiff, injected alcohol, which the plaintiff claimed caused him to suffer great pain. He also charges that all of the treatment and advice given him by the defendant physician was improper and injurious and was not called for by the plaintiff's condition and that if the defendant had exercised the proper care and skill in his treatment of the plaintiff, that he would not have treated him in the manner in which he had done. The plaintiff further claimed that by reason of the defendant's advice he had lost his teeth, suffered great pain and was obliged to expend a great sum of money in his endeavor to be cured.

When the action was reached on the calendar and the plaintiff was pressed to proceed with its trial, it was abandoned and the complaint dismissed in favor of the doctor.

### State Charities Inspection of Children's Institutions

Senate Int No 228 (conc Assembly Int 236)  
—A bill introduced in the Senate by Senator J Griswold Webb of Westchester County, concurrent Assembly Int 236, by Assemblyman T C Moore of Westchester County, would amend State Charities Law, by adding new section 16, empowering State Charities Board, among other things, to visit all institutions in which children are received or cared for, and to establish rules therefor

Referred to General Laws Committee of Senate and to Judiciary Committee of Assembly  
No further comment as yet

### Insanity Qualifications for Examiners in Lunacy

Senate Int No 263—A bill introduced in the Senate by Senator James A Higgins of Kings County, would amend section 81, Insanity Law, relative to qualifications of examiners in lunacy

Referred to General Laws Committee

*Comment* Your Committee is in receipt of two communications objecting to the purport of this bill Your Chairman is taking the liberty of quoting from one of the letters

"This bill does not affect me and cannot, unless some wise bird eliminates from it (Sec 81) the words 'certified after date from which this act shall take effect' The element of 'retroactivity of a law' does not in any sense apply as this is one of those conditions which the Police Power of the State may 'limit, regulate and prohibit,' regardless of any pre-existing privilege I just want you to assume that some clever bird succeeds in doing that very thing so that it would apply to me as well as to the young man about to graduate who does not see fit to spend two years in an insane asylum to qualify for Examinership in Lunacy, but who, like me, is disposed to use his mind along every line and has the faculty of using his common sense and 'jury instinct' in the consideration of mental cases Such a man would be debarred from certifying as to the mental condition of one of his own patients who had become disturbed when, as a matter of fact, he knows more in a minute about the 'changes in personality of his patient' than an institutionalist could know in a year

"It is not very long ago (1914) when one of these gentlemen, with a string of hospital attachments and affiliations as long as your arm said, under oath, that he had examined 23,000 cases and Had Never Made a Mistake"

This is one of the several criticisms offered against the bill, and so, therefore, your Committee on Legislation would ask that the Chairmen of the various County Societies give us what opinions they may have "for" or "against" the measure, in view of the comment which appeared in the last number of the Journal

### County Law. Public Health Nurses

Senate Int No 283 (conc Assembly Int 399)  
—A bill introduced in the Senate by Senator J Griswold Webb of Clinton Corners, N Y, concurrent Assembly Int 399, by Assemblyman Frank H Lattin of Orleans County, would amend section 12, County Law, by authorizing County Supervisors to provide expenses for Public Health nurses, who shall work under the public health committee of the board, providing for appointment of advisory committee of citizens and relative to duties of nurses

Referred to Internal Affairs Committees of both houses

*Comment* Much opposition has developed on the part of individual members of the Society to this bill One letter very aptly puts it that the bill is another illustration of lay control, which is reasoning that has lain dormant in the minds of your Committee on Legislation, and from the communications which have been received we have sent a letter of opposition to the bill, as it now stands, to the introducer of it

The nursing and care of the sick primarily originates with the physician and the physician should be represented by his profession on every committee which has to deal with the public health, by reason of his thought along medical lines, and because of his citizenship he should be able to view the good to be done apart from the medical side

He should be the balancing power in such movements

To him these lay boards must turn, and do turn for much advice, in many instances given gratis and sought gratuitously "because the doctor is the best posted on this matter"

This physician, in order to serve, should be freed from the entanglements of state governmental function and should represent solely his professional brethren

The desire on the part of half educated persons to initiate partial or complete medical treatment upon their own judgment and without proper supervision is becoming more and more apparent, and instead of the physician being sought for his advice, we find that in many movements in behalf of the public health the paid secretary of a welfare organization is the one first sought out

This means the commercialization of public health in its ultimate analysis, so much so, that not long ago it has come to the ears of your Chairman, a certain welfare organization hired certain people to go out and dig up cases of sickness and indigency that their money for that year might be expended and thus their call for funds in the ensuing year might theoretically legalize their existence

Your Committee on Legislation takes a stand in opposition to the bill as it is drawn, and asks

## SUMMARY OF BILLS INTRODUCED IN LEGISLATURE IN SENATE

### Public Health, Narcotic Bill

Senate Int No 115 (conc Assembly Int 215)  
—A bill introduced in the Senate by Senator Morton J Kennedy of New York, concurrent Assembly Int 215, by Assemblyman Morris Weinfeld of New York, would add new article 22, and amend section 4-b, Public Health Law, and repeals section 1746, Penal Law, relative to habit forming drugs

Referred to Public Health Committees of both houses

*Comment* Further comment might be made that this bill is of vital interest to the medical profession

Your Committee on Legislation believes it should be passed and that aid should be given Senator Kennedy and Assemblyman Weinfeld by the County Legislative Chairmen communicating with their various representatives asking their support of the bill

### Licensing Institutions of Drug Addicts

Senate Int No 116 (conc Assembly Int 216)  
—A bill introduced in the Senate by Senator Morton J Kennedy of New York, concurrent Assembly Int 216, by Assemblyman Morris Weinfeld of New York, would add new section 177, Insanity Law, requiring the licensing of private institutions for treatment of narcotic drug addiction

Referred to General Laws Committee of Senate, and to Judiciary Committee of Assembly

*Comment* This bill goes hand in hand with the preceding bill relating to habit-forming drugs, and the same comment applies relative to the County Legislative Chairmen aiding its passage

### State Department of Education Bill Amending Medical Practice Act

Senate Int No 211 (conc Assembly Int 307)  
—A bill introduced in the Senate by Senator John L Karle of Queens County, concurrent Assembly Int 307, introduced in the Assembly by Assemblyman Russell Dunmore of Oneida County, would amend Sections 164, 169, 170, 173, 174, and repeal section 171, Public Health Law, relative to practice of medicine, by providing among other things, for the registration and licensing of physicians

Referred to Public Health Committees of both Houses

*Comment* From the paucity of communications received from individuals, and no affirmative or negative resolutions from County So-

cieties, your Committee on Legislation can only feel that the same position maintains in relation to this bill as was taken last year at the very end of the session by the State Society, and consequently your Committee on Legislation can only take the same position as it did last year until frank and open opposition comes to the front.

If it is reasoned that the Chairman and the Committee must use its own discretion in legislation without hearing direct from the County Societies or from individuals, then whatever of criticism shall be offered later can only be placed on those Societies and those individuals who have remained silent in their relations with their County Societies or with the State Society, and who feel themselves not bound by the votes of their constituents, but who feel free to undermine the efforts of the duly accredited delegates or officers of the various County Societies and of the State Society

In conversation with some members of the State Society it has been learned that they are covertly opposing as individuals measures upon which even their own County Societies have passed favorable resolutions, and your officers of the State Society, especially the Committee on Legislation, cannot work to the best advantage of the State Society under such conditions unless the weight of the majority of the Society is openly expressed "for" or "against" a measure.

Legislation is always a matter of the best thought and consequent action of the majority of any group, but many times the best of such may be defeated, and often is negated by the selfish interests of individuals who hold themselves out in very confidential conversation to legislators as representing "an enormous and far-reaching group opposed to the publicly expressed will of the majority"

Thus it can be seen that time and effort on the part of volunteers who are elected or appointed to carry out the will of the majority may go for naught, and the burden of defeat may have to be borne silently by them, and the criticisms heaped upon them may have to go unanswered, since they have no means of expressing the reasons of defeat broadly to those who have placed them in positions of trust

Your Committee on Legislation feels that if the County Societies and individuals are "for" or "against" this measure, they should be guided by what the will of the majority in the County Societies and the judgment of the State Society have dictated

ten and chapter six hundred and twenty-seven of the laws of nineteen hundred and thirteen, is hereby amended to read as follows

§ 570 Medical inspection to be provided Medical inspection shall be provided for all pupils attending the public schools in this state, except in cities [of the first class] *which were cities of the first class on the first day of August, nineteen hundred and thirteen*, as provided in this article Medical inspection shall include the services of a trained registered nurse, if one is employed, and shall also include such services as may be rendered as provided herein in examining pupils for the existence of disease or physical defects and in testing the eyes and ears of such pupils

§ 2 This act shall take immediately

*Comment* Your Committee is in favor of this bill which, if passed, would exempt only cities of the first class which were such on the first day of August, 1913, but would not include any city which might become a city of the first class in the ensuing years

In the old bill any cities which might become first class would be exempted, while under this new bill the only cities exempted for good and all are those which were cities of the first class August 1, 1913

#### **Workmen's Compensation Permitting Employees to Engage Medical Attendance at Employer's Expense**

Senate Int No 594 (conc Assembly Int 301)  
—A bill introduced in the Senate by Senator William Love of Brooklyn, N Y, concurrent Assembly Int 301, by Assemblyman Frank H Lattin of Orleans County, would amend the Workmen's Compensation Law, by permitting injured employees at employer's expense, to engage medical or other attendance

Referred to Labor and Industry Committee of both Houses

*Comment* This bill is the same as Assembly Int 301, commented on in the February 13th Journal, page 182

Free choice of physician at least to a limited degree if not entirely, if that which the medical profession has been aiming at ever since the Workmen's Compensation Law was passed

County Chairmen are asked to write Senator William L Love thanking him for introducing it in the Senate and to write Senator James S Truman, chairman of the Labor and Industry Committee in which the bill lies

They are also urged to write as in the comment on Assembly Int No 301

#### **Tax Deductions from Income of Expenses for Medical, Surgical and Dental Services**

Senate Int No 600 (conc Assembly Int 791)  
—A bill introduced in the Senate by Senator George Fearon of Syracuse, N Y, concurrent

Assembly Int 791, by Assemblyman Phelps Phelps, of New York, would amend section 360, Tax Law, by providing for deduction from income of expenses paid for medical, surgical or dental services, where net income does not exceed \$5,000

Referred to Taxation and Retrenchment Committee of both houses

*Comment* If there is no criticism offered the bill will be dropped

#### **Education Striking Out 20-Minute Periods of Instruction in Physical Training**

Senate Int No 629 (conc Assembly Int 940)  
—A bill introduced in the Senate by Senator Bernard Downing of New York, concurrent Assembly Int No 940, by Assemblyman Peter J Hamill of New York, would amend section 695, Education Law, by striking out provision for 20 minute periods of instruction in physical training

Referred to Public Education Committees of both Houses

*Comment* This bill simply amends the old law by dropping out the period of time (20 minutes) during which physical training shall be indulged in, leaving it thereafter to the Commissioner of Education to determine the length of time If there be no comment thereon, the bill will be dropped

#### **Public Health Pharmacies Conducted by Corporations**

Senate Int No 632 (conc Assembly Int 802)  
—A bill introduced in the Senate by Senator J F Williams of Troy, N Y, concurrent Assembly Int 802, by Assemblyman Edward J Donohue of Rensselaer County, would amend section 234, Public Health Law, by permitting a corporation to conduct pharmacies or drug stores if a licensed pharmacist is employed in each place

Referred to Public Health Committees of both Houses

No 660

Int. 632

IN SENATE,

February 10, 1925

Introduced by Mr J F Williams—read twice and ordered printed, and when printed to be committed to the Committee on Public Health

#### **AN ACT\***

To amend the public health law, in relation to the conduct of pharmacies by corporations

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section two hundred and thirty-four of chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," as last amended by chapter two hundred and sixty-nine of the laws

\* Matter in italics is new matter in brackets [ ] is old law to be omitted

the County Chairmen to write to the members of the Senate and Assembly Committees on Internal Affairs in opposition

**Senate Committee on Internal Affairs** Ferris (Chairman), Westall, Hewitt, Thompson, Campbell, Williams, J F Pitcher, Keck, Wendell, Truman, Knight, McGarry, Burchill, Byrne, Twomey

**Assembly Committee on Internal Affairs** Bartholomew (Chairman), Bentley, of Greene County, Underwood, of Yates County, Congdon, of Albany, Messer, of Steuben County, Skinner, of Oneida, Downs, of Suffolk, Slater, of Monroe, Watson, of Cattaraugus, Knapp, of Sullivan, Davis, of Ulster, Hearn, of Kings, Hayes, of Albany

#### **Education Medical Inspection in Public Schools**

Senate Int No 302 (conc Assembly Int 748)  
—A bill introduced in the Senate by Senator Ernest E Cole of Bath, N Y, concurrent Assembly Int 748, by Assemblyman Irving F Rice of Cortland County, would amend sections 571, 571-a, 572, 575, Education Law, relative to medical inspection and health service in public schools

Referred to Public Education Committees of both Houses

*Comment* We have had no comments from any of the County Legislative Chairmen or from individual members of the Society in reference to this bill and would ask their immediate judgment in regard to it

#### **Workmen's Compensation Injured Employee to Select Physician**

Senate Int No 380 (conc Assembly Int 570)  
—A bill introduced in the Senate by Senator Daniel J Farrell, of Kings County, concurrent Assembly Int 570, by Assemblyman Gerald F Dunne of Kings County, would amend section 13, Workmen's Compensation Law, relative to medical and surgical attendance of injured employees, by providing employee shall select his physician

Referred to Labor and Industry Committee of both houses

*Comment* Your Committee on Legislation would ask that the County Chairmen and individual members of the State Society work for the passage of this measure

#### **Public Health Drugless Practitioners Bill**

Senate Int No 473—A bill introduced in the Senate by Senator Leonard W H Gibbs of Erie County, would add new article 13-a, Public Health Law, relative to practice of all systems or sciences constructed or developed for treatment of disease and removal of abnormality, injury or deformity of human beings, except practice of medicine, osteopathy and Christian Science

Referred to Public Health Committee

*Comment* Your Committee would ask that opposition to this measure be voiced to the Senate Public Health Committee from every source, as interests in favor of the bill are working to have it passed, but your Committee feels that the good sense of the legislature, if backed by public sentiment, will keep it from passage

#### **Public Health Medical Examination of Workers in Shell Fish Industry**

Senate Int No 530 (conc Assembly Int. 756)  
—A bill introduced by the Joint Committee on Pollution of Waters, should add new section 343-d, Public Health Law, providing for cleanliness in shellfish industry and for medical examination of workers

Referred to Public Health Committee

*Comment* Unless comment or request is received this bill will be dropped

#### **Education Establishing Institution for Mental Defectives**

Senate Int 551—A bill introduced in the Senate by Senator Leonard W H Gibbs of Erie County, would appropriate \$200,000 for establishing institution for mental defectives

Referred to Finance Committee

*Comment* None, the bill will be dropped

#### **Education Medical Inspection of School Children**

Senate Int No 586 (conc Assembly Int. 850)  
—A bill introduced in the Senate by Senator Ernest E Cole of Bath, N Y, concurrent Assembly Int No 850, by Assemblyman Irving F Rice of Cortland County, would amend section 570, Education Law, relative to medical inspection of school children by excepting only cities which were cities of the first class on August 1, 1913

Referred to Public Education Committee

No 614

Int 586.

IN SENATE,

February 9, 1925.

Introduced by Mr Cole—read twice and ordered printed, and when printed to be committed to the Committee on Public Education

#### **AN ACT\***

To amend the education law, relative to medical inspection of cities

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section five hundred and seventy of chapter twenty-one of the laws of nineteen hundred and nine, entitled "An act relating to education, constituting chapter sixteen of the consolidated laws," as amended by chapter one hundred and forty of the laws of nineteen hundred and

\* Matter in *italics* is new matter in brackets [ ] is old law to be omitted



oath to the board any facts required by the board, shall pay the registration fee of two dollars and shall receive a certificate of registration that must be conspicuously displayed at all times in the pharmacy, drug store or store with all licenses. Every person, partnership, association or corporation doing business as the proprietor or proprietors of a pharmacy, drug store or store shall cause the name of such proprietor or proprietors to be displayed upon a sign conspicuously placed upon the exterior of the building and this sign shall be presumptive evidence of ownership of such pharmacy, drug store or store. The proprietor that opens a pharmacy, drug store or store subsequent to the month of January shall, within thirty days of opening, make this report, pay the fee and display the certificate and the sign. Every proprietor of a wholesale or retail pharmacy, drug store or store is responsible for the strength, quality and purity of all drugs sold or dispensed by him, subject to the guaranty provisions of this article.

§ 2 This act shall take effect immediately.

*Comment* This bill does not concern the medical profession to any degree except where it has to do with physicians who own pharmacies, in that it will allow corporations to own drug stores if a licensed pharmacist be employed.

Unless comment is received the bill will be dropped.

#### **Workmen's Compensation Authorizing Physical Examinations, Results to Be Made Part of Record**

Senate Int No 647 (conc Assembly Int 184)—A bill introduced in the Senate by Senator Frank E Johnson of Brooklyn, N Y, concurrent Assembly Int 184, by Assemblyman F A Miller, of Brooklyn, N Y, would amend section 118, Workmen's Compensation Law, by authorizing physical examinations and practical tests of claimant to determine loss of use and proportionate loss of use of a member, result and test to be a part of record.

Referred to Labor and Industries Committees of both Houses.

*Comment* Comment by a member of the Advisory Committee on Legislation brings forth the fact that the commissioner, board, referee or deputy may make such physical examinations and the result of such examinations and tests shall be made a part of the record.

The wording of the bill is not good and your Committee on Legislation has asked the introducer of the bill in both Senate and Assembly to change the wording so that the examination shall be made by a physician perhaps in the presence of the commissioner, board, referee or deputy, and thus keep it within medical lines.

"If the legislature is to give laymen the power to make physical examinations to determine the loss of use of parts of the human system, it would establish a bad precedent."

#### **Education Crippled Children**

Senate Int No 671

(Conc Assembly Int No 868)—A bill introduced in the Senate by Senator Ernest E Cole of Bath, N Y, concurrent Assembly Int No 868, by Assemblyman John Boyle, Jr, of Suffolk County, would amend sections 2, 5, 23, Children's Court Act, sections 130, 132, 136, State Charities Law, sections 275, 310, 573, 650, 652, 653, 1020, 1200, 1201, 1203, 1204, 1206, 1208, adds new sections 1203-a, 1208-a, Education Law, relative to physically handicapped persons.

Referred to Judiciary Committees of both houses.

*Comment* This bill is an Omnibus Bill amending the laws of the State in behalf of Crippled Children. While there are sections to which the individual medical man might take exception the bill as a whole cannot be objected to.

It is requested that individual members of the Society or groups thereof, after reading the bill on page 288, will forward their opinions, criticisms or the like to your Legislative Bureau.

#### **Coroner of Westchester County**

Senate Int No 673

A bill introduced in the Senate by Senator Seabury C Mastick of Westchester County, would abolish the office of coroner, Westchester County, and create the office of county medical inspector.

Referred to Internal Affairs Committee.

*Comment* This is a local bill and unless your Legislative Bureau hears from the local County Society, the bill will be dropped.

#### **Penal Law Dissected Body May Be Incinerated**

Senate Int. 681

(Conc Assembly Int 986)—A bill introduced in the Senate by Senator Ernest E Cole of Bath, N Y, concurrent Assembly Int 986 by Assemblyman Irving F Rice of Cortland County, would amend sections 2211, 2215, Penal Law, by providing in cases in which right to dissect dead body is conferred by law, such body may be incinerated, section now requires burial.

Referred to Codes Committee of both houses.

*Comment* Deferred until later.

of nineteen hundred and twenty-three, is hereby amended to read as follows

§ 234 Pharmacies, drug stores, stores Except as prescribed in this article, it shall not be lawful for any person to practice as a pharmacist, druggist, apprentice or storekeeper, or to engage in, conduct, carry on, or be employed in the dispensing, compounding or retailing of drugs, chemicals, medicines, prescriptions or poisons within this state. Every place in which drugs, chemicals, medicines, prescriptions or poisons are retailed, or dispensed or compounded, shall be a pharmacy, a drug store, or a store, shall be under the personal supervision of a pharmacist, a druggist, or a storekeeper and shall be annually registered in the month of January by the board as conducted in full compliance with law and the rules

Every pharmacy shall be owned by a licensed pharmacist and every drug store shall be owned by a licensed druggist, and no copartnership shall own a pharmacy unless all the partners are licensed pharmacists and no copartnership shall own a drug store unless all the partners are licensed druggists, *and except that any corporation heretofore or hereafter organized in this state for such purpose may own and conduct pharmacies or drug stores if a licensed pharmacist be employed in each pharmacy or drug store so owned and conducted, and except that any corporation, organized and existing under the laws of [the state of New York or of] any other state of the United States and authorized to do business in the state of New York and empowered by its charter to own and conduct pharmacies or drug stores, and, at the time of the passage of this act, still owns and conducts a registered pharmacy or pharmacies or a registered drug store or drug stores in the state of New York, may continue to own and conduct the same and may establish and own additional pharmacies or drug stores in accordance with the provisions of this article, but any such corporation which shall not continue to own at least one of the pharmacies or drug stores theretofore owned by it or ceases to be actively engaged in the practice of pharmacy, shall not be permitted thereafter to own a pharmacy or a drug store, and except that any person, not a licensed pharmacist or a licensed druggist, who at the time of the passage of this act owns a registered pharmacy or a registered drug store in the state of New York, may continue to own and conduct the same in accordance with the provisions of this article, and except that the administrator, executor or trustee of the estate of any deceased owner of a registered pharmacy or drug store, or the widow, heirs or next of kin of such deceased owner, may continue to own and conduct such registered phar-*

macy or drug store, in accordance with the provisions of this article

**Pharmacies** It shall be lawful for a pharmacist in conformity with the rules, to take, use and exhibit the titles pharmacist and registered pharmacy and to have charge of, engage in, conduct or carry on for himself or for another the dispensing, compounding, or sale of drugs, chemicals, medicines, prescriptions or poisons anywhere within the state, but he shall have personal supervision of not more than one pharmacy or drug store at the same time

**Drug stores** It shall be lawful for a druggist in conformity with the rules to take, use, and exhibit the titles druggist and registered drug store, and to have charge of, engage in, conduct or carry on for himself or for another the dispensing, compounding or retailing of drugs, chemicals, medicines, prescriptions or poisons anywhere within the state, in a place of not more than one thousand inhabitants, but he shall have charge of not more than one drug store at the same time. He may be employed for the purpose of dispensing or retailing drugs, chemicals, medicines, prescriptions and poisons in a registered pharmacy under the management and personal supervision of a licensed pharmacist, he may also perform such duties during the temporary absence of the pharmacist, except in cities of more than one million inhabitants

**Temporary permits** In places and villages of a thousand inhabitants or less that do not have within three miles a pharmacy or drug store

1 Physicians may compound medicines, fill prescriptions and sell poisons labeled as required by this article

2 Storekeepers may in accord with the rules sell medicines and poisons for a period not exceeding one year upon the payment of a fee of three dollars. The storekeeper's certificate is limited to the village or place where the storekeeper resides and may be limited to the sale of certain classes of poisons sold only in original packages and put up by a licensed pharmacist whose name and business address is displayed on the package

**Stores** It shall be lawful for the storekeeper in conformity with the rules to take, use and exhibit the titles certified storekeeper and registered store and to sell medicines and poisons for a period not exceeding one year in a village or place of the state with less than one thousand inhabitants that has no pharmacy or drug store within three miles of it

Every person practicing as a pharmacist or druggist must at all times display his license conspicuously in his place of business. The proprietor of every pharmacy, drug store or store shall annually in the month of January report under

*Comment* This bill is exactly the same as a bill introduced last year in the Senate by Mr O'Brien, which appeared in the April 11, 1924, NEW YORK STATE JOURNAL OF MEDICINE, and your Legislative Bureau has no objections filed last year to the same. The comment therefore rests the same as last year which was as follows:

"The Medical Society has nothing to fear from such a bill, but believes that ample power now rests with the State Department of Education, and therefore remains neutral on the question unless the bill as amended includes all licensed professions as well as those who are extra jure in relation to certain professions."

**Public Health Establishing Division of Rural Hygiene in State Department of Health**

Senate Int 716 (conc Assembly Int 969)—  
A bill introduced in the Senate by Senator Leigh

G Kirkland of Randolph, N Y, concurrent Assembly Int 969, by Assemblyman Frank H Lattin of Orleans County, would add new article 2-b, Public Health Law, establishing a division of rural hygiene in State Health Department and appropriating \$10,000

Referred to Finance Committee of Senate, and to Ways and Means Committee of Assembly

*Comment* This bill smacks in its title of state medicine and of giving further power to the state health department, though as a copy for printing cannot be obtained for this issue unless at the last moment, your Committee on Legislation would ask that when the bill appears it, and the comment be read carefully

---

IN ASSEMBLY

**Labor Requiring Employers to Furnish Nursery First Aid Service in Factories, Etc.**

Assembly Int No 120—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would add new section 213, Labor Law, requiring employers to furnish nursing first aid service in factories, mercantile, and other establishments

Referred to Labor and Industry Committee

*Comment* No further comment as yet

**Education Providing for Medical Inspection in Schools**

Assembly Int No 127—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would amend sections 570, 571, Education Law, by providing that boards of education and trustees shall appoint physicians and dentists and may employ nurses for service in schools

Referred to Public Education Committee

*Comment* No further comment except that County Chairmen should oppose this bill in its present form, which prescribes "treatment" in its inclusive measures

**Workmen's Compensation Examination After Injury**

Assembly Int No 184—A bill introduced by F A Miller of Kings County, would amend section 118, Workmen's Compensation Law, by authorizing physical examinations and practical tests of claimants to determine loss of use and proportionate loss of use of a member, result and test to be part of record

Referred to Labor and Industry Committee

See concurrent Senate Int No 647, page 275, for digest and comment

**Chiropractic Bill**

Assembly Int No 185—A bill introduced in the Assembly by Assemblyman William Nicoll of Schenectady County, would define and regulate the practice of Chiropractic

Referred to Public Health Committee

*Comment* The concurrent Senate bill has not yet appeared, but that should not deter the continuance of opposition to this vicious form of breaking down the present Public Health Law, in relation to the practice of medicine

**Workmen's Compensation Providing for Compensation for Poisoning by Chlorine, Iodine Derivatives, Etc**

Assembly Int No 201—A bill introduced in the Assembly by Assemblyman Frederick L Hackenberg of New York County, would amend section 3, Workmen's Compensation Law, by providing for compensation for disabilities or death resulting from poisoning by benzine, or by chlorine or iodine derivatives of petroleum products, etc

Referred to Labor and Industry Committee

*Comment* No further comment and unless there be criticism thereof, the bill will be dropped

**Two Narcotic Bills**

Assembly Int No 215 (conc Senate Int 115)—See concurrent Senate Int 115, page 270, for digest and comment

Assembly Int No 216 (conc Senate Int 116)—See concurrent Senate Int 116, page 270, for digest and comment

**Education Providing Supervisors for Educating Children with Retarded Development**

Assembly Int No 229—A bill introduced in

**Public Health Practice of Medicine by Bachelor of  
Medicine from a Foreign Country**

Senate Int No 693

(Conc Assembly No 950)—A bill introduced in the Senate by Senator John L. Karle of Queens County, concurrent Assembly Int 950, by Assemblyman Frank H. Lattin of Orleans County, would amend section 166, Public Health Law, relative to practice of medicine by a bachelor of medicine from a medical school in a foreign country

Referred to Public Health Committee of both houses

February 12, 1925  
Int No 693

IN SENATE,

Introduced by Mr. Karle.

AN ACT\*

To amend the public health law, in relation to the practice of medicine

Section 1 Subdivision five of section one hundred and sixty-six of chapter forty-nine of the laws of nineteen hundred and nine, entitled, "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," as last amended by chapter two hundred and eighty-two of the laws of nineteen hundred and twenty-four, is hereby amended to read as follows

5 Has either received the degree of bachelor or doctor of medicine from some registered medical school in this country or Canada, or the degree of *bachelor or* doctor of medicine from a medical school in a foreign country (remainder—same as old law)

§ 2 This act shall take effect immediately

*Comment* This bill is one which recognizes that in the medical schools of Canada, the degree of bachelor of medicine (M.B.) is synonymous with our American degree of doctor of medicine, and has been introduced for the purpose of recognizing the degrees so given by colleges of equal standing in foreign countries

Unless there be objection in the straightening out of the law, your Bureau will drop this bill

**Public Health Revocation of Licenses to Practice  
Medicine**

Senate Int 701—A bill introduced in the Senate by Senator Nathan Straus, of New York, would add new section 170-a, Public Health Law, empowering Supreme Court to revoke license to practice medicine

Referred to Public Health Committee

Int. No 701

IN SENATE,

Introduced by Mr. Straus

AN ACT

To amend the public health law, in relation to the revocation of licenses to practice medicine by direction of the supreme court.

Section 1 Chapter forty-nine of the laws of nineteen hundred and nine, entitled, "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," is hereby amended by inserting therein a new section, to follow section one hundred and seventy, to be section one hundred and seventy-a to read as follows

§ 170-a Revocation of license by direction of the supreme court In addition to the method prescribed by the preceding section for revocation by the regents, the supreme court shall have power to direct the revocation of the license of a practitioner of medicine as prescribed in this section The state commissioner of health, the local health office, the state board of medical examiners, or a county medical society, may present to the supreme court of the county in which the physician therein mentioned resides, a verified petition alleging that such physician is guilty of fraud or deceit in his practice or is guilty of a crime or misdemeanor or has violated sections eighty or eleven hundred and forty-two of the penal law or is guilty of malpractice or professional misconduct and praying that the license of such physician be revoked The court shall thereupon refer the matter to an official referee, who shall take proofs of the allegations and report to the court, with his findings If the court confirm the report of such official referee it shall make such order as justice may require If the report of such referee and the order confirming the same shall determine that the allegations of the petition have been substantially sustained, such order shall contain a direction to the regents of the University of the State of New York that the license of such physician to practice medicine in this state be revoked by such regents, and his registration annulled, and such regents shall forthwith make such revocation and annulment If the court shall determine that the allegations of the petition have not been substantially sustained the court shall dismiss the petition and may make an order directing the expenses of the proceeding to be paid by the petitioner

§ 2 This act shall take effect immediately

\* Matter in italics is new, matter in brackets [ ] is old law to be omitted

passing the examination, be issued a license valid for six years from the date of such declaration of intention and upon failure of such licensee to furnish evidence of his having actually become a citizen his license shall become invalid and automatically become revoked and his registration shall be annulled. Applicants examined and licensed by other state examining boards registered by the regents as maintaining standards not lower than those provided by this article and applicants who matriculated in a New York state medical school before June fifth, eighteen hundred and ninety, and who received the degree of doctor of medicine from a registered medical school before August first, eighteen hundred and ninety-five, may without further examination, on payment of twenty-five dollars to the regents and on submitting such evidence as they may require, receive from them an indorsement of their licenses or diplomas conferring all rights and privileges of a regents' license issued after examination. The commissioner of education may in his discretion on the approval of the board of regents indorse a license or diploma of a physician from another state, provided the applicant has met all the preliminary and professional qualifications required for earning a license on examination in this state, has been in reputable practice for a period of ten years, and has reached a position of conceded eminence and authority in his profession. Any physician, who was actually engaged in the practice of medicine in this state prior to September first, eighteen hundred and ninety-one, and who failed to register, although eligible to do so at the time, or any physician, whose registration is not legal because of some error, misunderstanding or unintentional omission, may on the unanimous recommendation of the state board of medical examiners that he has submitted satisfactory proof of having complied with all the requirements prescribed by law at the time of his failure to register, or his incomplete registration, receive from the regents under seal a certificate of the facts which may be registered *in accordance with this act* [by any county clerk and shall make valid his registration.] Before any license is issued it shall be numbered and recorded in a book kept in the regents' office, and its number shall be noted in the license, and a photograph of the licensee filed with the records. This record shall be open to public inspection, and in all legal proceedings shall have the same weight as evidence that is given to a record of conveyance of land.

§ 3 Section one hundred and seventy of such chapter is hereby amended to read as follows

§ 170 *Registration* [Registry, revocation of license, annulment of registry. Every licensee to practice medicine shall, before the licensee begins

practice thereunder, be registered in a book kept in the clerk's office of the county where such practice is to be carried on, with name, residence, place and date of birth, and source, number and date of his license to practice. Before registering, each licensee shall file, to be kept in a bound volume in a county clerk's office, an affidavit of the above facts, and also that he is the person named in such license, and had, before receiving the same, complied, with all requirements as to attendance, terms and amount of study and examinations required by law and the rules of the university as preliminary to the conferment thereof, that no money was paid for such license, except the regular fees paid by all applicants therefore, that no fraud, misrepresentation or mistake in any material regard was employed by any one or occurred in order that such license should be conferred. Every license, or if lost a copy thereof legally certified so as to be admissible as evidence, or a duly attested transcript of the record of its conferment, shall before registering, be exhibited to the county clerk, who, only in case it was issued or indorsed as a license under seal by the regents, shall indorse or stamp on it the date and his name preceded by the words "registered as authority to practice medicine in the clerk's office of \_\_\_\_\_ county." The

clerk shall thereupon give to every physician so registered a transcript of the entries in the register with a certificate, under seal that he has filed the prescribed affidavit. The licensee shall pay to the county clerk a total fee of one dollar for registration, affidavit and certificate. The regents shall have power at any and all times to inquire into the identity of any person claiming to be a licensed or registered physician and after due service of notice in writing, require him to make reasonable proof, satisfactory to them, that he is the person licensed to practice medicine under the license by virtue of which he claims the privilege of this article. When the regents find that a person claiming to be a physician, licensed under this article, is not in fact the person to whom the license was issued, they shall reduce their findings to writing and file them in the office of the clerk of the county in which said person resides or practices medicine. Said certificate shall be prima facie evidence that the person mentioned therein is falsely impersonating a practitioner or a former practitioner of a like or different name. The regents may revoke the license of a practitioner of medicine, or annul his registration, or do both, in any of the following cases

(a) A practitioner of medicine who is guilty of any fraud or deceit in his practice, or who is guilty of a crime or misdemeanor, or who is guilty of any fraud or deceit by which he was admitted to practice, or

the Assembly by Assemblyman A Spencer Feld of New York County, would add new section 579-b, Education Law, providing for county supervisors to supervise education of children with retarded mental development

Referred to Public Education Committee

*Comment* No further comment

Assembly Int No 236 (conc Senate Int 228)  
—See concurrent Senate Int 228 for digest and comment

**Workmen's Compensation Permitting Employees to Engage Medical Attendance at Employers' Expense**

Assembly Int No 301 (conc Senate Int 594)  
—A bill introduced in the Assembly by Assemblyman Frank H Lattin of Orleans County, would amend section 13, Workmen's Compensation Law, by permitting injured employees at employers' expense, to engage medical or other attendance

Referred to Labor and Industry Committee

See concurrent Senate Bill Int 594 for digest and comment

**State Department of Education Bill Amending Medical Practice Act**

Assembly Int No 307 (conc Senate Int 211)  
—See concurrent Senate Int 211 for digest and comment

Assembly Int No 386 (conc Senate Int 308)  
—See concurrent Senate Int 308 for digest and comment

Assembly Int No 399 (conc Senate Int 283)  
—See concurrent Senate Int 283 for digest and comment

**Permitting Physicians and Nurses to Disclose Professional Information in Actions to Annul Marriage**

Assembly Int No 422—A bill introduced in the Assembly by Assemblyman Samuel Rosenman of New York County, would amend section 352, Civil Practice Act, by providing physicians and nurses may disclose professional information as witnesses in action to annul marriage on ground of fraud

Referred to Codes Committee

*Comment* It is asked of the County Chairmen whether they have written to the Assembly Committee on Codes in opposition to this bill

Assembly Int No 570 (conc Senate Int 380)  
—See concurrent Senate Int 389 for digest and comment

**Chiropractic Bill**

Assembly Int 649—A bill introduced in the Assembly by Assemblyman Burton D Esmond

of Saratoga County, would amend sections 164, 169, 170, 173, 174, adding new article 8-b, Public Health Law, relative to the practice of medicine, and to chiropractic.

Referred to Public Health Committee

STATE OF NEW YORK

No 710

Int 649

IN ASSEMBLY,

February 3, 1923.

Introduced by Mr Esmond—read once and referred to the Committee on Public Health.

**AN ACT\***

To amend the public health law, in relation to the practice of medicine.

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section one hundred and sixty-four of chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty five of the consolidated laws," is hereby amended to read as follows

§ 164 Expenses The fees derived from the operation of this article, *except as otherwise provided in section one hundred and seventy-three, subdivision five*, shall be paid into the state treasury, and the legislature shall annually appropriate therefrom for the education department an amount sufficient to pay all proper expenses incurred pursuant to this article

§ 2 Section one hundred and sixty-nine of such chapter as last amended by chapter two hundred and eighty-two of the laws of nineteen hundred and twenty-four, is hereby amended to read as follows

§ 169 Licenses On receiving from the state board an official report that an applicant has successfully passed the examinations and is recommended for license, the regents shall issue to him a license to practice according to the qualifications of the applicant Every license shall be issued by the university under seal and shall be signed by the president and secretary of the board and by the officer of the university who approved the credential which admitted the candidate to examination, and shall state that the licensee has given satisfactory evidence of fitness as to age, character, preliminary and medical education and all other matters required by law, and that after full examination he has been found properly qualified to practice Applicants examined and licensed in accordance with the provisions of this act, who, when admitted to the licensing examination, were citizens of a foreign country, and who had declared intention of becoming citizens of the United States, shall, upon

\* Matter in *italics* is new, matter in brackets [ ] is old law to be omitted.

October first of each year, after the first registration, shall mail or cause to be mailed to every physician registered in his office, a blank form of application for registration addressed to the last known post-office address of such physician or may cause such blank form of application to be sent to such physicians through the secretary of any duly incorporated medical society. The form of application shall be such as to contain proper spaces for the insertion by the applicant of the information required under paragraph two of this section.

4 The secretary of the board shall issue to any duly licensed physician in this state, upon his application therefor in accordance with the provisions hereof, a certificate of registration under the seal of the university for the year ensuing and ending December thirty-first.

Upon the first of March in each year, or within ten days thereafter, the secretary of the board shall publish and cause to be mailed to each physician registered hereunder in this state, a printed list of the duly registered physicians in this state and each such published list shall contain at the beginning thereof these words:

"Each registered physician receiving this list is requested to report to the secretary of the board and to the secretary of any duly incorporated county medical society existing in the county of his residence or to the secretary of any incorporated state medical society in which said county medical society is represented, the name and address of any person known to be practicing medicine whose name does not appear in this registry. The names of persons giving such information will not be divulged."

The names of physicians which shall in any year be added to said list after the same shall have been so printed and distributed as aforesaid, shall be reported quarterly to the secretary of any duly incorporated state medical society of which county medical societies are components.

5 Any licensed physician who having failed or neglected to register by January first of any year as required by the provisions of this section shall be required to pay upon registration, in addition to the fee of two dollars, a further fee of one dollar for each thirty days or part thereof, that he is in default, and any licensed physician who engages in practice and wilfully refuses or omits to register hereunder, shall be subject to a civil penalty of one dollar for each day that such wilful refusal or omission shall continue, provided that if the same continues for more than thirty days the penalty thereafter shall be five dollars per day so long as the said wilful refusal or omission shall continue, said penalty shall be recoverable in an action by the attorney-general of the state maintained in the name of the people of the state of New York.

6 The penalties provided in this section for failure, neglect or omission of a duly licensed physician to register under this article shall be the only penalties that may be imposed therefor, and the legality of his license shall not be effected thereby, and such penalties may for good cause shown, in the discretion of the regents, upon the recommendation of the board of medical examiners, be remitted or compromised.

7 Each licensed physician shall conspicuously display his proper registration certificate in his office at all times.

§ 4 Section one hundred and seventy-one of such chapter as amended by chapter fifty-three of the laws of nineteen hundred and fifteen is hereby repealed.

§ 5 Section one hundred and seventy-two of such chapter is hereby renumbered section one hundred and seventy-one.

§ 6 Section one hundred and seventy-three of such chapter as last amended by chapter two hundred and eighty-two of the laws of nineteen hundred and twenty-four is hereby renumbered section one hundred and seventy-two and amended to read as follows:

[173] 172 Construction of this article. [This article shall not be construed to affect commissioned medical officers serving in the United States army, navy or marine hospital service, while so commissioned, or any one while actually serving on the resident medical staff of any legally incorporated hospital, or any one while actually serving as an interne in a state hospital or other state institution in which medical service is provided, or any legally registered dentist exclusively engaged in practicing dentistry, or any person or manufacturer who mechanically fits or sells lenses, artificial eyes, limbs, or other apparatus or appliances, or is engaged in the mechanical examination of eyes, for the purpose of constructing or adjusting spectacles, eyeglasses and lenses, or any lawfully qualified physician in other states or countries meeting legally registered physicians in this state in consultation, or any physician residing on a border of a neighboring state and duly licensed under the laws thereof to practice medicine therein, whose practice extends into this state, and who does not open an office or appoint a place to meet patients or receive calls within this state, or any physician duly registered in one county called to attend isolated cases in another county, but not residing or habitually practicing therein, or the furnishing of medical assistance in case of emergency, or the domestic administration of family remedies, or the practice of chiropody, or the practice of the religious tenets of any church. This article shall be construed to repeal all acts or parts of acts authorizing conferment of any degree in medicine causa

(b) Is an habitual drunkard or habitually addicted to the use of morphine, opium, cocaine, or other drugs having a similar effect, or,

(c) Who undertakes or engages in any manner or by any ways or means whatsoever, to procure or perform any criminal abortion as the same is defined by section eighty of the penal law, or,

(d) Who offers or undertakes by any manner or means to violate any of the provisions of section eleven hundred and forty-two of the penal law

Proceedings for revocation of a license or the annulment of registration shall be begun by filing a written charge or charges against the accused. These charges may be preferred by any person or corporation, or the regents may on their own motion direct the executive officer of the board of regents to prefer said charges. Said charges shall be filed with the executive officer of the board of regents, and a copy thereof filed with the secretary of the board of medical examiners. The board of medical examiners, when charges are preferred, shall designate three of their number as a committee to hear and determine said charges. A time and place for the hearing of said charges shall be fixed by said committee as soon as convenient, and a copy of the charges, together with a notice of the time and place when they will be heard and determined, shall be served upon the accused or his counsel, at least ten days before the date actually fixed for said hearing. Where personal service or service upon counsel can not be effected, and such fact is certified on oath by any person duly authorized to make legal service, the regents shall cause to be published for at least seven times, for at least twenty days prior to the hearing, in two daily papers in the county in which the physician was last known to practice, a notice to the effect that at a definite time and place a hearing will be had for the purpose of hearing charges against the physician upon an application to revoke his license. At said hearing the accused shall have the right to cross-examine the witnesses against him and to produce witnesses in his defense, and to appear personally or by counsel. The said committee shall make a written report of its findings and recommendations, to be signed by all its members, and the same shall be forthwith transmitted to the executive officer of the board of regents. If the said committee shall unanimously find that said charges, or any of them are sustained, and shall unanimously recommend that the license of the accused be revoked or his registration be annulled, the regents may thereupon in their discretion, revoke said license or annul said registration, or do both. If the regents shall annul such registration, they shall forthwith transmit to the clerk of the county or counties in which said accused is registered as a physician, a certificate

under their seal certifying that such registration has been annulled, and said clerk shall, upon receipt of said certificate, file the name and forthwith mark said registration "annulled." Any person who shall practice medicine after his registration has been marked "annulled" shall be deemed to have practiced medicine without registration. Where the license of any person has been revoked, or his registration has been annulled as herein provided, the regents may, after the expiration of one year, entertain an application for a new license in a like manner as original application for licenses are entertained, and upon such new application they may in their discretion, exempt the applicant from the necessity of undergoing any examination.]

1 *Every person now lawfully engaged in the practice of medicine within the state and every person hereafter duly authorized to practice medicine, shall, on or before January first of each year, apply to the secretary of the board of medical examiners for a certificate of registration with the regents of the university upon a blank form which shall be furnished by said secretary and shall pay at such time to said secretary a fee of two dollars, provided that any physician who has registered for five consecutive years hereunder shall register annually without the payment of fee and be so registered during the time he shall thereafter continuously practice medicine in this state*

2 *A physician in making his first registration hereunder shall write or cause to be written upon the application blank so furnished by said secretary, his full name, post-office and residence address, the date and number of his license and such other facts for the identification of the applicant as a licensed practitioner of medicine as the regents may deem necessary and shall duly execute and verify the same before an officer empowered to take acknowledgments of deeds and deliver the same to said secretary by mail or in person. Subsequent registrations after the first registration need not be upon a sworn application by the applicant unless in a particular case the regents, for reasons satisfactory to them, may require that the application be under oath, such subsequent registration shall be made with as little inconvenience to duly licensed practitioners of medicine as possible and to that end the secretary of the board may employ and use in obtaining such subsequent registrations, the assistance of the secretary of duly incorporated medical societies who shall be empowered as a representative of the secretary of the board to receive and transmit such application blanks from physicians after the physicians' first registration, together with the license fees payable upon such applications*

3 *The secretary of the board, on or before*



October first of each year, after the first registration, shall mail or cause to be mailed to every physician registered in his office, a blank form of application for registration addressed to the last known post-office address of such physician or may cause such blank form of application to be sent to such physicians through the secretary of any duly incorporated medical society. The form of application shall be such as to contain proper spaces for the insertion by the applicant of the information required under paragraph two of this section.

4 The secretary of the board shall issue to any duly licensed physician in this state, upon his application therefor in accordance with the provisions hereof, a certificate of registration under the seal of the university for the year ensuing and ending December thirty-first.

Upon the first of March in each year, or within ten days thereafter, the secretary of the board shall publish and cause to be mailed to each physician registered hereunder in this state, a printed list of the duly registered physicians in this state and each such published list shall contain at the beginning thereof these words:

"Each registered physician receiving this list is requested to report to the secretary of the board and to the secretary of any duly incorporated county medical society existing in the county of his residence or to the secretary of any incorporated state medical society in which said county medical society is represented, the name and address of any person known to be practicing medicine whose name does not appear in this registry. The names of persons giving such information will not be divulged."

The names of physicians which shall in any year be added to said list after the same shall have been so printed and distributed as aforesaid, shall be reported quarterly to the secretary of any duly incorporated state medical society of which county medical societies are components.

5 Any licensed physician who having failed or neglected to register by January first of any year as required by the provisions of this section shall be required to pay upon registration, in addition to the fee of two dollars, a further fee of one dollar for each thirty days or part thereof, that he is in default, and any licensed physician who engages in practice and wilfully refuses or omits to register hereunder, shall be subject to a civil penalty of one dollar for each day that such wilful refusal or omission shall continue, provided that if the same continues for more than thirty days the penalty thereafter shall be five dollars per day so long as the said wilful refusal or omission shall continue, said penalty shall be recoverable in an action by the attorney-general of the state maintained in the name of the people of the state of New York.

6 The penalties provided in this section for failure, neglect or omission of a duly licensed physician to register under this article shall be the only penalties that may be imposed therefor, and the legality of his license shall not be effected thereby, and such penalties may for good cause shown, in the discretion of the regents, upon the recommendation of the board of medical examiners, be remitted or compromised.

7 Each licensed physician shall conspicuously display his proper registration certificate in his office at all times.

§4 Section one hundred and seventy-one of such chapter as amended by chapter fifty-three of the laws of nineteen hundred and fifteen is hereby repealed.

§5 Section one hundred and seventy-two of such chapter is hereby renumbered section one hundred and seventy-one.

§6 Section one hundred and seventy-three of such chapter as last amended by chapter two hundred and eighty-two of the laws of nineteen hundred and twenty-four is hereby renumbered section one hundred and seventy-two and amended to read as follows:

[173] 172 Construction of this article [This article shall not be construed to affect commissioned medical officers serving in the United States army, navy or marine hospital service, while so commissioned, or any one while actually serving on the resident medical staff of any legally incorporated hospital, or any one while actually serving as an interne in a state hospital or other state institution in which medical service is provided, or any legally registered dentist exclusively engaged in practicing dentistry, or any person or manufacturer who mechanically fits or sells lenses, artificial eyes, limbs, or other apparatus or appliances, or is engaged in the mechanical examination of eyes, for the purpose of constructing or adjusting spectacles, eyeglasses and lenses, or any lawfully qualified physician in other states or countries meeting legally registered physicians in this state in consultation, or any physician residing on a border of a neighboring state and duly licensed under the laws thereof to practice medicine therein, whose practice extends into this state, and who does not open an office or appoint a place to meet patients or receive calls within this state, or any physician duly registered in one county called to attend isolated cases in another county, but not residing or habitually practicing therein, or the furnishing of medical assistance in case of emergency, or the domestic administration of family remedies, or the practice of chiropody, or the practice of the religious tenets of any church. This article shall be construed to repeal all acts or parts of acts authorizing conferment of any degree in medicine causa

honoris or ad eundem or otherwise than on students duly graduated after satisfactory completion of a preliminary medical course not less than that required by this article as a condition of license ]

*I This article shall not be construed so as to prevent the following. (1) The practice of medicine in this state in obedience with the requirements of the laws of the United States, of any commissioned medical officer serving in the United States army, navy, or public health service while engaged in the performance of the actual duties prescribed for him under the United States statutes or (2) the practice of medicine in a duly incorporated hospital operating pursuant to the state charities law, of a duly appointed member of the resident medical staff or of an interne, or (3) the practice of medicine by any physician duly licensed to practice medicine in a bordering state, who resides on a border of such neighboring state, whose practice extends into this state and who does not open an office or appoint a place to meet patients or receive calls within this state, or (4) any lawfully qualified physician in other states or countries meeting legally registered physicians in this state in consultation, or (5) the furnishing of medical assistance in case of emergency, or (6) the domestic administration of family remedies, or (7) the practice of chiropody, dentistry, chiropractic, or veterinary medicine, provided those practicing are legally authorized and licensed under the laws of this state so to do, or (8) the practice of the religious tenets of any church, or (9) the fitting or selling of lenses, artificial eyes, limbs or other apparatus or appliances by any person or manufacturer of the same or the engaging in the mechanical examination of eyes for the purpose of constructing or adjusting spectacles, eyeglasses and lenses*

*II This article shall be construed to repeal all acts or parts of acts authorizing conferment of any degree in medicine causa honoris or ad eundem or otherwise than on students duly graduated after satisfactory completion of a preliminary medical course not less than that required by this article as a condition of license*

It is further provided that any person who shall be actively engaged in the practice of osteopathy in the state of New York on the thirteenth day of May, nineteen hundred and seven, and who shall present to the board of regents satisfactory evidence that he is a graduate in good standing of a regularly conducted school or college of osteopathy within the United States which at the time of his or her graduation required a course of study of two years or longer, including the subjects of anatomy, physiology, pathology, hygiene, chemistry, obstetrics, diagnosis and the theory and practice of osteopathy, with actual attendance of not less than twenty

months, which facts shall be shown by his or her diploma and affidavit, shall upon application and payment of ten dollars be granted, without examination, a license to practice osteopathy, provided application for such license be made within six months after the thirteenth day of May, nineteen hundred and seven. A license to practice osteopathy shall not permit the holder thereof to administer drugs or perform surgery with the use of instruments. Licenses to practice osteopathy shall be registered in accordance with the provisions of this article, and the word osteopath be included in such registration, and such license shall entitle the holder thereof to the use of the degree D O, or doctor of osteopathy.

§ 7 Section one hundred and seventy-four of such chapter is hereby renumbered section one hundred and seventy-three and amended to read as follows

§[174 Penalties and their collection] 173 Penalties [Any person who, not being then lawfully authorized to practice medicine within this state and so registered according to law, shall practice within this state without lawful registration or in violation of any provisions of this article, and any person who shall buy, sell or fraudulently obtain any medical diploma, license, record or registration, or who shall aid or abet such buying, selling or fraudulently obtaining, or who shall practice medicine under cover of any medical diploma, license, record or registration illegally, obtained, or signed or issued unlawfully or under fraudulent representations or mistake of fact in a material regard, or who, after conviction of a felony, shall attempt to practice medicine, or shall so practice, and any person who shall in connection with his name use any designation tending to imply or designate him as a practitioner of medicine within the meaning of this article without having registered in accordance therewith, or any person who shall practice medicine or advertise to practice medicine under a name other than his own, or any person not a registered physician who shall advertise to practice medicine, shall be guilty of a misdemeanor. Any person who shall practice medicine under a false or assumed name, or who shall falsely personate another practitioner or former practitioner of a like or different name, shall be guilty of a felony. When any prosecution under this article, or under sections eleven hundred and forty-seven of the penal law, and any amendments thereto, is made on the complaint of any incorporated medical society of the state, or any county medical society entitled to representation in a state society, any fines collected shall be paid to the society making the complaint, and any excess of the amount of fines so paid over the expense incurred by the said society in enforcing the medical laws of this

state, shall be paid at the end of the year to the county treasurer ]

1 Any person who shall,

(a) Sell or fraudulently obtain or furnish any medical, chiropractic or osteopathic diploma, license, record or registration, or aid or abet in the same, or

(b) Practice medicine under cover of any diploma, license, record or registration illegally or fraudulently obtained or signed or issued unlawfully or under fraudulent representation or mistake of fact in a material regard, or

(c) Advertise to practice medicine under a name other than his own or under a false or assumed name, and

2 Any person, who not being then lawfully licensed and authorized to practice medicine within this state and so registered according to law, shall

(a) Practice or advertise to practice medicine, or

(b) Use in connection with his name any designation tending to imply or designate him as a practitioner of medicine, or

(c) Use the title "doctor" or any abbreviation thereof in connection with his name or with any trade name in the conduct of any occupation or profession involving or pertaining to the public health, unless duly authorized by law to use the same, and

3 Any person, who during the time his license to practice medicine, shall be suspended or revoked shall practice medicine shall be guilty of a misdemeanor

Such misdemeanor shall be punishable by imprisonment for not more than one year or by a fine of not more than five hundred dollars or by both such fine and imprisonment for each separate violation

4 All courts of special sessions within their respective territorial jurisdictions are hereby empowered to hear, try, and determine such crimes without indictment and to impose in full or in part the punishment of fines and imprisonment herein prescribed

Such misdemeanors shall be prosecuted upon the private information of any person by the district attorney of the county wherein the same are committed

5 The display in any manner or by implication of a sign or an advertisement bearing a person's name as a practitioner of medicine or containing any other matter forbidden by law shall be presumptive evidence in any prosecution or hearing that the person whose name is so borne is responsible for the display of such sign or advertisement and of a holding out and of the practice of medicine by such person for each separate

day such sign or advertisement is anywhere displayed by anyone, but such presumptions are rebuttable by the defense It shall be necessary to prove in any prosecution or hearing under this article only a single act prohibited by law or a single holding out or attempt, without proving a general course of conduct, in order to constitute a violation

6 In any action for damages for personal injuries or death against a person not licensed hereunder for any act or acts constituting the practice of medicine as herein defined, where such injuries or death were contributed to by such act or acts, the fact that such person practiced medicine as herein defined without being duly licensed shall be deemed *prima facie* evidence of negligence

7 All violations of this act when reported to the regents and duly substantiated by affidavits or other satisfactory evidence, shall be investigated and if the report is found to be true and the complaint substantiated, the regents shall report such violation to the attorney-general or district attorney The regents may appoint such inspectors as are necessary at such salaries as the regents may determine within the appropriations made therefor and it shall be the duty of such inspectors under the direction of the regents, to investigate promptly and thoroughly such violations and to procure where possible legal evidence of the same for prosecution of the offenders

§ 8 Article eight of such chapter is hereby amended by adding thereto a new section to be section one hundred and seventy-four, to read as follows

§ 174 Revocation of certificates and annulment of registrations

1 Whenever any practitioner of medicine shall be convicted of a felony, there may be presented to the regents a certified or exemplified copy of the judgment of such conviction thereupon the registration of the person so convicted shall be annulled and his license revoked

Upon reversal of the conviction of such practitioner the regents shall upon receipt of a certified copy of the judgment or order of reversal vacate their order of revocation and annulment of registration but nothing herein contained shall divest the regents of power to proceed against such practitioner under the next subdivision

2 The regents may revoke or suspend the license of a practitioner of medicine and annul his registration or reprimand or discipline as in their discretion they may deem best for the public interest in any of the following cases

Upon finding after due hearing

a That a physician is guilty of fraud or deceit in the practice of medicine or in his admission to the practice of medicine or in his procuring registration, or

b That a physician has been convicted in a

court of competent jurisdiction, either within or without this state, of a crime involving moral turpitude, or

c That a physician is a habitual drunkard, or addicted to the use of morphine, cocaine or other drugs having a similar effect, or has become insane, or

d That a physician is guilty of untrue, fraudulent, misleading or deceptive advertising, or advertising that he can cure diseases which are recognized by the medical profession as incurable, or advertising that he can cure or treat disease by a secret method, procedure, treatment or medicine, or that he can treat, operate or prescribe for any human condition by a method, means or procedure which he refuses to divulge upon demand to the regents, or

e Who undertakes or engages in any manner or by any ways or means whatsoever to procure or perform any criminal abortion as same is defined by the penal law

3 Proceedings for revocation of a license, suspension of a practitioner from practice or the annulment of registration under subdivision two of this section shall be begun by filing a written charge or charges against the accused. These charges may be preferred by any person, corporation or public officer, or by the executive officer of the board of regents. Any charges shall be filed with the commissioner of education and a copy thereof filed with the secretary of the board of medical examiners. The president of the board of medical examiners, when charges are preferred, shall designate three of its members as a committee to hear and determine said charges and such committee shall contain at least one member who represents the same school of practice as the physician against whom the charges are preferred. A time and place for the hearing of said charges shall be fixed by said committee as soon as convenient, and a copy of the charges, together with a notice of the time and place when they will be heard and determined, shall be served upon the accused or his counsel at least ten days before the date actually fixed for said hearing. Where personal service or service upon counsel cannot be effected, and such fact is certified on oath by any person duly authorized to make legal service, the secretary of the board of medical examiners shall cause to be published for at least four times, at least thirty days prior to the hearing, a notice of hearing, in a newspaper published in the county in which the physician was last known to practice, and a copy of such notice shall also be mailed to the accused at his last known address. All such notices of charges shall contain a plain and concise statement of the material facts, without unnecessary repetition, but not the evidence by which the charges are to be proven, with a notification that a stenographic record of such proceedings will be kept and that the accused

will have opportunity to appear either personally or by counsel at the hearing, with the right to produce witnesses and evidence upon his own behalf, to cross-examine such witnesses, to examine such evidence as may be produced against him and to have subpoenas issued by the board. The said committee shall make a written report of its findings and recommendations, to be signed by all its members, and the same shall be forthwith transmitted to the board of regents with the entire record and evidence. If the said committee shall unanimously find that the said charges, or any of them are sustained, and shall unanimously recommend that the license of the accused be revoked or the practitioner suspended from practice, and his registration annulled, or that he be otherwise reprimanded or disciplined, the regents may thereupon in their discretion, revoke or suspend said license and annul said registration or otherwise reprimand or discipline as in their discretion they may deem best for the public interest, provided that no greater penalty than that recommended by said committee be imposed. Where the license of any person has been revoked, or his registration has been annulled as herein provided, the regents may, after the expiration of one year, entertain an application for a restoration of license and registration, in like manner as original applications for licenses are entertained, and upon such new application they may in their discretion exempt the applicant from the necessity of undergoing any examination. The regents may in their discretion restore to good standing any physician who has been suspended from practice.

4 Any licensed practitioner found guilty under the provisions of this section on charges or whose license is otherwise revoked or suspended or registration annulled, or who has been refused registration, or who is otherwise reprimanded or disciplined by the board of regents under this article shall have an order of certiorari for the purpose of receiving such determination returnable before the appellate division of the judicial department where the board of regents made the determination complained of, but no such determination of the board of regents shall be stayed or enjoined except upon application to such appellate division, after notice to the state commissioner of education, and upon a showing that the determination of the board of regents was unwarranted, that the constitutional rights of the applicant have been violated or that the board of regents made its determination without jurisdiction. The board of medical examiners or the board of regents may issue subpoenas and administer oaths pursuant to section sixty-one of the public officers law in connection with any hearing or investigation under this article and it shall be the duty of such boards to issue sub-

poenas at the request of and upon behalf of the defense

§ 7 Such chapter is hereby amended by inserting therein a new article, to follow article eight-a, to be article eight-b, to read as follows

## ARTICLE 8-B

### Chiropractic

#### Section 189 Definitions

- 189-a The New York state chiropractic society, incorporated
- 189-b Board of examiners, organization
- 189-c Powers of board
- 189-d Present practitioners exempt from examination
- 189-e Qualifications of applicants for examination and license
- 189-f Examination of applicants
- 189-g Licenses
- 189-h Waiver of examination
- 189-i Registry of license
- 189-j Display of license and evidence of registration
- 189-k Rights of licensed practitioners
- 189-l Revocation and cancellation of licenses
- 189-m Proceeding for revocation
- 189-n Fines and penalties
- 189-o Violations

§ 189 Definitions As used in this act, "regents" means board of regents of the university of the state of New York "Society" means New York State Chiropractic Society, Incorporated

"Board" means the state board of medical examiners of the state of New York, as provided in section one hundred and sixty-two of the public health law as modified by this act

"Chiropractic school" means any school, college or department of a university teaching and giving instructions in the subjects required for a proper chiropractic standard as herein defined, which schools, upon making proof of giving such teaching and instruction may be registered and approved by the regents

"Proper chiropractic standard" means a course of study extending over a period of twenty-four months, during which an aggregate of at least two thousand one hundred hours of sixty minutes each of instruction is given in the following subjects Anatomy, including histology and embryology, hygiene and sanitation including bacteriology, physiology, biological chemistry including dietetics, diagnosis and symptomatology, pathology, chiropractic analysis, and science and practice of chiropractic

"Practitioner" means one who practices chiropractic

"License" means a license granted and issued by the board of regents of the university of the state of New York under this act to practice chiropractic within this state

"Licensed practitioner" means one who has received a license and is entitled to practice chiropractic within this state under the provisions of this act

The practice of chiropractic is defined as follows A person practices chiropractic within the meaning of this act, who holds himself out as being able to locate and to adjust by hand misaligned or displaced vertebrae of the human spine, for the purpose of relieving nerve pressure caused thereby

§ 189-a The society The New York State Chiropractic Society, Incorporated, is continued, and the officers thereof shall be entitled to hold office until the expiration of their respective terms and the elections and qualifications of their successors, but the existence of said society shall in no way affect the validity of this act

§ 189-b Board of examiners, organization Within twenty days after the first one hundred licenses have been issued under this act, the regents shall appoint one of such licensees as an additional member of the state board of medical examiners Such appointee shall not be a medical doctor Before entering upon his term of office such examiner shall file with the secretary of state his oath of office The term of office shall be three years Before the day when the official term of a member of the board shall expire, the regents shall appoint his successor to serve for a term of three years Such appointment shall be made from the licensed and registered chiropractors of the state The regents in the same manner shall also fill vacancies in the board Such appointee shall not be a doctor of medicine Cause being shown before them, the regents may remove an examiner from office on proven charges of gross misconduct or neglect of duty

§ 189-c Powers of the board 1 Any member of the board may administer oaths, summon witnesses and compel their attendance, and take testimony concerning any matter within the jurisdiction of the board

2 The board of examiners shall, by a majority vote of its members subject to the approval of the regents, make such rules and regulations, not inconsistent with law, as may be necessary for the proper performance of its duties

3 The board of examiners shall have charge of the preparation and grading of examination papers required by this act, which examination shall be uniform in respect of subjects required of applicants for license to practice medicine, and shall hold examinations in at least four places in the state during each calendar year

4 The board shall, after a hearing, upon notice given, recommend to the regents the suspension or revocation of the license of a practitioner and the suspension or annulment of his registration, for any misrepresentation or false or fraud-

ulent statement in his application or examination for a license, for his conviction of a crime involving moral turpitude or for a violation of any of the provisions of this act Upon such recommendation being made the regents may suspend or revoke such license and may suspend or annul such registration Whereupon the practitioner must surrender his license to the regents who shall certify the facts to the county clerk of each county in which the practitioner is registered

5 The board may investigate violations of the provisions of this act and conduct hearings in respect thereto, when, in its discretion, it appears to be necessary, and to bring the same to the notice of any state or county official

§ 189-d Present practitioners exempt from examination For the period of six months after this act takes effect, upon application made in writing and the payment of a fee of ten dollars, the regents shall issue a license, without examination by the board of examiners, to such persons who are twenty-one years of age, of good moral character and otherwise qualified in any one of the following

(a) Graduates after a resident course of two years of six months each, or twelve months altogether, in a school teaching chiropractic, who during the last five years immediately preceeding and at the time of taking effect of this act have been actually engaged in the practice of chiropractic in this state

(b) Graduates after a resident course of three years of six months each, or eighteen months altogether, in a school teaching chiropractic, who during the last three years immediately preceding and at the time of taking effect of this act have been actually engaged in the practice of chiropractic in this state

(c) Graduates after a resident course of two years of four months each, or not less than nine months altogether if taken continuously, in a school teaching chiropractic, who during the last ten years immediately preceding, and at the time of taking effect of this act have been actually engaged in the practice of chiropractic in this state

Proof of the course of study, age and period of practice of each applicant, under subdivisions "a," "b" and "c" of this section, shall be made by the affidavit of the applicant filed with the regents, proof of the good moral character of such applicant shall be made by the affidavit of two reputable citizens, the certificate of the chiropractic school as to such applicant's resident course of study and graduation shall be prima facie proof thereof

§ 189-e Qualifications of applicants for examination and license The board shall admit to the examination for license any applicant who shall have paid to the board of examiners an ex-

amination fee of twenty-five dollars and submitted satisfactory evidence verified by oath or affirmation that he possesses the following qualifications

1 That he is more than twenty-one years of age, and

2 That he is a person of good moral character, and

3 That he has an education equivalent to graduation from a four year high school course registered by the regents or an education accepted by the regents as equivalent, provided such course shall have included elementary biology, elementary physics, elementary chemistry as taught in secondary schools, and

4 That he has actually taken a resident course and graduated from a chiropractic school which maintained during the time of his attendance, a resident course of study extending over a period of twenty-four months, during which course at least two thousand and one hundred hours of sixty minutes each of actual instruction were given, and which included in its curriculum all of the subjects specified in the next section

§ 189-f Examination of applicants All applicants for examination for license shall be required to pass a written examination conducted in the English language in the following subjects Anatomy including histology and embryology, hygiene and sanitation including bacteriology, physiology, biological chemistry including dietetics, diagnosis and symptomatology, pathology, chiropractic analysis, and science and practice of chiropractic The board of examiners shall submit to the regents, as required, a list of questions for examination in the subjects enumerated From these lists the regents shall select questions for all the subjects An additional list of questions shall be submitted by the board, from which the regents shall select a number equal to fifty per centum of the original questions, which additional questions shall be included in the examination on the subjects embryology, histology, anatomy and physiology, and relate exclusively to the nervous system To entitle the applicant to a license he must pass the examination with a rating of at least seventy-five per centum in each subject

§ 189-g Licenses On receiving from the board of examiners an official report that an applicant has successfully passed the examination and is recommended for license, the regents may issue to him a license to practice chiropractic in this state Every license shall be issued by the regents under seal, and shall be signed by the president and secretary of the board of examiners and by an officer of the regents Before any license is issued, it shall be numbered and recorded in a book kept in the regents' office and its number shall be noted in the license This record shall be open to public inspection and in all legal proceedings shall have the same weight

as evidence that is given to a record of conveyance of land. Any license under this act shall entitle the holder thereof to the use of the degree D C or doctor of chiropractic.

**§ 189-h Waiver of examination.** The regents may waive the examination of any applicant for license hereunder who presents satisfactory proof that he has been duly licensed as a practitioner in any other state of the United States having licensing requirements equal to New York state, upon such waiver and the payment of the fee of twenty-five dollars the regents may issue to him a license as provided in section eight of this act.

**§ 189-i Registry of license.** Every licensed practitioner shall before beginning practice under his license, cause such license to be registered in the office of the clerk of the county in which his practice is to be principally carried on, in a book to be provided by the clerk for such purpose, in which shall be entered the name, residence, place and date of birth, number and date of license and an affidavit signed by such licensed practitioner verified before such clerk to the effect that he is the person named in the license, and has complied with all of the provisions of this act. The clerk shall indorse upon such certificate the date and his name, preceded by the words "registered to practice chiropractic, in the clerk's office of \_\_\_\_\_ county." The clerk shall thereupon give to the licensed practitioner so registered a certified transcript under his official seal of the entries in the register. The county clerk shall be paid a fee of one dollar for registration, affidavit and certificate. If the registration of the practitioner be suspended or annulled by the regents, upon receipt of a certificate to that effect the clerk shall stamp upon the record of registry "registration suspended" or "registration annulled" as the case may be with the date of such suspension or annulment. If such registration be thereafter reinstated the clerk shall note that fact on the registration record. If a registered practitioner remove his office or maintain an office in another county he shall register also in such county and notify the board of such fact. He shall present a transcript of registration and pay a fee of twenty-five cents, whereupon the clerk shall endorse thereon "registered also in \_\_\_\_\_ county." "Chiropractors shall annually register under the provisions of the amendment of the medical act requiring all licensed physicians to annually register."

**§ 189-j Display of license and evidence of registration.** Each licensed practitioner must at all times keep conspicuously displayed in his principal office his license and registration certificate, and in any office in which he practices chiropractic his county registration certificate. Every unrevoked license with indorsement of registry thereon shall be presumptive evidence in all courts and places that the person named therein

is legally licensed and registered under the provisions of this act.

**§ 189-k Rights of licensed practitioners.** Each duly licensed practitioner who shall have fully complied with all provisions of this act shall have the right to practice chiropractic within this state and shall be subject to all the disabilities, limitations and restrictions and entitled to the civil rights, privileges and immunities imposed upon and granted to all professional persons by the civil practice act and the judiciary law.

**§ 189-l Revocation and cancellation of licenses.** The regents may revoke the license of a practitioner or annul his registration, or both, in any of the following cases:

(a) A practitioner who is guilty of any fraud or deceit in his practice, or who is guilty of a crime involving moral turpitude, or who is guilty of any fraud or deceit by which he was admitted to practice, or

(b) To an habitual drunkard or habitually addicted to the use of morphine, opium, cocaine, or other drugs having similar effect, or

(c) Who prescribes or administers drugs, or practices surgery or obstetrics, or

(d) Who undertakes to engage in any manner or by any ways or means whatsoever, to procure or perform any criminal abortion as the same is defined by section eighty of the penal law, or

(e) Who offers or undertakes by any manner or means to violate any of the provisions of section eleven hundred and forty-two of the penal law.

**§ 189-m Proceeding for revocation.** Proceedings for revocation of a license or the annulment of registration shall be begun by filing a written charge or charges against the accused. These charges may be preferred by any person or corporation or the regents may on their own motion direct a member of the board of examiners to prefer said charges. Said charges shall be filed with the secretary of the board of examiners. The board of examiners shall hear and determine said charges. A time and place for the hearing of said charges shall be fixed by said board as soon as convenient, and a copy of the charges, together with a notice of the time and place when they will be heard and determined, shall be personally served upon the accused or his counsel, at least ten days before the date actually fixed for said hearing. Where personal service upon counsel cannot be effected, and such fact is certified on oath by any person duly authorized to make legal service, the board shall cause to be published in the manner prescribed for the service by publication of a summons, a notice to the effect that at a definite time and place a hearing will be had for the purpose of hearing charges against the practitioner upon an application to re-



voke his license At said hearing the accused shall have the right to cross-examine the witnesses against him and to produce witnesses in his defense, and to appear personally or by counsel The said board shall make a written report of its findings and recommendations and the same shall be forthwith transmitted to the executive officer of the board of regents If the said board shall find that said charges, or any of them are sustained, and shall recommend that the license of the accused be revoked or his registration be annulled, the regents may thereupon in their discretion, revoke said license or annul said registration, or do both If the regents annul such registration they shall forthwith transmit to the clerk of the county or counties in which said accused is registered as a practitioner, a certificate, under their seal, certifying that such registration has been annulled, and said clerk shall upon receipt of said certificate, file the same and forthwith mark said registration "annulled" Any person who shall practice chiropractic after his registration has been marked "annulled" shall be deemed to have practiced without a registration

§ 189-n Fees and penalties All fees, fines, penalties and other moneys derived from the operation of this act shall be paid into the state treasury and the legislature shall annually appropriate for the department an amount sufficient to pay all proper expenses incurred by them in administering this act, including the salary and expenses of the board

§ 189-o Violations Any person who shall violate any of the provisions of this act shall be guilty of a misdemeanor Any person not duly licensed under this act who engages in the practice of chiropractic shall be guilty of a misdemeanor

§ 8 This act shall take effect January first, nineteen hundred and twenty-six

Comment No concurrent Senate bill has appeared as yet Your Committee on Legislation would especially urge the County Chairmen to forward opposition to this bill to the Committee on Public Health, as the introducer of the same is the one who has always forwarded the interests of cult practice, especially of this cult, and will undoubtedly find an introducer later in the Senate and attempt to pass it in both Houses at the last moment, unless your legislators are made acquainted with its provisions and are unanimous in opposition to it

Assembly Int No 756 (conc Senate Int 530)  
—See concurrent Senate Int 530 for digest and comment

Assembly Int No 748 (conc Senate Int 302)  
—See concurrent Senate Int 302 for digest and comment

Assembly Int No 791 (conc Senate Int. 600)  
—See concurrent Senate Int 600 for digest  
Assembly Int No 802 (conc. Senate Int. 632)  
—See concurrent Senate Int 632 for digest and bill in full

Assembly Int No 850 (conc Senate Int 586)  
—See concurrent Senate Int 586 for digest and printed bill

Assembly Int No 868 (conc Senate Int. 671)  
—See concurrent Senate Int 671 for digest and printed bill

#### Education Crippled Children

STATE OF NEW YORK,  
No 893

Int. 868

IN ASSEMBLY,

February 11, 1926.

Introduced by Mr Boyle—read once and referred to the Committee on Judiciary

#### AN ACT\*

To amend the children's court act of the state of New York, the state charities law and the education law, in relation to physically handicapped persons.

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section two of chapter five hundred and forty-seven of the laws of nineteen hundred and twenty-two, entitled "An act establishing children's courts, defining their jurisdiction, power and duties and regulating procedure therein," as last amended by chapter four hundred and thirty-six of the laws of nineteen hundred and twenty-four, is hereby amended by adding a new subdivision, to be subdivision seven-a, to read as follows

7-a A "physically handicapped child" is one who, by reason of a physical defect or infirmity, whether congenital or acquired by accident, injury or disease, is or may be expected to be totally or partially incapacitated for education or for remunerative occupation

§ 2 Subdivision one of section five of such chapter five hundred and forty-seven of the laws of nineteen hundred and twenty-two is hereby amended to read as follows

1 Children The children's court in each county shall have within such county exclusive original jurisdiction of all cases or proceedings involving the hearing, trial, parole, remand or commitment of children actually or apparently under the age of sixteen years for any violation of law, and in all cases involving juvenile delinquency, children who are material witnesses as provided by law, children who are mental defectives as provided by law, *children who are physically handicapped*, improper guardianship, or neglected children, as provided herein Subject to the limitations herein provided, the court also shall have jurisdiction in proceedings to deter-

\* Matter in italics is new matter in brackets [ ] is old law to be omitted



mine the question of the rightful custody of children whose custody is subject to controversy, as related to their immediate care

The "court" shall have like jurisdiction and authority as is now conferred on "county courts" as concerns "adoption" or and "guardianship"

§ 3 Section twenty-three of such chapter five hundred and forty-seven of the laws of nineteen hundred and twenty-two is hereby amended to read as follows

§ 23 Mental and physical examinations, treatment The court in its discretion, either before or after a hearing, may cause any child within its jurisdiction to be examined by a physician or psychologist appointed or designated for the purpose by the court *In the case of a physically handicapped child the court may accept the certificate of the state department of health as to the need for treatment and care* If it shall appear to the court that any child within its jurisdiction is mentally defective, he may cause such child to be examined as provided in the mental deficiency law and if found to be a mental defective as therein defined, he may commit such child in accordance with the provisions of said law Whenever a child within the jurisdiction of the court and under the provisions of this act appears to the court to be in need of medical or surgical care a suitable order may be made for the treatment of such child in its home, a hospital or other suitable institution, and the expenses thereof, when approved by the court and duly audited, shall be a charge upon the state, the county or the proper subdivision thereof, but the court may adjudicate that the person or persons charged with the liability under the laws to support such child shall pay a part or all of the expenses of such treatment as provided in section forty of this act

§ 4 Section one hundred and thirty of chapter fifty-seven of the laws of nineteen hundred and nine, entitled "An act relating to state charities, constituting chapter fifty-five of the consolidated laws," as last amended by chapter three hundred and sixty-seven of the laws of nineteen hundred and twenty-three, is hereby amended to read as follows

§ 130 Establishment of the New York State Orthopedic Hospital for Children The state hospital, known as the New York State Orthopedic Hospital for Children, established at West Haverstraw, is hereby continued for the care and treatment of any [indigent] children who may have resided in the state of New York for a period of not less than one year, who are crippled or deformed or are suffering from disease from which they are likely to become crippled or deformed No patient suffering from an incurable disease shall be admitted to said hospital Said hospital shall provide for and permit the freedom of religious worship of said inmates to the extent

and in the manner required in other institutions, by section twenty of the prison law

§ 5 The opening paragraph of section one hundred and thirty-two of such chapter fifty-seven of the laws of nineteen hundred and nine, as last amended by chapter four hundred and forty-nine of the laws of nineteen hundred and ten, is hereby amended to read as follows

§ 132 Powers and duties of board of managers The board of managers shall have the general direction and control of the property and affairs of said hospital, which are not otherwise specially provided by law, subject to the inspection, visitation and powers of the state board of charities They may acquire and hold, in the name of and for the people of the state of New York, by grant, gift, devise or bequest, property to be applied to the maintenance of [indigent] children who are crippled or deformed or are suffering from diseases through which they are likely to become crippled or deformed, in and for the general use of the hospital *They may receive or collect from parents, guardians or other persons moneys in payment, wholly or in part, for the care and treatment of patients in the hospital or for braces, crutches or other appliances, and shall transmit any moneys so received to the state treasurer*

They shall

§ 6 Section one hundred and thirty-six of such chapter fifty-seven of the laws of nineteen hundred and nine, as thus renumbered by chapter four hundred and forty-nine of the laws of nineteen hundred and ten and last amended by chapter one hundred and seventy-two of the laws of nineteen hundred and eleven, is hereby amended to read as follows

§ 136 [Who may receive treatment] *Admission and discharge of patients* No patient shall be received except [upon application of a county superintendent of the poor or commissioner of charities in any county or city within the state,] under rules to be established by the board of managers [showing that the patient is unable to pay for private treatment] *Such rules shall provide for preferential admission of children whose parents or those bound by law to maintain them are unable to pay full charges for surgical treatment and hospital care* If there was an attending physician before the patient entered the hospital, [it shall be accompanied by the] a certificate of such physician giving previous history and condition of the patient shall accompany the patient upon his admission to the hospital The superintendent shall have authority, subject to rules established by the board of managers, to discharge any patient at his discretion A written record shall be kept showing as to each pa-

*tient his condition upon admission to the hospital, the treatment given him and the results thereof, his condition at time of discharge and the reason for such discharge. The state advisory commission for physically handicapped persons shall have access to such records at all reasonable times*

§ 7 Section two hundred and seventy-five of chapter twenty-one of the laws of nineteen hundred and nine, entitled "An act relating to education, constituting chapter sixteen of the consolidated laws," as last amended by chapter one hundred and forty of the laws of nineteen hundred and ten, is hereby amended by adding a new subdivision, preceding the closing paragraph, to be subdivision twenty, to read as follows

*20 To provide for physically handicapped children, transportation, home teaching, special classes or special schools, scholarships in non-residence schools, tuition or tuition and maintenance in elementary, secondary, higher, special and technical schools, and on recommendation of the state department of health, surgical, medical or therapeutic treatment, hospital care, crutches, braces and other appliances*

§ 8 Section three hundred and ten of such chapter twenty-one of the laws of nineteen hundred and nine, as last amended by chapter one hundred and forty of the laws of nineteen hundred and ten, is hereby amended by adding a new subdivision to be subdivision twenty-three, to read as follows

*23 To provide for physically handicapped children, transportation, home teaching, special classes or special schools, scholarships in non-residence schools, tuition or tuition and maintenance in elementary, secondary, higher, special and technical schools, and on recommendation of the state department of health, surgical, medical or therapeutic treatment, hospital care, crutches, braces and other appliances*

§ 9 Section five hundred and seventy-three of such chapter twenty-one of the laws of nineteen hundred and nine, as added by chapter six hundred and twenty-seven of the laws of nineteen hundred and thirteen, is hereby amended to read as follows

§ 573 Examinations by medical inspection. Each principal or teacher in charge of a public school shall report to the medical inspector having jurisdiction over such school the names of all pupils who have not furnished health certificates as provided in the preceding section, or who are physically handicapped children as defined by article one of the children's court act, and the medical inspector shall cause such pupils to be separately and carefully examined and tested to ascertain whether any of them are suffering from defective sight or hearing or from any other physical disability tending to prevent them from receiving the full benefit of school work, or re-

quiring a modification of such work to prevent injury to the pupils or to receive the best educational results. If it be ascertained upon such test or examination that any of such pupils are afflicted with defective sight or hearing or other physical disability as above described the principal or teacher, having charge of such school, shall notify the parents or other persons with whom such pupils are living, as to the existence of such defects and physical disability. If the parents or guardians are unable or unwilling to provide the necessary relief and treatment for such pupils, such fact shall be reported by the principal or teacher to the medical inspector, whose duty it shall be to provide relief for such pupils.

§ 10 The opening paragraph and subdivision four of section six hundred and fifty of such chapter twenty-one of the laws of nineteen hundred and nine, as last amended by chapter four hundred and eighty of the laws of nineteen hundred and fourteen, are hereby amended to read as follows

§ 650 School census in cities of the first class, except the city of New York. A permanent census board is hereby established in each city of the first class, except the city of New York. In the city of New York provision shall be made by the board of education for taking a school census in connection with the work of enforcing the compulsory education law. Such permanent census board shall consist of the mayor, the superintendent of schools, the police commissioner or officer performing duties similar to those of a police commissioner. The mayor shall be the chairman of such board. Such board shall have power to make such rules and regulations as may be necessary to carry out the provisions of this article. Such board shall have power to appoint a secretary and such clerks and other employees as may be necessary to carry out the provisions of this article and to fix the salaries of the same. Such board shall ascertain through the police force, the residences and employments of all persons between [the ages of four] birth and eighteen years of age residing within such cities, and shall ascertain with regard to each whether or not he be blind or deaf or have any crippling condition and shall report thereon from time to time to the school authorities of such cities. These children having some crippling condition such board shall report by name, age and address to the advisory commission for physically handicapped persons. Under the regulations of such board, during the month of October, nineteen hundred and nine, it shall be the duty of the police commissioners in such cities of the first class to cause a census of the children of their respective cities to be taken. Thereafter such census shall be amended from day to day by the police, precinct by precinct, as

changes of residence occur among the children of such cities within the ages prescribed in this article and as other persons come within the ages prescribed herein and as other persons within such ages shall become residents of such cities, so that said board shall always have on file a complete census of the names and residences of the children between such ages and of the persons in parental relation thereto. It shall be the duty of persons in parental relation to any child residing within the limits of said cities of the first class to report at the police station house of the precinct within which they severally reside, the following information:

4 In case a child between [the ages of four] *birth* and eighteen years of age becomes a resident of one of said cities of the first class for the first time the residence and such other facts as the census board shall require. Such census shall include all persons between [the ages of four] *birth* and eighteen years of age, the day of the month and the year of the birth of each of such persons, their respective residences by street and number, the names of their parents or guardians, such information relating to *physical defects*, to illiteracy and to the enforcement of the law relating to child labor and compulsory education as the school authorities of the state and of such cities shall require and also such further information *including names and addresses of children having physical defects* as such authorities shall require.

§ 11 Section six hundred and fifty-two of such chapter twenty-one of the laws of nineteen hundred and nine, as last amended by chapter one hundred of the laws of nineteen hundred and nineteen, is hereby amended to read as follows:

§ 652 School census in school districts. The trustee or board of trustees of every school district shall annually on the thirtieth day of August cause a census to be taken of all children between [the ages of five] *birth* and eighteen [to] years of age including all such facts and information as are required in the census provided for in section six hundred and fifty of the education law. This census shall be taken in duplicate in their respective school districts, and one copy thereof filed with the teacher on the first day of school and the other copy filed with the district superintendent on or before the fifteenth day of September. Such census shall include the reports and information required from cities as provided in section six hundred and fifty of this article.

§ 12 Section six hundred and fifty-three of such chapter twenty-one of the laws of nineteen hundred and nine, as last amended by chapter one hundred and forty of the laws of nineteen hundred and ten, is hereby amended to read as follows:

§ 653 Penalty for withholding information. A parent, guardian or other person having under his control or charge a child between [the ages of four] *birth* and eighteen years of age who withholds or refuses to give information in his possession relating to such child and required under this article, or any such parent, guardian or other person who gives false information in relation thereto, shall be liable to and punished by a fine not exceeding twenty dollars or by imprisonment not exceeding thirty days.

§ 13 Subdivision two of section ten hundred and twenty of such chapter twenty-one of the laws of nineteen hundred and nine, as added by chapter five hundred and fifty-nine of the laws of nineteen hundred and seventeen and last amended by chapter three hundred and seventy-eight of the laws of nineteen hundred and eighteen, is hereby amended to read as follows:

2 The board of education of each city and of each union free school district shall furnish suitable educational facilities for deaf, blind, crippled or otherwise physically defective children by means of home-teaching, transportation to school or by special classes. The need of the individual child shall determine which of the indicated services shall be rendered [in which there] Where there are ten or more children who are deaf, blind, crippled or otherwise physically defective such board shall establish such special classes as may be necessary to provide instruction adapted to the mental attainments and physical conditions of such children. Provided, however, that in each city or union free school district in which schools for the deaf, blind, crippled or otherwise physically defective now exist or may hereafter be established, which are incorporated under the laws of the state and are found by the board of education to be adequate to provide instruction adapted to the mental attainments and physical conditions of such children, the board of education shall not be required to supply additional special classes for the children so provided for.

The board of education of such cities or union free school districts is hereby authorized and empowered to contract with such schools for the education of such children in special classes therein.

§ 14 Subdivision three of section ten hundred and twenty of such chapter twenty-one of the laws of nineteen hundred and nine, as added by chapter five hundred and fifty-nine of the laws of nineteen hundred and seventeen, is hereby amended to read as follows:

3 The board of education of each city and of each union free school district, and the board of trustees of each school district, which contains less than ten children who are deaf, blind, crippled or otherwise physically defective, shall fur-

*nish suitable educational facilities for such children by means of home-teaching, or transportation to school. The needs of the individual child shall determine which of the indicated services shall be rendered [is hereby]. Such board is also authorized and empowered to contract with the board of education of another city or school district for the education of such children in special classes organized in the schools of the city or district with which such contract is made.*

§ 15 Subdivision four of section ten hundred and twenty of such chapter twenty-one of the laws of nineteen hundred and nine, as added by chapter one hundred and ninety-three of the laws of nineteen hundred and twenty-four, is hereby amended to read as follows

4 [If] *When* the board of education of a city or union free school district establishes one or more special classes for the instruction of deaf, blind, crippled or otherwise physically defective children, as provided in this article, and shall employ one or more teachers for the instruction thereof, the commissioner of education shall apportion to such city or district, in the same manner as teachers' quotas are apportioned thereto, an amount equal to one-half the salary paid to each of such teachers, but not to exceed one thousand dollars (\$1,000) for each teacher so employed. *He shall also apportion to such city or district an amount equal to one-half the cost of transportation furnished for blind, crippled or otherwise physically defective children.* No such apportionment shall be made on account of a teacher so employed unless there shall have been issued to such teacher by the commissioner of education a certificate authorizing such teacher to teach such special classes or unless such teacher shall possess the qualifications prescribed by the commissioner of education

§ 16 Section twelve hundred, subdivisions one and four of section twelve hundred and one and sections twelve hundred and two and twelve hundred and three of such chapter twenty-one of the laws of nineteen hundred and nine, as added by chapter seven hundred and sixty of the laws of nineteen hundred and twenty, are hereby amended to read as follows

§ 1200 Short title This article shall be known and may be cited as "the [rehabilitation] physically handicapped law"

§ 1201 Definitions As used in this article the terms

1 "Physically handicapped person" shall mean any person who, by reason of a physical defect or infirmity, whether congenital or acquired by accident, injury or disease, is or may be expected to be totally or partially incapacitated for *education or for remunerative occupation*

4 "Commission" shall mean the advisory commission for [the rehabilitation of] physically handicapped persons

§ 1202 Limitation of article This article shall not apply to

1 Aged persons or [helpless] persons *over the age of twenty-one years* requiring permanent, custodial care, or blind persons under the care of the state commission for the blind, or

2 Any person [in any state institution or,] confined in any [correctional or] penal institution, or

3 Epileptic, *insane* or feeble-minded persons or to any person who, in the judgment of the commissioner of education, may not be susceptible of rehabilitation [, or

+ Persons of the age of fourteen years and under]

§ 1203 [State] *An* advisory commission for [the rehabilitation of] physically handicapped persons There is hereby [created] *continued* an advisory commission for [the rehabilitation of] physically handicapped persons, to be composed of the commissioner of education, who shall be chairman, of [a member of] the state industrial commissioner, [to be designated annually by the governor, and] of the commissioner of health and of the *president of the state board of charities*. Any member of the commission may designate an officer in his department to represent him on the commission and the acts of such officer shall be deemed to be the acts of the person who designated him. The commissioner of education shall designate the officer of the department of education charged with the administration of this act to act as secretary of the commission

§ 17 Such chapter twenty-one of the laws of nineteen hundred and nine, as amended by chapter one hundred and forty of the laws of nineteen hundred and ten, is hereby amended by adding a new section, to be section twelve hundred and three-a, to read as follows

§ 1203-a Purpose of the commission *The purpose of the commission shall be*

1 *To rehabilitate persons needing and capable of rehabilitation*

2 *To stimulate all private and public efforts and to co-ordinate them with the work and functions of governmental agencies designed to relieve, cure, or educate physically handicapped children*

§ 18 The opening paragraph of section twelve hundred and four of such chapter twenty-one of the laws of nineteen hundred and nine, as added by chapter seven hundred and sixty of the laws of nineteen hundred and twenty, is hereby amended to read as follows

§ 1204 Power of the commission *The commission shall have power and it shall be its duty*

§ 19 Section twelve hundred and four of such chapter twenty-one of the laws of nineteen hundred and nine, as added by chapter seven hundred and sixty of the laws of nineteen hundred and twenty, is hereby amended by adding two new subdivisions, to be subdivisions seven and eight, to read as follows

7 To carry out the provisions of section twelve hundred and three-a of this article

8 To maintain a register of physically handicapped children and to use all means and measures necessary to insure that the physical and education needs of such children are adequately met, as provided by law

§ 20 Section twelve hundred and six of such chapter twenty-one of the laws of nineteen hundred and nine, as added by chapter seven hundred and sixty of the laws of nineteen hundred and twenty, is hereby amended by adding two new subdivisions, to be subdivisions four and five, to read as follows

4 Make physical examination of physically handicapped children prospectively or actually incapacitated for the normal pursuit of an education, and make recommendations for treatment

5 On its own initiative or on request of the commission provide such surgical, medical or therapeutic treatment or hospital care and necessary appliances and devices for physically handicapped children as in its judgment are needed

§ 21 Section twelve hundred and eight of such chapter twenty-one of the laws of nineteen hundred and nine, as added by chapter seven hundred and sixty of the laws of nineteen hundred and twenty, is hereby amended by adding a new subdivision, to be subdivision eleven, to read as follows

11 To provide home-teaching, transportation, scholarships in non-residence schools, tuition, or maintenance and tuition in elementary, secondary, higher, special and technical schools, for physically handicapped children, in whole or in part from funds of the department, when not otherwise provided by parents, guardians, local authorities or by other sources public or private

§ 22 Such chapter twenty-one of the laws of nineteen hundred and nine, as amended by chapter one hundred and forty of the laws of nineteen hundred and ten, is hereby amended by adding a new section to be section twelve hundred and eight-a, to read as follows

§ 1208-a Duty of the state board of charities It shall be the duty of the state board of charities to report to the advisory commission for handicapped persons from time to time handicapped persons in institutions under the supervision of organizations coming under the visitation of the board and such other information as the board deems advisable

§ 23 The titles to article thirty-nine-a and section ten hundred and twenty of such chapter twenty-one of the laws of nineteen hundred and nine, as added by chapter five hundred and fifty-nine of the laws of nineteen hundred and seventeen, are hereby amended to read as follows  
*[Physically Defective Children] Home-Teaching and Special Classes*

§ 1020 Physically [defective] handicapped children

§ 24 The title to article forty-seven of such chapter twenty-one of the laws of nineteen hundred and nine, as added by chapter seven hundred and sixty of the laws of nineteen hundred and twenty, is hereby amended to read as follows

*[Rehabilitation] Physically Handicapped Persons*

§ 25 In addition and supplemental to the appropriations which shall be made in the appropriation act of nineteen hundred and twenty-five for the purpose of carrying out the powers and duties prescribed in article forty-seven of the education law for the fiscal year beginning July first, nineteen hundred and twenty-five, there is hereby appropriated, from any moneys in the treasury not otherwise appropriated, the sum of one hundred thousand dollars (\$100,000), or so much thereof as may be necessary, to the department of education and the sum of fifty thousand dollars (\$50,000), or so much thereof as may be necessary, to the department of health

§ 26 This act shall take effect July first, nineteen hundred and twenty-five

See comment on Senate Int 671, on page 275

#### Railway Emergency Kits

Assembly Int No 870—A bill introduced in the Assembly by Assemblyman Maurice Z. Bungard of Brooklyn, N Y, would add new section 71-a, Railroad Law, requiring railroads to provide each passenger car with kit containing bandage, medicated cotton, spirits of ammonia, flashlight and peroxide

Referred to Public Service Committee

Comment This bill is the same as was introduced by the same Assemblyman last year and your Committee on Legislation has nothing to say concerning it

#### Penal Sale of Wood Alcohol

Assembly Int No 908—A bill introduced in the Assembly by Assemblyman Frank H. Lattin of Orleans County, would add new sections 446, 447, 447-a, Penal Law, forbidding sale of wood or methyl alcohol, except as methanol, and making it a felony to sell food or drink or medicinal or toilet preparations for internal use in which there is methanol

Referred to Codes Committee

February 11, 1925

Int No 908

IN ASSEMBLY

## AN ACT

Introduced by Mr Lattin—To amend the penal law, in relation to the name, sale, use and labeling of methanol, formerly known as wood naphtha, wood alcohol or methyl alcohol

Section 1 The penal law is hereby amended by inserting therein at the end of article forty, three new sections to be sections four hundred and forty-six, four hundred and forty-seven and four hundred and forty-seven-a, to read as follows

§ 446 On and after September first, nineteen hundred and twenty-five, the liquid known as wood naphtha, otherwise known as wood alcohol or methyl alcohol, either crude or refined, whatever may be the name or trade mark under or by which the said liquid may be called or known, shall hereafter be designated and known as methanol, and the use of the terms wood naphtha, wood alcohol, methyl alcohol, or any other term or designation of the liquid, except methanol, is forbidden and shall be discontinued

§ 447 Any person who shall sell, offer for sale, give away, deal in, or supply, or have in his or her possession with intent to sell, offer for sale, deal in, or supply, any article of food or drink, or any medicinal or toilet preparation intended for internal human use which contains methanol, either crude or refined, whatever may be the name or trade mark under or by which methanol was formerly called or known, is guilty of a felony

§ 447-a No person shall sell, offer for sale, give away, deal in, or supply, or have in his or her possession with intent to sell, offer for sale, give away, deal in, or supply, any methanol, either crude or refined, whatever may have been the name or trade mark under or by which methanol was heretofore called or known, unless the container in which the same is sold, offered for sale, given away, dealt in, or supplied, shall have imprinted upon said container, or upon a label pasted upon the container, the following device and words, in bold characters in red colors, viz

(Skull and cross bones represented)

## POISON

WARNING—It is unlawful to use this fluid in any article of food, beverage, or medicinal or toilet preparation, intended for internal human use

Any violation of the provisions of this section shall be a felony

§ 2 This act shall take effect September first, nineteen hundred and twenty-five.

*Comment* This bill your Medical Society

should favor, in the opinion of the Committee on Legislation, inasmuch as it will clarify a situation which has occurred in all professions which have the handling of wood so called, methyl alcohol.

## Public Health Reciprocity of Licensure

Assembly Int No 925—A bill introduced in the Assembly by Assemblyman Edward J Coughlin of Brooklyn, N Y, would amend section 169, Public Health Law, relative to licensees to practice medicine who have received license in another state

Referred to Public Health Committee

Int No 925

IN ASSEMBLY,

## AN ACT\*

Introduced by Mr Coughlin.—To amend the public health law, in relation to the qualification of licensees to practice medicine

Section 1 Section one hundred and sixty-nine of chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health—constituting chapter forty-five of the consolidated laws," as last amended by chapter two hundred and eighty-two of the laws of nineteen hundred and twenty-four, is hereby amended to read as follows

§ 169 Licenses On receiving \* \* \* provided by this article and applicants who [matriculated in a New York state medical school before June fifth, eighteen hundred and ninety, and who received the degree of doctor of medicine from a registered medical school before August first, eighteen hundred and ninety-five, may], *having received a license in another state after graduation from a registered medical school prior to August first, nineteen hundred, have practiced their profession in another state or states for fifteen years or more,* shall without further examination \* \* \*

Section 2 This act shall take effect immediately

\* \* \* indicate same as old law

*Comment* No comment as yet, but from the wording of the bill your Committee will attempt to ascertain the reason of its introduction and advise the members later of the purport of the bill

Assembly Int No 940 (conc Senate Int 629)  
—See concurrent Senate Int 629 for digest

Assembly Int No 950 (conc Senate Int 693)  
—See concurrent Senate Int. 693 for digest

Assembly Int. No 969 (conc Senate Int 716)  
—See concurrent Senate Int 716 for digest.

\* Matter in italics is new matter in brackets [ ] is old law to be omitted.

**Public Health Giving State Department of Health  
Fiscal Control of State Institute on Study of  
Malignant Disease**

Assembly Int 973—A bill introduced in the Assembly by Assemblyman Julius S. Berg of Bronx County, would amend section 345, Public Health Law, by giving State Health Department fiscal control of State Institute for Study of Malignant Disease

Referred to Ways and Means Committee

*Comment* This is a local bill and except as we shall hear from the Council or Executive Committee of the State Society we shall not take any action even though the future policies of the State Institute may be changed under regulations issuing from the State Department of Health which might affect physicians

---

**HEARINGS**

Wednesday, March 4th, at 2 P M in Assembly Chamber

Joint hearing before Senate and Assembly Public Health Committees Bills to be considered

Senate 211, conc Assembly 307—Amending Medical Practice Act (Karle and Dunmore)

Senate 473—Drugless Therapy (Gibbs)

Assembly Int 649—Chiropractic Bill (Esmond)

Assembly Int 185—Chiropractic Bill (Nicolli)

*Note*—For the information of County Chairmen and members of the Society

In the Senate to February 14th, there have been introduced 727 bills

In the Assembly to February 14th, there have been introduced 986 bills



# State Department of Health



## INDEFINITE DIAGNOSES SHOULD BE CHECKED UP

The busy practitioner occasionally is called upon to see a patient, makes a more-or-less hasty examination, calls the case one of grippe, leaves some medicine or a prescription and doesn't see the patient again. Although perhaps in most instances such a procedure does not result in harm, either to the patient or to others, sometimes such a sin of omission may have serious consequences.

Not long ago there came to the attention of the Department a case of this sort, in which the patient was subsequently found to have smallpox, but, in the meantime, others had been exposed to

the patient and an outbreak of smallpox resulted.

More recently, a physician was called to see a child who was vomiting and who had indefinite, grippy pains and a temperature of 101°. No second call was made by the doctor, who called it "grippe." Three weeks later, the father of the child brought her to the doctor and it was then found that she had a definite paralysis of the right arm, due to poliomyelitis.

These instances suggest the advisability of checking up on all cases with indefinite, acute febrile conditions.

## HEALTH OFFICER GIVES ADVICE ON FAINTING

Dr. Mortimer B. Downer, Health Officer of the Town of Woodstock, Ulster County, is the author of a series of interesting, popular articles on medical subjects which are appearing in his local paper, *The Woodstock Weekly*.

Writing on "Fainting," he gave the following very sensible advice:

"If you want to assist a person that has fainted, do not do, I beg of you, as the hero does in the movies when the leading lady faints. He rushes to her prostrate form and with his strong arms sits her up or stands her on her feet. She promptly recovers and 'comes back to life.' If fainting persons are lying prone, allow them to lie in this position. If they are lying

on their faces, turn them on their backs. If they are in a sitting position, lower their heads, and, if you can get their heads lower than their bodies, so much the better. These measures will allow more blood to flow to the bloodless brain." Dr. Downer follows this with further simple advice, familiar to physicians and which we shall not repeat in these columns.

Dr. Downer is a rural health officer, the only physician in his town. He is one of the comparatively few who are taking advantage of their opportunities to promote public health education among the people, for whose health they are responsible.

## IT PAYS TO INVESTIGATE ADULT CHICKENPOX

Recently a child was reported to the health officer of Amsterdam as a case of chickenpox, but, through error, the attending physician stated the age of the patient as 25 years. As it is a rule in that city to investigate all adult cases of chickenpox, this one was looked up, as a matter of routine, and it was found that there was not only a mistake in the age, but also in diagnosis. The case was one of smallpox and it probably would have remained undiscovered, except for the error in stating the age.

Within the same week, two other cases of chickenpox in adults were reported, these were also examined by the city health officer and the district state health officer and both were found to be cases of smallpox. One of them denied having had prodromal symptoms, but it was found that eight days previously this man had been reported to the health department as suffering with influenza.

## PLUMBISM IN AN INFANT

In the January, 1925, *Industrial Hygiene Bulletin*, published by the New York State Department of Labor, note is made of a case of plumbism in a nursing mother, caused by using a lead nipple shield. We made further inquiry about this case, particularly regarding the baby, and find that lead was recovered from the mother's

milk and that "the infant showed stippling of the red blood cells, anemia and other signs of lead poisoning."

Presumably, the baby became poisoned directly from the lead nipple, while in the case of the mother the absorption was through the skin or mammary tissue, or both.



# NEWS NOTES

## ALLERGY AND PRE-ASTHMATIC CONDITIONS IN PERIODIC HEALTH EXAMINATIONS

By ROBERT A. COOKE, M.D.,

NEW YORK CITY

Abstract of the Thirteenth Lecture in the Symposium on Health Examinations, conducted by the Medical Society of the County of New York, given January 27, 1925

By the words "hypersensitiveness" and "allergy" we mean the abnormal clinical response to absorbed substances, and we consider that a response is abnormal when it is obtainable in only a small percentage of persons. An example is the occasional acute symptoms, such as swellings, urticaria, vomiting, purging, dyspnoea, cyanosis, and collapse, produced in infants by eggs.

The substances which produce allergy may enter the body, 1, by the inhalation of pollen, or animal dander, and other air-borne dust, 2, by foods or drugs swallowed, 3, through the skin, as by drugs, or poison ivy, or the subcutaneous injection of serums, and 4, from foci of chronic infections.

The tissues affected are essentially those of epiblastic origin—the skin, and the mucous membranes of the respiratory and digestive tracts.

The skin manifestations are urticaria, angio-neurotic edema, eczema, dermatitis, or vesicular, erythematous, and papular lesions.

A common manifestation in the upper respiratory tract is hay fever, or rhinitis.

The typical manifestation in the bronchi is asthma.

The manifestations in the digestive tract are acute food poisoning as shown by vomiting, purging, and cyanosis, and often collapse. The symptoms may be confined to a portion of the tract and appear as gastritis, enteritis, or colitis. In some cases they are not acute, but are mild and appear as anorexia, under nutrition, nervous irritability, and sleeplessness. When these symptoms appear in childhood, the children are always below par in weight, bone, and muscle development, and mental activity. At times the clinical symptoms are paroxysmal and explosive, as in the periodic vomiting of children. The chronic, and some of the acute symptoms of food allergy are caused by some of the more commonly used foods and often to some particular food toward which the child has an instinctive dislike.

The special object of this talk is two fold, first, how can we recognize the allergies in their pre-clinical or developmental stage and, second, what measures can be taken to thwart the development or manifestation of the clinical symptoms.

These conditions are common, and every phy-

sician who makes a worthy periodic health examination must inquire into them.

There is a hereditary element in the causation of allergy. In the investigation of several hundred normal individuals, a history of allergy was found in the ancestors of only seven per cent, while in 796 allergic cases, 58 per cent had ancestors who gave a positive allergic history.

When both parents of an allergic case gave a history of allergy, the clinical symptoms of 89 per cent began before the age of ten years.

When one parent was allergic, 31 per cent of the cases began before the age of ten.

When no inheritance was evident, only 20 per cent of the cases showed symptoms before 10 years of age. The more complete the inheritance, the earlier was the age of onset.

Among children who have an allergic inheritance from both parents, 70 per cent will be likely to show allergy, while if only one parent is allergic only 58 per cent will be allergic.

A positive family history of allergy should arouse suspicion as to the nature of disease manifestations in a child.

The clinical manifestations of allergy are often different from those in the parent. The inheritance is not of the condition itself, but rather a tendency to some allergic state.

The majority of allergic cases will react to more than one substance. Some are known to react to twenty-five substances.

An individual may show only one clinical manifestation to many different substances. He may have asthmas from pollen and show angio-neurotic edema from fish or shell fish. An infant may give a clear history of egg allergy, which is later replaced by an asthma from dander, and still later the individual may become sensitive to pollen and have seasonal hay fever.

The diagnosis and management of these changing and complicated cases is often difficult.

Asthma is probably the most common and important of the recognized allergies, because, 1, it tends to a chronic condition which interferes seriously with education work and comfort, and 2, the complications and sequelae are many and serious, and include emphysema, chronic infections of the respiratory tract and chronic infection of the paranasal sinuses.

The causative factors of asthma vary with the age of onset. Rarely do pollens or animal danders cause trouble before the third year of age. An offending food usually produces symptoms the first time it is taken. Children subject to food allergy may have eczema which is severe and protracted.

Attacks of asthma in infants caused by infection are gradual in development, and the infection is limited to the upper respiratory tract and bronchi. They usually begin with frequent attacks of bronchitis with increasing wheezing until they finally become true asthma. These infants usually have definite lymphoid hyperplasia in the pharynx and tonsils.

Asthma that develops from the third to the thirtieth year is usually caused by air-borne substances, and the onset is gradual. Usually the first symptoms are coryza, later colds in the head, and finally true asthma.

Asthma developing after the thirtieth year is usually the result of chronic foci of infection in the bronchi, tonsils, teeth, or sinuses. It is important that the early manifestations be recognized as pre-asthmatic, for their further development may often be stopped and their complications prevented.

In the infant, the only pre-asthmatic clue lies in the family history.

A food allergy is a definite condition that should be diagnosed readily. The treatment is to withdraw the offending food absolutely, and for an indefinite time.

Infections occurring frequently in the upper respiratory tract and bronchi in infants with an allergic inheritance, calls attention to infected

adenoids and tonsils. Since these children are likely to become sensitive to air-borne substances later in life, the plain indication is to keep them away from pollens and dusts which are known to produce asthma in older people. Cats and other pets are to be excluded from the house. Mattresses and pillows are to be of clean hair, box springs excluded from the bed, and stuffed furniture from the rooms, and only small rugs allowed on the floor. The object is to keep the surroundings free from dust. The diet is to be simple, and of a variety of foods.

Drugs are to be prescribed to asthmatics with care. These persons are often peculiarly sensitive to aspirin, and quinine, and to poultices made of flax seed or mustard. Bronchitis may be turned into violent asthma by a poultice of flax seed or mustard.

As a summary, we may say that much may be done for cases of allergy by an early recognition of the condition, and a prevention of the clinical symptoms. These clues for early diagnosis are four fold:

- 1 In the family history
- 2 In the past history of the individual, especially manifestations of allergy early in life such as poisoning by milk, or egg, or eczema, or periodic vomiting, or urticaria
- 3 In the present history, a definite allergy, such as hay fever, brings suspicion or recurring colds and bronchitis as a possible forerunner of asthma
- 4 Chronic foci of infection in any part of the respiratory tract are always suspicious and demand attention promptly and efficiently

## WOMEN'S MEDICAL SOCIETY

Saturday, February 7th, the Council of the Women's Medical Society of New York State met in the Vassar Rooms of the Hotel Allerton, 57th Street and Lexington Avenue. The President, Dr. Julia Kimball Qua, presiding.

Dr. Eliza M. Mosher of Brooklyn, who is celebrating this year her fiftieth year in active practice, and Dr. Sarah J. McNutt of New York, who will celebrate her fiftieth year of practice in 1927, were among those present.

The Scientific Program Committee, which consists of Edith R. Hatch, Lulu Hunt Peters, Rosalie Slaughter Morton, are preparing a most interesting program for the State Meeting.

Dr. Florence A. Sherman of Albany, Chairman of the Legislative Committee, reported that she has visions of much work ahead of her.

Dr. Mary T. Green of Castle, told of the progress of our three women medical students, whom we are educating and initial steps were taken to have the Women's Medical Society of the State of New York incorporated, so that we may legally receive legacies for our Educational Committee, and in time become well endowed.

This was the best attended and most enthusiastic Council meeting we have ever had and if coming events cast their shadows before, the annual meeting, May 11th in Syracuse, will be the best meeting we have ever had.

## TESTIMONIAL DINNER

A testimonial dinner will be tendered by the Eastern Medical Society to Dr. Samuel J. Kopselsky, President of the County Medical Society, on March 12, 1925, at the Commodore Hotel. The

medical profession and their ladies are invited to be present. Tickets may be obtained by communicating with the treasurer, Dr. Philip Horowitz, 57 West 73d Street, N. Y. City.



# THE DAILY PRESS



While typhoid fever has ceased to be a leading heading in the newspapers, oysters continue to be a favorite subject of comment

The New York *Herald-Tribune*, February 11, carries a statement of the conclusions of the United States Public Health Service regarding typhoid and oysters, based on an investigation by officials of the service. The report says that the infection came from one dealer who has a shipping station on Long Island. The newspaper says:

"The preponderance of the evidence is that the general supply of no large distributor of oysters was uniformly infected," said a Public Health Bureau statement today, 'but that oysters infected in one or more beds or part or parts of one or more beds, or at one or more floats, and constituting but a small proportion of the total, were introduced into and distributed with a large supply of oysters of good sanitary quality

"A detailed report of the investigation will be submitted by the service as soon as practicable, it was announced, today's statement being intended to clarify a situation which it said not only had brought about a practical cessation of the oyster industry, but had seriously affected traffic in other fish products

"The report based its opinion that raw oysters sold since December 20 'have been free from any considerable degree of typhoid infection' and are safe to eat, on temperature changes in some bed or beds, discontinuance of receipts from the infected source or sources, and sanitary measures which have been carried out by the oyster producers within the vicinity of their floats and on their dredging boats"

The *Brooklyn Eagle*, February 13, quotes from an open letter of Dr Matthias Nicoll, Jr. Commissioner of Health of New York State, to Surgeon General Hugh S. Cumming of the U. S. Public Health Service, criticizing him for fastening the responsibility for the spread of typhoid on one Long Island dealer in oysters, "without submitting the slightest proof." The newspaper quotes from Dr. Nicoll's letter:

"While I do not question the authority of the service to make the investigation or to state its conclusions. I think it would have been a little more courteous and in accordance with public health practice if the data upon which these definite conclusions were based had been presented to the State Department of Health, which up to the present time has been able to obtain no facts definitely incriminating oysters taken from Long Island waters"

What the officers of the U. S. Public Health Service seem to have found was that some persons who have typhoid fever had eaten oysters that were taken from barrels which bore the labels of a certain reliable Long Island oyster dealer. It is well known among oystermen that dishonest dealers take the empty barrels of the oystermen whose names stand for honesty and reliability and fill them with a polluted product taken from polluted waters. The honesty of dealers is one of the greatest factors in the certification of the purity of oysters.

The Conservation Commissioner of New York State and the State Department of Health are seeking a plan of action whereby the misbranding of oyster containers will be impossible. They are further seeking a practical means of marking individual oysters. It would seem to be possible to invent a machine which would print the name of a firm indelibly on an oyster, but no one has yet succeeded in doing it. A huge prize will be the reward which oystermen will gladly pay to the successful inventor of an oyster-branding device.

Pollution of oyster grounds is not the only basis for proceeding against municipalities for inadequate purification of their sewage. The *Middletown Times Press*, January 30, contains a long account of a hearing conducted by State Health Commissioner Matthias Nicoll, Jr., regarding the nuisance caused by the discharge of the city's sewage into the Monhagan Brook and thence into the Walkill River. The testimony was largely untechnical and related to odors, the destruction of fish, and the contamination of milk cows. But some technical testimony was introduced to show that the water in the brook is nine-tenths sewage and that in the Walkill River is over one-half sewage during the summer low water.

The account states that the defense of the city is that in the year 1879 the Legislature passed a law granting permission to use the brook and river for sewage purposes, and that therefore the city has the right to use them to any extent it chooses.

This defense is an illustration of the respect which Americans have for the law of the land. In spite of the fact that the law is unjust and was never intended to cover the present conditions, yet the Department of Health and the Conservation Committee will probably have great difficulty in overriding or changing the law, and in removing the evident pollution of the Walkill River.

The Mayor and the Health Officer are in

favor of constructing a proper sewage disposal plant, while the city lawyer visits on the legal rights of the city and seems to offer no constructive remedy for the pollution

The medical search for the fountain of youth has been replaced in these modern times by the quest for a universal antiseptic drug which will kill bacteria and yet be harmless to the human body. The New York *Herald-Tribune*, February 11, states that such a drug, called hexylresorcinol, has been found by the research workers of Johns Hopkins School of Hygiene and Public Health after ten years. The newspaper article says

"He first fed the antiseptic to rabbits. When the animals showed no ill effects, he swallowed some of it and was not inconvenienced. Assured of its harmlessness, he and six men who were working with him began to take daily doses of increasing size in order to study its effects in the body.

"It was then that the antiseptic was applied for the first time to the actual treatment of disease. In some cases infections of the kidneys, which had been of long standing, were cleared up in forty-eight hours, according to the records. The cures appeared to be permanent, it was said.

"A committee of fifteen has been appointed by the National Research Council to work with him in further researches to determine how broad might be the application of hexylresorcinol to disease in general. The substance is being sent to medical schools and hospitals for tests."

We wonder if the discoverer will meet the same difficulty which the Danish investigator encountered when he found that the dead and disintegrated tubercle bacteria which were killed in the body by his gold preparation, were far more toxic than the living germs. It would seem that the great value of the newly discovered antiseptic would be as preventive rather than a cure. But until we see an authoritative account of the new drug in a scientific medical journal we shall be skeptical regarding its alleged virtues.

The *Binghamton Press*, February 5, calls attention to the shortage of physicians in the State Hospitals and quotes Dr. W. C. Garvin, the Superintendent of the Binghamton State Hospital

"A shortage of physicians is reported in the various state hospitals, according to Dr. W. C. Garvin, superintendent of the Binghamton State Hospital, and he says that good men of the right training are in demand throughout the state. The great amount of shifting and changes constantly going on among the medical workers in state hospitals is shown by the fact that only

five of the local staff have been in service for two years."

Medical service in the State Hospitals, like that in the Army and Navy, requires a high quality of professional skill and administrative ability. Advancement is usually by examination which is thorough and searching. The State, like a big corporation, will probably always have difficulty in filling its higher positions.

Last week we commented on the difficulties which doctors have in reaching their patients. The *Auburn Citizen*, February 4, contains an account of physicians' experiences which remind us of the heroic dash of the dog sled drivers to carry antitoxin to plague-stricken Nome. We read

"Stories of country and city doctors making valiant fights through drifted country roads and choked highways to administer to the sick during the recent snow deluge come filtering through from the snow-bound countryside as the roads out of Auburn begin to open up before the onslaughts of snow shovel and snow plows.

"While the city doctor was confronted with unusual problems, those which the country physician had to overcome were unprecedented. Toil some journeys through the dead of night over fences and stiles, through fields on snowshoes, or battling deep drifts along the highways behind teams of exhausted horses, form the basis of a narrative that could interestingly be fictionized.

"Both city and country physicians responded whenever urgent calls were made. One country doctor characterized the spirit of his brethren when he stated 'We had difficulties, but we overcame them. We had to get to our patients, and we did. It was all in the day's work.'

"Individual experiences of both Auburn and country doctors make interesting reading and reflect the character of the city and country doctors.

"Dr. A. B. Chidester of Cato covered his territory by sleigh and snowshoe, often having to resort to both in a single call. On one occasion it took this physician three hours to travel an eighth of a mile by sleigh, and on another he was held up for three days before he could reach a patient six miles away. On one snowshoe trip he spent three hours in traveling.

"Dr. B. K. Howe of Sherwood reported similar obstacles in his attempts to get around among his patients. Snowshoes and horse-drawn cutters were used by the doctor, who also has a snow tractor which he will use just as soon as the roads open a bit.

"Dr. C. E. Goodwin of Weedsport has been able to attend to his village patients through operation of a 'snowmobile' improvised from his automobile."

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 7

NEW YORK, N Y

FEBRUARY 27, 1925

## RECURRENT VOMITING IN ITS RELATIONS TO ABNORMALITIES OF THE GASTRO INTESTINAL TRACT\*

By CHARLES GILMORE KERLEY, M D  
NEW YORK CITY

**I**N different contributions during the past ten years, the writer has called attention to the possibilities of defective gastro intestinal mechanics as a factor in the disturbances of gastro intestinal function in infants and children

Recurrent or periodic vomiting has been repeatedly referred to as being dependent upon congenital or acquired abnormalities at some point in the gastro intestinal system This contribution will deal only with a few cases in which the etiology was proven to rest upon defective mechanics

The number of cases of persistent digestive disorder upon whom serial X-ray observations have been made now number 147

H J—Aged five years, male, weight 38½



FIG. 1



FIG. 2

pounds The patient developed recurrent vomiting attacks at the age of 2 years The seizures occurred from 6 to 8 weeks interval and usually lasted from 24 to 48 hours During this time there was repeated vomiting attacks There was moderate prostration during the attack and usually a moderate elevation of the temperature from 101 to 102 X-ray (fig 1) showed 4 loops in the sigmoid and one in the descending colon This portion of the intestine was fully five times its normal length The cecum showed a secondary dilatation

B D—Aged five years, male, weight 36 pounds, like the above had suffered from per-

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester, April 23, 1924



FIG 3

sistent gastro intestinal disorders since 2 years of age. There were periodic attacks of vomiting at 4 to 8 weeks' interval, there was habitual eructations of gas, stomach pain and loss of appetite. The unusual symptoms complained of were dizziness during the seizure and pain in the rectum.

X-ray (fig 2) stomach contained food residue after 5½ hours. The lower border of the stomach was on a level with the umbilicus, the sigmoid was elongated making 3 loops. The highest point of the sigmoid at the medium line was 1½ inches above the umbilicus, it turned toward the left making another loop over the left iliac bone before it joined the descending colon.

E M—Age nine and one-half years, weight 42 pounds, there had been periodic attacks of vomiting since the child was 18 months of age. The appendix was removed when 4 years of age without improvement in the seizures. During the past 6 months there were four attacks of vomiting which were very severe and lasted from 1 to 3 days. Glucose was given intravenously in one of the attacks. This case was seen in association with Dr Allen Brown of Toronto.

X-ray (fig 3) showed a definite V shaped loop in the transverse colon, the inverted apex being about 3 inches below the umbilicus. In fig 5, the same patient, the descending colon is elongated, the sigmoid is about 3 times the average length and presents the usual looping.

W F—Male, age 5½ years, weight 28¾ pounds. There had been repeated vomiting seizures, severe and prolonged, lasting from 2 to 4 days at from 4 to 12 weeks interval for 3 years. A temperature of 2 or 3 degrees was usually present, the child showed moderate prostration and lost from 2 to 3 pounds during each attack.

X-ray showed a marked redundancy of colon and sigmoid, amounting to 4 times its



FIG 4

normal length. There were 2 loops in the descending colon and 2 in the sigmoid.

F L—Age 10 years, male, weight 107 pounds. There had been recurrent attacks of indigestion 6 to 10 weeks interval for several years, always with nausea, occasionally vomiting which was never severe. The tongue was invariably heavily coated and the breath foul at the time of the attack. The temperature rarely rose above 101.

X-ray showed an elongated pelvic colon with 3 loops together with dilatation of the rectum. Same patient, taken in the standing position shows a marked prolapse of the colon.



FIG 5



FIG 6

M M—Female, age 3 years, weight 31¼ pounds, has had convulsions every 3 or 4 months since 1 year of age. For the past 9 months there were periodic vomiting seizures accompanying the convulsions at 3 to 4 weeks interval, rarely passing the fourth week. The mother dated her social engagements to conform with the anticipated convulsions and vomiting seizures.

X-ray showed marked elongation of the colon with looping, one loop passed 3 inches above the umbilicus reaching to the top of the transverse colon. The ascending colon showed a peculiar cork screw effect due to the elongation of that portion of the gut.

T W—Age 5 years, male, weight 33 pounds. Child well until 6 months ago, since then he has had 12 vomiting seizures gradually shortening the interval, he vomits 3 or 4 times in each attack, which covers from 24 to 36 hours. The interval between the last 3 attacks was 10 days.

X-ray showed dilated mobile cecum, 2 complete loops of the sigmoid which pass to the level of the transverse colon and show definite stasis when examined with the opaque meal. The sigmoid passes 3 inches above the umbilicus and is 4 times the anatomic length.

F G—Age 22 months, female, weight 24¼ pounds, markedly undernourished, came because of repeated attacks of acute indigestion and convulsions. Convulsions and vomiting occurred simultaneously. During the attacks the temperature was always very high and the abdomen greatly distended.

X-ray (fig 5) shows dilatation of the stomach to an excessive degree, moderate elongation of the sigmoid, and the cecum was dilated.

J R—Age 5 years, female, weight 44½ pounds. For three years child has had recurrent attacks of vomiting associated with a great deal of pain. Constipation was habitual, medication required daily.

X-ray showed marked redundancy of the pelvic colon, a loop extending 2 inches above the umbilicus in the standing position. The first portion of the loop was parallel with the descending colon. The distal part of the loop passes to the right of the medium line, descends into the pelvis to join the rectum producing a figure 8 appearance. No evidence of pyloric spasm, stomach empties in 4 hours.

S B—Age 2½ years, male, weight 40 pounds. Had frequent convulsions, nine in the past year, associated with gastro intestinal disturbances. There was delayed stomach emptying, after 5 hours and 35 minutes, a portion of the bismuth meal is still present, there were 3 extra loops in the sigmoid, two pass 1½ inches above the level of the umbilicus, the third loop was in the pelvis where the pelvic colon passes to join the rectum.

L W—Age 5 years, female, weight 32 pounds. Child thin, pale and anemic. There had been repeated attacks of vomiting associated with colitis at 3 to 4 months interval since 2 years of age. The abdomen was very much distended.

X-ray (fig 6) shows an extreme dilatation of the stomach with ptosis, the greater curvature being on a level with the umbilicus. The size of the stomach is 10 inches x 4 x 4. There was an absence of peristaltic wave. At the end of 5 hours there was a large stomach retention. The colon showed extreme elongation of the sigmoid flexure which passes to a point 3½ inches above the umbilicus, it is from 3 to 4 inches the normal length.

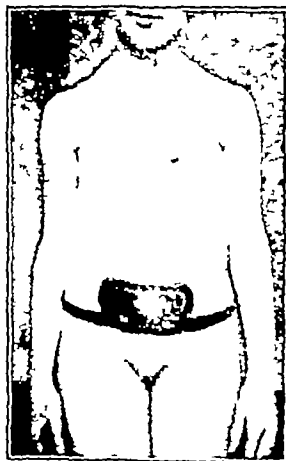


FIG. 7

The above cases have made complete recoveries or show satisfactory improvement with the exception of case M. M., the child with convulsions and vomiting attacks in association. Prompt results were not forthcoming and the parents placed the child under the care of an endocrinologist.

Considering the etiology of our cases of recurrent vomiting and we have seen a great many such, we believe that it is the expression of a systemic intoxication from intestinal sources. Among the 147 patients with persistent digestive disorders upon whom a serial X-ray study was made there was found with few exceptions structural abnormalities of the gastro intestinal tract resulting in emptying delay either of the stomach or intestine. We have found ptosed stomachs, stomachs that showed pylorospasm, ptosed and dilated cecums, V shaped transverse colons, and elongated and sacculated sigmoids in large number. The dilated rectum in association with a spastic sphincter has been frequently encountered.

It would seem that we have failed to appreciate the possibility of systemic poisoning from intestinal sources and our results which are usually most satisfactory, and in some almost dramatic, have followed our efforts at the prevention of delayed waste material in the intestines.

Our management comprises abdominal support, a diet in which vegetables, fruits and cereals are used freely, abdominal massage and adequate elimination. Many of our cases have enlarged pendulous abdomens with relaxed muscles (fig 1). We give such children support using the



FIG 8



FIG 9

Nicholson Universal Supporter (figs. 7-8) or the Bassler Belt (fig 9).

In the long angulated sigmoids the peristalsis is always defective as shown fluoroscopically. For these we always prescribe massage and give the fluid extract of Cascara Sagrada Aromatic in sufficient dosage three times a day to produce at least two free evacuations.

Often times in patients of this sort the history shows that there is a daily evacuation but the evacuation arrives two or three days behind schedule, giving plenty of time for the absorption of toxic products.

The proof that our cases of recurrent vomiting represent a definite systemic poisoning rests in the relief supplied when the intestinal stasis is corrected. Delayed stomach emptying furthermore, is almost invariably in association with delayed emptying of the lower level.

In all cases of persistent gastro intestinal disorders in children a serial X-ray study of the gastro intestinal tracts is essential.

#### CLOSING DISCUSSION

In all our cases of recurrent vomiting we find out where the trouble is and then go ahead and correct it along the lines referred to in my paper.

The reason for the small success of many in the management of cases of this sort is that they never locate the seat of the trouble.

Some have postural defects, many do not. If you depend upon faulty posture to explain things you will miss many cases.



## ENDOCRINE THERAPY IN STERILITY\*

By TIMOTHY F. DONOVAN, M.D.,

BUFFALO, N. Y.

IN treating of endocrine therapy in sterility, I speak, not as an endocrinologist, but as a surgeon. I have learned that in the practice of surgery, a knowledge of the activities of the ductless glands is of great aid. It reduces the number of needless operations, and, in some cases of definitely surgical conditions, the organic extracts have proved to be valuable adjuncts in the treatment.

This is not a statistical report of successes and failures. It is an effort to point out certain facts that may be discovered from the history and examination of the sterile patient. These facts are important in indicating the gland or glands at fault, and in aiding in prognosis and treatment. As illustrative of these facts but a few case histories will be cited.

A knowledge of the modern conception of menstruation is important, because disturbances in rhythm of the menstrual cycle are present in almost all cases of sterility. Time will not permit of a detailed study of this cycle. A brief review of the functions of the ovary, however, will be necessary.

The ovary has two functions, the production of ova, and an internal secretory one. These two functions depend upon the presence in the ovary of the follicles, the corpus luteum, and the interstitial cells.

The follicles are (1) the primordial follicles and (2) the graafian follicles. Before puberty, the primordial follicles, having reached a certain size, become atresic. This occurs, also, after puberty, only relatively few of the primordial follicles developing into graafian follicles.

The interstitial cells develop from the atresic follicles. These cells are said to be abundant before puberty, and during pregnancy and lactation. They are an important factor in the nutrition of the uterus, and in the development of the secondary sex characters.

The graafian follicles and the corpora lutea do not begin to function until puberty.

The graafian follicle is the cause of the endometrial phenomena of the first half of the menstrual cycle. It has been thought that the stimulus for these changes comes from the maturing ovum, or from the follicles as a whole. Recently, Allen and Doisy, of St. Louis, reported that they were able to obtain, from the large graafian follicles in hog ovaries, an alcoholic extract from the liquor folliculi. This extract injected into spayed animals (rats and mice) produced the phenomena of heat. These animals acted during mating as do normal animals. And its injection

into young rats, immediately after weaning, produced maturity 20-40 days before control animals from the same litter.

The corpus luteum develops from the graafian follicle after ovulation, and it is the cause of the endometrial changes in the second half of the menstrual cycle. Its function is to inhibit ovulation, and to sensitize the endometrium so that nidation may occur. Its secretion is elaborated by the luteal cells. This secretion, according to Loeb, is present in the guinea pig only from the second or third to the 8th or 9th day after ovulation, and he has demonstrated that the quantity secreted has an important bearing on the production of the decidua.

The ovarian sequence is follicular ripening, ovulation, corpus luteum formation. So menstruation is said to be indicative of a previous ovulation. But in some cases in which menstruation occurs, as Bandler has reminded us, the ovarian capsule is so thick that rupture of the follicle is impossible.

The uterus.—We will consider (1) the endometrium, and (2) the size and shape of the uterus.

1 There are three points in regard to the endometrium.

(a) Most important is the change in the endometrium which permits the embedding of the fertilized ovum. This is the result of the sensitizing influence of the corpus luteum, and the mechanical stimulus of the fertilized ovum.

(b) The endometrium elaborates a substance which prevents the clotting of the menstrual blood. The significance of the absence of this substance is not known.

(c) Bandler warns against a too thorough curettement as a possible cause of ovarian atrophy.

2 Size and shape of the Uterus. Sterility is in most instances associated with a hypoplastic condition of the uterus. In such uteri the ratio between body and cervix is abnormal.

Novak, following Aschoff, divides the uterus into body, isthmus and cervix. And he says, "It would be of value to the gynecologist to think of the uterus as a composite organ, in the sense that it is made up of three separate segments. At various periods of life one or the other of these segments predominates in size and perhaps in function. Each segment apparently has its own function and each seems to be under the control of a different endocrine influence."

The upper limit of the isthmus is the anatomical internal os, and, the lower one, the histological

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester April 23, 1924.

internal os Aschoff calls it the "hinge" of the uterus, because every flexion examined by him occurred at the middle of the isthmus

Novak describes three types of hypoplastic uteri—the foetal, the infantile and the subpubescent

(a) In the foetal type of uterus, the body is rudimentary, the isthmus practically undeveloped, and the cervix composes most of the organ. No differentiation is possible between the body and the cervix

(b) In the infantile type, growth is arrested in infancy or childhood, the cervix is larger than the body, but can be differentiated

(c) The subpubescent type, may be nearly normal in size, but the cervix is usually longer than the body. In a small uterus the segmental differentiation may be normal, and in a uterus of normal size the segmental differentiation may be infantile.

These subnormal uteri are associated with amenorrhea and dysmenorrhea. Amenorrhea is the predominating symptom in the foetal and infantile types, and dysmenorrhea in the subpubescent type. In the subpubescent type, the periods may be excessive, normal or scanty

These hypoplastic uteri are significant because they direct our attention to the endocrine glands. What glands are particularly concerned in the development of the genitals?

1 The ovary. Bilateral oophorectomy is followed by atrophy of the uterus, as well as of the external genitals and the breasts. Louise McIlroy has shown, by transplantation experiments, that the uterus does not atrophy until after the interstitial cells have degenerated. Another significant point in the development of the uterus is this. In a uterus removed from a girl of 14 in whom menstruation had been established, the body was almost twice the size of the uterine body in a patient 9 years old (Novak). And we have seen that the graafian follicles and the corpora lutea do not begin to function until puberty. What glands other than the ovary have a stimulating effect on the body of the uterus?

*The Pituitary*—A number of investigators (Aschner, Crowe, Cushing and Homans) have shown that after partial removal of the anterior pituitary in young animals the sexual organs remain infantile in character. In the males there are impotence and absence of spermatogenesis. The females show absence of the sexual instinct and failure of ovulation. In adult animals, hypoplastic changes and diminished sexual activity resulted. Furthermore, Goetsch caused early sexual development and over-activity of the sex glands by feeding extract of the anterior pituitary to young rats

*The Thyroid*—Leopold-Levi and Rothschild state that "Otto Lanz has shown that early thyroidectomy, in the female, prevents the appearance of the secondary sex character, of the sexual instinct, and of menstruation." And the same authorities say that atrophy of the sexual organs (Von Rostharn), a permanent atrophic state of the graafian follicles (Hazmeister), and an ovarian atrophy (Dolche) follow thyroidectomy

*The Parathyroids*—"No direct relationship has been established between the parathyroids and the female sex organs. No morphological changes in the parathyroids have been noted during pregnancy, yet apparently there is a connection between the parathyroids and the sex problems in the female." "Tetany, the clinical evidence of insufficient parathyroid function, is somewhat prone to occur in menstruating, pregnant and puerperal women, as well as patients suffering from gynecological conditions." And, "In the treatment of maternal tetany, the administration of calcium in large doses is followed by beneficial results in the great majority of cases" (Pool)

*The Pineal*—It is the opinion of Krahbe that "our knowledge of the function of the pineal gland is very defective." Its influence in the body is unknown. The association of precocious puberty with tumors of the pineal gland does not prove that the gland normally acts on the sexual glands. The tumors are almost invariably teratomas

*The Thymus*—Hammar states that "The old theory of the age involution has thus undergone revision to the effect that the involution does not appear until puberty and that it certainly causes a gradual reduction of the parenchyma, but in such a way, however, that a functioning parenchyma remains as a rule, even in old age. Under such circumstances there can no longer, of course, be any question of a 'existence of the thymus in the usual meaning of that term.'" Pappenheimer thinks that the evidence as to the influence of the thymus on the gonads is contradictory

*Adrenals*—Hyperplasia of the adrenal cortex is frequently found with pseudo hermaphroditism. "Adrenal hypernephromata are almost invariably characterized in children by precocious growth of the body generally and of the sexual organs in particular, with overgrowth of hair and fat." They are "much commoner in females than in males, and tend to increase the male primary and secondary sexual characters at the expense of the female" (Swale Vincent)

Atrophy of the gonads is found in Addison's disease

It is evident then, that the organs which merit our particular attention are the ovary, the thyroid and the pituitary. Sterility is frequently associated with under-functioning of one or more of

these organs, and only the characteristic signs and symptoms of such under-functioning will be considered

*The Ovary*—A frequent cause of under-function of the ovary is Acute Interstitial Oophoritis. This may result from (a) local infection (gonorrhea or puerperal sepsis), (b) from acute infectious diseases (typhoid, mumps, scarlatina, measles, chicken-pox and diphtheria), (c) haematogenous infections (tonsils and teeth). The ovary becomes swollen and oedematous and shows the gross histological signs of acute inflammation. It may show small multiple abscesses or a single large one.

Davis reports the results of cultures, from 65 ovaries, made by Rosenow and Davis. There were three acute cases. Of these two showed the streptococcus viridans, and the third, the gonococcus. The other 62 were the seat of fibrous and cystic degeneration. Ten showed negative cultures. Of the remaining 52, 30 showed streptococcus viridans, 8 being pure culture. In the other twenty-two, streptococcus was mixed with other organisms. Most of these patients had no history indicating a pelvic inflammation.

The more common end-results are (a) Subsidence of inflammation without any recognizable or histological lesions. (b) A mild or severe degree of destruction. (c) Sclerosis of the ovary.

With pelvic peritonitis there is seen an acute peri-oophoritis. The capsule may act as a barrier to bacterial invasion of the organ proper. Later, in some cases, the capsule is so thickened that ovulation is prevented and cystic disease of the ovary develops. The organ may be involved in adhesions, which interfere with the blood supply, resulting in destruction of the ovary.

Goodall states that hemorrhage is not at all uncommon, the most frequent cause being acute fevers. The hemorrhage may be into the corpus luteum, or there may be an extravasation with destruction of ova.

If primary ovarian underfunction occurs before puberty the chief symptoms are late puberty, amenorrhea, or scanty, irregular flow, hypoplasia of uterus and appendages, and absence of secondary sex characters. These patients are apt to be of the eunuchoid type tall, slender, extremities disproportionately long as compared to the trunk, with a long, slender hand.

If the under-functioning appears in adult life, hot flashes, changes in disposition, insomnia, digestive disturbances, a tendency to obesity are the commonest symptoms. Quite frequently if the condition has existed for some time, atrophy and sclerosis of the uterus are found.

A brief history of three cases will be given to indicate different types of cases to be met with.

Case I Mrs G. First seen December 22, 1912, in acute alcoholic delirium. She was 32 yrs of age, 5 feet 6 inches tall and weighed 111 lbs. After her recovery it was learned that she had always been sickly and anemic as a girl. Her periods began at 17, were always regular, scanty and of 2 days duration. She had been married 14 yrs and had never been pregnant. Various physicians had been consulted about her condition, and finally, in 1905, she was examined by a noted gynecologist, who said that he did not think she would become pregnant as she had an infantile uterus. In discouragement she acquired the alcohol habit. In February, 1913, corpus luteum Gr V t.i.d was prescribed. Within a few days she returned to her home, and was not seen again until February, 1914. In the meantime, she had taken the corpus luteum continuously, and she weighed 150 lbs and was 5 months pregnant. She was delivered on May 20, 1914, of a normal baby girl. She was last seen in April, 1924. She had not taken corpora lutea since the birth of her child, and had never again become pregnant.

Case II Mrs C, when first seen on September 16, 1920, was 21 years old, had been married for 3 years and had never been pregnant. She had all the diseases of childhood, none of them severely, and frequent attacks of sore-throat. Her periods began at the age of 14 yrs, always regular up to three months ago, since then they have been from 3-7 days late, she flowed from 3-6 days, and for the past year always passed many small clots. Her periods were preceded and accompanied by severe abdominal pain. There was no history of pelvic inflammation, but she had an adherent, infantile retroverted uterus. Operation was advised. On October 4, 1920, she was operated upon. Adhesions between uterus and ovaries broken up, a Baldy operation was done, and both ovaries, which were of the small cystic type, were resected leaving, of each ovary, a piece the size of a pea. Her uterus was infantile and hard. She showed improvement after the operation until February, 1921, when she showed moderate enlargement of the thyroid, and complained of constipation and that her hair had been falling out. She was given thyroid nucleo-proteid tablets (5%) t.i.d. On June 3rd, she was feeling much better, her constipation was relieved, her hair had stopped falling out, and a note made at the time says that "The uterus seems larger; stump of right ovary larger and tender, that of the left not felt." Her thyroid enlarged during her periods, and thyroid medication was stopped and ovarian nucleo-proteid (10%) t.i.d prescribed, to be taken two weeks in every month. Under this treatment the menstrual enlargement of her thyroid did not appear, her periods came "at four o'clock every fourth Tuesday," lasted for 3 days. She had no pains or clots. On December

6, 1921, she said that morning vomiting had been present for a month, her last period having started on October 12, 1921, and she showed all the presumptive signs of pregnancy. She was delivered of a normal baby at term by Dr. Victor Pchellas.

Case III Mrs. N. Age 31 yrs. Seen April 16, 1924. Married 8 yrs.

#### Complaints—Dysmenorrhea and Sterility

**Menstrual**—Began at age of 13 years, regular every 28 days, scant flow for 2 days, no clots, general abdominal pain begins one day pre-menstrual, and is very severe on the second day. She had been dilated and curetted 2 months before with no relief. She had Typhoid Fever at the age of 6 yrs., Measles and Chicken-pox. At the age of 18 yrs. had a severe attack of Mumps. She doesn't remember whether she had any abdominal or pelvic pain following the Mumps. Frequent attacks of tonsilitis. Examination shows a moderate enlargement of the thyroid, more marked in the left lobe. This has been present as long as she can remember. Pelvic examination shows an acutely retroflexed, adherent, subpubescent uterus. Ovarian nucleoprotein (10%) tablets t.i.d. were prescribed, and abdominal exploration advised. I believe that neither alone will relieve her. It remains to be seen if both combined will do so.

**The Thyroid**—You are all familiar with the complete forms of thyroid insufficiency—cretinism and myxoedema. But the frequency of the incomplete forms (called "hypothyroidism," "chronic mild hypothyroidism," "masked hypothyroidism") is not recognized.

Retardation or cessation of growth may be the only sign. The delay in growth is "brought about by the late appearances of the bone nuclei and extremely slow ossification of centers already laid down. The epiphyses may be absent many years after they are due to appear and their closure with the shafts of long bones be indefinitely delayed. It has been demonstrated that this phenomena is one of the earliest and most common in hypothyroidism" (Janney).

Usually these patients sweat only after great effort. They usually tire easily and their fatigue is more marked in the morning. The color is pale or sallow, the hair dry and apt to fall out, there may be scantiness of the eyebrows, with absence of the outer third. Quite frequently there is a saddle nose. The hands may be spade-like and show brittle or ridged finger nails, with white spots under the matrix.

Obesity, or a tendency to it, is mentioned in all texts as a common finding. This obesity is characterized by its general distribution, and the formation of supra- and infra-clavicular fat pads. I have seen a number of cases of amenorrhea following influenza, in which the menstrual disorder and the general condition (fatigue, anorexia, and

constipation) cleared up on thyroid medication. When first seen they were underweight, after treatment they all showed a gain in weight. One of these cases was particularly interesting. She was married, had two children, and two years before had a severe attack of influenza, from which she dated the onset of her symptoms. A round ligament shortening had been done for a retroverted uterus, which was expected to relieve her complaints. From a technical viewpoint the result of the operation was perfect, but symptomatically she was worse. Then because of a loss in weight of 22 lbs. tuberculosis was suspected. When I saw her in February, 1921, she was 25 lbs. underweight, and complained of fatigue, anorexia, constipation and scanty irregular periods. On thyroid, to which ovarian extract was subsequently added, her symptoms gradually disappeared, and in six months she had gained 40 lbs.

The gastro-intestinal tract is commonly affected. Children have poor appetites, and adults "eat more from reason than from appetite." There is commonly intestinal atony and insufficient intestinal secretions. This is doubtless due to the degenerative changes seen in the vagal nuclei. Constipation which is frequent may be associated with mucous colitis.

The history is important. It may show the presence of familial thyroid disturbance (for example goitre, or hyperthyroidism) or the occurrence of an infection. (The infections, according to Sajous, which are most frequently followed by hypothyroidism are influenza and syphilis.) It may also show that there was delay in walking, talking or teething. Delayed dentition with decay early in adult life are frequent symptoms.

Leopold-Levi and Rothschild describe two types of menstrual disturbances associated with this condition. In the first group is included scanty, late or suppressed menstruation, and, in the second group, the periods may be early, of prolonged duration, and profuse. Thyroid medication has in the first group a stimulating, and in the second, a regulating effect. Then there is Hertoghe's syndrome of thyroid insufficiency characterized by (a) late puberty, (b) scanty periods, and (c) early senility.

Examination in any of these groups, "show an infantile or pubescent uterus, and anterior, posterior or lateral mal-positions."

Sajous says that the thyroid gland in hyperthyroidism passes through 3 stages: (1) stage of overfunction, when thyroid medication will do harm; (2) transitional stage, when symptoms are mixed, and in which thyroid in small doses may help; and (3) the stage of underfunction, when more or less of the gland has become fibrous, and in which thyroid medication is indicated.

The practical importance of this is that an individual in the stage of underfunction may

show some degree of exophthalmos, and this, with the goitre, may lead us to believe that thyroid medication is not indicated

*The Pituitary*—In our study of the pituitary the classification of Engelbach and Tierney will be used

The pituitary gland is made up of two parts, the anterior and posterior lobes. The posterior lobe consists of the pars intermedia and the pars nervosa

Conditions of hyperfunction and of hypofunction may be classified as to the time of their inception into pre-adolescent and post-adolescent (the normal period of adolescence is from the tenth to the fifteenth years), and, as to the presence or absence of a tumor, into neoplastic and aneoplastic

"The anterior lobe controls and regulates (a) the skeletal growth, (b) the function and development of the genital organs and the secondary sex characters. The posterior lobe is definitely concerned with (a) the regulation of carbohydrate metabolism—glycosuria, hyperglucemia, sugar tolerance and obesity, (b) the contraction of involuntary and unstriated (muscle-peristalsis and uterine contraction), (c) the renal secretions—polyuria, (d) the blood-pressure and (e) the body temperature"

Each lobe may show evidence of under- and over-activity, singly or together, or one lobe may be under-active and the other over-active. We are concerned chiefly with the manifestations of under-function of the anterior lobe, whether this under-function is complete or incomplete

"The best indicators of the state of functional activity of the anterior lobe are muscle tonus and genital function" If this lobe is under-functioning there are fatigue, disturbances of menstruation, frigidity and sterility

In the complete form of the preadolescent type there is skeletal undergrowth, absence of the secondary sex characters, "small head, small sinuses and small sella", type "en petit" hand, which is one-third smaller than normal (the fingers being short), nails small, absence of white crescents at bases, infantile uterus, tubes and ovaries, under development of the external genitals. The teeth erupt at the normal time but are deficient in enamel and apt to decay early. The lower teeth are very often crowded, while the upper ones show fair occlusion

In the incomplete form of pre- or post-adolescent type, there is under-growth of the short and flat bones only, the patients are of normal height or tall, the external genitals are more or less incompletely developed, the uterus and ovaries are apparently normal in size, but, histologically, the ovary shows a small number of graafian follicles, and undergrowth of the stroma, late puberty

(15-17 yrs) frequently amenorrhea, dysmenorrhea and metrorrhagia-dysmenorrhea, sterility and frigidity are almost always present. Fatigue-ability is invariably present. Some of these patients instead of showing the "small hand" have a type in which the fingers are long in comparison with the palm

Engelbach and Tierney give three types of menstrual disturbances as a result of insufficiency of the anterior lobe (a) amenorrhea due to pre-adolescent complete inactivity, (b) metrorrhagia, early, post-adolescent, incomplete form; and (c) dysmenorrhea late post-adolescent partial inactivity

Early cases of anterior lobe deficiency are not apt to show other gland dyscrasias, but later on there may follow an under-function of the posterior lobe, of the thyroid and of the gonads. Underfunctioning of the posterior lobe manifests itself by "migraneous headaches, dyspnoea, syncope attacks, severe gastro-intestinal attacks, incapacitating abdominal and lumbar pains, polyuria, polydipsia, girdle type of obesity etc" The abdominal pains are frequently associated with attacks of mucous colitis

Still later the signs of pituitary tumor may be seen—headaches, ocular disturbances, signs of intra-cranial pressure, etc. Only 6 per cent in over 200 cases showed tumors (Engelbach and Tierney)

Hyperpituitarism also, may be of pre- or post-adolescent development. To help distinguish these types, certain measurements are taken—the span, the torso and the lower. The span is obtained by measuring the laterally extended arms between the tips of the middle fingers—the torso, from the top of the head to the symphysis, and the lower, from the symphysis to the soles of the feet

*Hyperpituitarism*—(1) The preadolescent type is gigantism. These individuals are abnormally tall, have well developed uteri, ovaries and external genitals, normal periods, hand is the "en longe" type, one-third larger than normal, secondary sex characters present, upper incisors enlarged and separated, normal or over-developed muscle tone. Libido and fecundity are present

There are 3 kinds of gigantism. Normal in which span equals height and torso equals lower. Eunuchoid in which span is greater than height and torso less than lower. Acromegalic in which span is less than height and torso greater than lower

(2) Post-adolescent type is known as acromegaly. This form shows overgrowth of acral, short and flat bones. Patients are short and stocky, or normal in height. The hand "en large" (spade hand) in which the wrist is large and the

fingers clubbed Uterus, ovaries, external genitals well-developed Separation of upper and lower teeth A prognathous jaw is usually seen Libido and fecundity are present Muscle tonus over-developed, span less than height, torso greater than lower

The important thing to remember about these is that showing as they do all the skeletal signs of over-activity they may really be suffering from under-activity at the time of observation

The change from the stage of over-activity to under-activity is made apparent by the presence of a depressed and apathetic state of mind associated with lack of sexual desire, sterility and fatigueability

In the preadolescent type these changes usually come on in a few years, and in the post-adolescent variety they may not appear for a number of years

Case IV Mrs K. Referred by Dr Getman on March, 1924 She is married, age 33 yrs, and complains of fatigue and sterility Had measles, mumps and chicken-pox before puberty For four years had frequent attacks of sore throat Menstrual began at age of 17 years At first she flowed only every three or four months, scant for six days, since marriage, every 28 days and she has a scant flow for two days Severe supra-orbital headache, one week before her period, she is free from it during the flow, and it is present for a few days after the period is over She feels tired most of the time For eight months she was on a mixed gland preparation, then for a similar length of time on ovarian residue (P D & Co) Examination shows a woman 5 feet 2¼ inches, with shoes (and 5 foot 1 inch without shoes), tall, weighing 111¼ lbs, the "small" type of hand, concerning which she says there is always difficulty in getting gloves to fit her, the glove fingers being too long Her uterus is one of the subpubescent type, is acutely anti-flexed and has a small subperitoneal fibroid above the internal os, her ovaries are easily palpated and seem normal in size and consistency Her cervical secretion is slightly acid A skull picture shows a small sella, the anterior and posterior clinoids meeting A picture of her hands shows tufting of the terminal phalange The tufting is looked upon as an indication of over-function of the anterior pituitary It would be interesting to know if this tufting was present before Dr Getman began treatment, or if it is the result of treatment Because of her short stature, small, closed-in sella and "small hands," a diagnosis of anterior pituitary, with secondary ovarian, insufficiency was made Ovarian Residue (Schiefflin) MXV was prescribed t i d. On March 27th, after one week of medication, her pulse was 88, and her blood-pressure 128/80 At her first examination the pulse was 72, and the blood-pressure

116/70 The dose was cut to MX April 11th, three days after her period stopped, she was seen again She had no pre- or post-menstrual headache, she felt less tired, and had flowed for four days, the bleeding being more normal in color and amount She will be kept on this ovarian preparation until improvement stops, when an anterior pituitary will be given Later, if necessary, both will be given

This appears to be a favorable case for two reasons (1) the prompt response to medication, (2) the subpubescent uterus, which has the best prognosis of the hypoplastic types

*Prognosis and Treatment*—Rongy, in 1922, reported the results in 400 cases seen in private practice Among the number operated upon he stated that in nearly 75 per cent of cases who had from one to six operations for the cure of sterility, the sterility remained He was very much discouraged by his results from glandular therapy as well And he concludes that the final solution of the cause of sterility will be the work of the chemist and the biologist Falta expresses the same thought when he says, "the deficient knowledge of the chemical nature of the active substances given off by the ductless glands constitutes the weak point in the knowledge of the internal secretions and explains why even today we are often compelled to work with hazy ideas"

All who have used glandular extracts in the treatment of sterility know that these extracts are far from infallible as a cure

As Novak pointed out in speaking of ovarian therapy, "there are a number of perfectly rational indications for the employment of ovarian therapy in which the actual clinical results are of no special value" He thinks that the degreasing process used by most manufacturers, the methods of collection of the organs at the abattoir and the means of checking them at the pharmaceutical house, as well as the question of dosage are important factors in determining our results He, too, looks to the chemist to help us out of our dilemma

Lisser calls attention to the fact that the strength of different extracts of the anterior pituitary vary in potency "The dosage of different firms is not always equivalent—for example, one grain of Burroughs and Wellcome's organic extracts does not correspond with one grain of Armour's and of Parke and Davis"

For years John Rogers of New York has been telling the profession that the ordinary thyroid of the market was apt to be inert or toxic In 1915, I saw an illustration of the value of that observation A woman 25 years of age showed, what I thought, were typical symptoms of chronic hypothyroidism She was given ½ gr thyroid extract, t i d and within 10 days she showed toxic

symptoms After she had recovered from these she was given another thyroid preparation After which there was a gratifying amelioration of her old complaints

So it is apparent that the biologic chemist has much to do In the meantime, however, can the clinician contribute to the solving of this problem? And the clinician may be heartened in his labors by the words of Sir James Mackenzie, when he says "By a strange confusion of thought 'scientific' work, in medicine, is often used as synonymous with laboratory work Scientific work is any work done with accuracy and discipline of mind, and this should be as commonly maintained by those who see the sick in their homes or in the wards, of hospitals, as by those whose work lies in laboratories"

Blair Bell in his paper on "Intrinsic Dysmenorrhea" says that the average age of patients when they consulted him with that complaint was 33 years This means that the patients had undoubtedly consulted one or more doctors before going to him, as he is a gynecologist

He considers that "Intrinsic Dysmenorrhea" is most commonly seen with a type of subpubescent uterus, which he calls "the cochleate uterus" And we have learned that dysmenorrhea, and other menstrual abnormalities, and sterility, are frequent with the different types of hypoplastic uteri

Either we do not see our patients early enough, or, seeing them, fail to recognize the endocrine basis of their symptoms

If we see a patient who has begun to menstruate at the age of 14, but whose periods are irregular, scanty or profuse, or one whose periods did not appear until she was 16 or 17 years old, and since that time have shown disturbances of rhythm of the menstrual cycle, and if associated with these signs we find one of the types of hypoplastic uteri, examination of the patient with attention to the presence of the stigmata of endocrine disturbance is indicated (The more nearly normal the uterus, the better the prognosis The subpubescent type is the most, and the foetal the least, favorable type. Cases No I and II show that the infantile type is not necessarily hopeless)

Particular attention should be paid to the history of the occurrence of infectious disease We are apt to ignore the significance of scanty or absent menses following an infection like influenza, and thus lose valuable time If the patient has had a number of infectious diseases, or a severe attack of one of them, ovarian extract is indicated either alone or in combination with extract of the thyroid In administering ovarian extracts, as a general rule, first try corpus luteum, if no improvement is shown then administer extract of the whole gland

If the patient's history shows a late dentition, with a tendency to alopecia, gastro-intestinal symptoms, usually in the form of anorexia and constipation, thyroid is probably indicated The diagnosis can be confirmed by X-ray By means of the X-ray we can determine if the patient has the centers of ossification, present and complete, which are normal for her age Much valuable information on this point can be obtained from a recent paper by Engelbach and McMahon In their article they give two very useful charts one indicating the bone nuclei that should be present at a given age, and the other, parts to be X-rayed to obtain the required information When thyroid is indicated start with  $\frac{1}{2}$  grain doses three times a day, or thyroid nucleoprotein, in the strength of 2 per cent, 5 per cent or 10 per cent, may be given with equal frequency If the patient is obese, thyroxin is usually given, a daily dose of 16 mg has been shown by Kendall to be sufficient to keep the basal metabolism at a normal level

If, on the other hand, the patient is short of stature, with a small well-proportioned head, with the "small" type of hand, and small feet, and complaining of fatigueability, the anterior pituitary is at fault (Engelbach and Tierney think the children in pituitary families should be examined regularly as to height, growth of bones, etc, so that "prophylactic" treatment may be begun early) If those cases in which the anterior lobe of the pituitary is at fault, use extract of the anterior lobe, either by mouth, intramuscularly, or by both methods, it is given by mouth gr V t i d and intra-muscularly 1 c c at from one to four days interval Where extract of the posterior lobe is needed, give M V hypodermatically, increasing the dose by M V daily, until the given dose produces, within 15 to 20 minutes, abdominal cramps followed by a bowel evacuation Then this dose is to be continued, at daily or weekly intervals, depending upon the severity of the case

It is my belief that if we recognize these conditions early enough, we can by exhibiting the indicated extracts, more successfully restore the disturbed endocrine balance

And in the use of these remedies it is well to bear in mind what was said in an editorial in "Endocrinology" This editorial was called "Patience in organo-therapy", and the writer says in part "The unfortunately too common practice of prescribing a two-weeks' supply of gland capsules or tablets, and expecting positive achievements within such a very brief period, is quite absurd It is beside the point that the adrenal, ovarian, pituitary and testicular products at present available are far from perfect in standardization or potency Nothing can be expected from their haphazard administration, usually in

inadequate dosage over a few weeks time Not even thyroid extract will prove efficacious under such conditions

"Patience in organo-therapy is absolutely essential Many months of careful trial are necessary before failure must be admitted, and if beneficial results have been obtained, therapy must long be continued "Gland therapy should only be attempted where there is definite indication, and then its application should be continued with patient persistence until a fair judgment can be rendered after a fair trial"

#### REFERENCES

- Allen, Edgar and Doisy, Edw A An Ovarian Hormone. Preliminary Report on Its Localization, Extraction and Partial Purification and Action in Test Animals *J A M A*, Chicago, Vol lxxx, No 10, 819-821
- Anspach, B M *Gynecology*, Lippincott, 1921
- Aub, J C and Taylor, Martha The Effect of Body Tissues Other Than the Thyroid Upon the Basal Metabolic Rate. *Endo*, Los Angeles, Vol vi, No 1
- Bandler, S The Endocrines W B Saunders, 1920
- Barker, L F The Principles Underlying Organotherapy and Hormotherapy *Endo*, Los Angeles, Vol vi, 591-5
- Beck, H G Typophyseal Disorders with Special References to Froelich's Syndrome. *Endo*, Los Angeles, Vol iv, No 14
- Bell, W Blair Intrinsic Dysmenorrhea *J Obst & Gyn*, Brit. Emp xxx, 119-161
- Cannon, W B Some Conditions Affecting Thyroid Activity *Endo*, Vol iv, July-Sept. 1920, 386
- Child, Jr, C D Sterility and Conception Appleton, Monograph, 1922
- Cushing, H The Pituitary Body and Its Disorders Lippincott, 1912
- Davis, C H Contribution to Etiological Study of Ovaritis *S G O*, Chicago, Vol. xxiii, 1911, 560
- Edmunds, W Further Observations on Thyroid Gland *J Path & Bacteriology*, Cambridge, 1916-17, xxi, 23-7
- Engelbach, Wm Classification of Disorders of the Hypophysis *Endo*, Los Angeles, Vol iv, Serial No 15
- Engelbach, W, and McMahon, A Osseous Development in Endocrine Disorders *Endo*, Vol viii, Jan, 1924, 1-53
- Evans, Herbert M Endocrinology and Metabolism, Appleton, Vol ii, 573-598
- Editorial Patience in Endocrinology *Endo*, Vol viii, Jan, 1924, 120-122
- Falta, W, and Meyers, M K The Ductless Glandular Diseases, 2nd Edition, Blakiston
- Geist, S H The Relation of the Endometrium and Ovary to Haemorrhage. *S G O*, Vol xxiii, 1916, 68
- Geist, S H and Harris, W Experimental Investigation of the Value of the Various Commercial Ovarian Extracts *Endo*, Los Angeles, Vol vii, 1
- Goetsch, Emil The Relation of Pituitary Gland to the Female Generative Organs *Surg Gyn & Obst*, Vol xxv, 229-243
- Goodall, J R The Origin of Tumors of Ovary *Surg Gyn & Obst*, Vol xxv, No 3, Mar 20, 1923, 249-264
- Goodall, J R Endocrinology and Metabolism Appleton Vol ii, 601-608
- Graves, W P *Gynecology* W B Saunders Co, 1916
- Hoskins, R G Some Recent Work in the Internal Secretions *Endo*, Vol iv, Sept 1922, 621
- King, Jas E Endocrine Influence *Trans Am Ass Obst Gyn & Abd Surgeon*, No xxxii, 1920, 40-48
- King, Jessie L Study of Anti-Coagulating Substances in Endometrium. *Amer J Physiol*, Oct. 1, 1921, 57-444
- Kingsbury, B T The Endocrine Organs A Point of View *Endo*, Vol viii, Jan. 1924, 91
- Krabbe, Knead H The Pineal Gland, Especially in Relation to the Problem on Its Supposed Significance in Sexual Development. *Endocrinology*, Vol. vii, 3, 379-405
- Leighton, A P Luteum Extract—A Further Report. *Trans Am Ass Obst Gyn & Abd Surgeon*, No xxxiii, 1920, 209-215
- Lintz, W, and Markow, H Relation of Onset of Menstruation to Environment. *Endo*, Vol. vii, No. 1
- Lisser, H Hypopituitarism and Its Treatment *Endo*, Los Angeles, Vol vi, No 1
- Lissner, H L Hypopituitarism *Endo*, Vol. vi, July-Sept 1920, 403
- Loeb, L The Relation of the Ovary to the Uterus and Mammary Gland from the Experimental Aspect. *Surg Gyn & Obst*, Chicago, July to Dec. 1917, Vol. xxv, 300-315
- Leopold-Levi and Rothschild LaPetit Insuffisance Thyroïdienne et son Traitement-Paris O Doin et Fils, Editors, 1913
- Maranon, G The Critical Age A Biological and Clinical Study (La Edad Critica) Madrid, 1910. *Surg Gyn & Obst*, No 3, Vol. xxx, Abstract 204-214
- Marine, David The Thyroid Gland in Relation to Gynecology and Obstetrics *Surg Gyn & Obst*, Vol. xxv 272-275
- Mason, F Raoul Endocrine Glands Lippincott, 1922
- Matt, F W Changes in Central Nervous System in Hyperthyroidism *Roy Soc Med Lon Path Sec* 1917, v, 51-59
- McCorr, Carey Pratt The Pineal Gland. *Surg Gyn & Obst*, Vol xxv, 250-257
- McIlroy, Louise Some Experimental Work Upon the Physiological Function of the Ovary *Jour Obst Gyn Brit Empire*, Lond. 1912, xxii, 19-26
- Novak, Emil Menstruation and Its Disorders Appleton, Monograph, 1921
- Novak, Emil Endocrinology and Metabolism. Vol ii, Appleton, 611-637
- Novak, Emil The Hormone Theory and the Female Generative Organ *S G O*, Chicago, 1909, ix, 344-350
- Novak, Emil Atropine Treatment of Dysmenorrhea. *J A M A*, 1915, lxxv, 120-2
- Novak, Emil Study of Relation Between Degree of Menstrual Reaction in Endometrium and Clinical Character of Menstruation *J H Hosp Bull*, Balt, 1915, xxvi, 306
- Novak, Emil Infantilism and Other Hypoplastic Conditions of Uterus *J A M A*, Chicago, 1918, lxxv, 1101-1109
- Novak, Emil An Appraisal of Ovarian Therapy *Endocrinology* Vol v-vi, 599-620
- Novak, Emil Role of the Endocrine Glands in Certain Menstrual Disorders, with Special Reference to Primary Dysmenorrhea and Functional Uterine Bleeding *Endo*, Los Angeles, Vol iv, July-Sept. 1920, 411
- Pappenheimer, Alvin M The Thymus Gland and Its Possible Relation to the Female Genital Tract. *Surg Gyn & Obst*, Vol xxv, 276-283
- Paton, D Noel Regulators of Metabolism Mac Millan & Co, 1913
- Polak J O Pelvic Inflammation in Women. Appleton, Monograph, 1921
- Pool, Eugene H The Relation of the Parathyroid System to the Female Genital Apparatus *Surg, Gyn & Obst*, Vol xxv, 260-271



- Pottenger, F M The Special Services Rendered to the Human Organism by the Sympathetic and Parasympathetic Systems *Endo*, Vol. v, No 2
- Ramirez, E. Ovaries and Menstruation *Endo*, Los Angeles
- Rongy, A. J Primary Sterility *N Y Med Jour*, 1922, cxvi, 439
- Rosser, C. Endocrine Problems in Pelvic Surgery with Special Reference to Vicarious Menstruation *Endo*, Los Angeles, Vol. v, No 5
- Sajous, C. deM Internal Secretions and Principle of Medicine. F A Davis Co, 1914 and 1920
- Sansum, W D, and Bratherwick, U R. The Sources of Error in Organotherapy as Illustrated by the Preparation and Administration of Insulin *Endocrinology*, Vol. vii, No 5, 661-669
- Solomons Bethel Sterility *Surg Gyn & Obst*, Feb 1920, Vol. xxx, 2, 173-181

- Stacy, Leda V Anteponition and Retroposition of the Uterus Incidence and Symptoms *Collected Papers of the Mayo Clinic*, xiv, 1922, 393-397
- Tice Tice's System of Medicine, Vol. viii, W F Prior Co, 1923
- Tierney, John L. Classification and Treatment of Hypophyseal Disorders *Endocrinology*, Vol vii, No 4, July, 1923
- Timme, Walter Polyglandular Syndrome. *Endo & Meta*, Vol. ii, Appleton
- Vincent, Swale *Endocrinology and Metabolism* Vol ii, Appleton 551-571
- Vincent, Swale Experimental and Clinical Evidence as to the Influence Exerted by the Adrenal Bodies Upon the Genital System *Surg Gyn & Obst*, Vol xiv, 294-299
- Voegtlin, Carl The Physiological and Pathological Importance of the Parathyroid Gland from the Experimental Aspect. *Surg Gyn & Obst*, Vol. xiv, 244-249

## THE TREATMENT IN AUTOMOBILE ACCIDENTS \*

By JOHN J MOORHEAD, M D, F A C S,

NEW YORK CITY

**A** TITLE of this sort might with equal appeal interest a repairman of the human machine or a repairman of the latest 1925 model, irrespective of the location or the size of the "service station" maintained

The influence of the automobile in our professional life is not yet fully realized even by those of us who are closely in touch with the accident problem introduced by the widespread use of motor driven vehicles. We all appreciate the effect of the automobile as related to the out-of-doors existence now made possible to countless numbers hitherto dependent upon the trolley or the railway. We all realize the change it has made in our ability to make distant calls on patients, and realize also how patients at a distance have access to us in our office or at our hospital. Few physicians recognize, however, that this accessibility may act to our detriment as well, in that a swift journey in an automobile may take our patient to a distant confrere or a distant hospital instead of bringing that patient into our own care or into our own hospital.

A new responsibility has in reality been brought into our practice by this universal form of transportation, just as years ago a new responsibility was created by the advent of the railway and the advent of large industrial plants. Until a few years ago some of you may recall the infrequency of accident work among physicians who were located at a distance from railway or industrial centers. Then the ordinary accidents were those incident to horse drawn vehicles to accidents on the farm, to accidents of ordinary haphazard, to accidents of sport or

recreation. These were relatively few by comparison with the rapid increase incident to railway and trolley travel, to the increase that followed rapid industrial development.

Still earlier, traumatic surgery in the mass dated back to Civil War days, and in effect we can say that now we are repeating a cycle that began in the '60's, for we are once more in a post-war period characterized by great activity in transportation and industry.

Some of our preceptors and professors gained much of their proficiency in the treatment of the injured by an experience gained in the Civil War and the mechanical age that followed thereafter.

History is repeating itself and today we have reached a period where traumatic surgery is based on the experience of the World War and the very rapid development of motor transportation and industry. Railways, mining and industry were formerly the three occupations providing the greatest incidence of injury. Today the greatest single factor is easily the automobile, industry the second, railways the third, sports the fourth. Government statistics for 1923 indicate that 83 per cent of highway fatalities are due to motor vehicles.

It therefore behooves the medical man of 1925 model to bestir himself in an effort to make his surgical procedures the last word in human conservation.

Despite the increase in the number and variety of these traumaphies, there is, however, no basic or fundamental change in surgical principles growing out of our war or post-war experiences, but there are numerous important changes in technique that lead to a greater saving of life and of limbs.

\* From the Department of Traumatic Surgery, New York Post Graduate Medical School and Hospital.  
Read before the Post Graduate Medical Society, October 9, 1924.

inadequate dosage over a few weeks time Not even thyroid extract will prove efficacious under such conditions

"Patience in organo-therapy is absolutely essential Many months of careful trial are necessary before failure must be admitted, and if beneficial results have been obtained, therapy must long be continued "Gland therapy should only be attempted where there is definite indication, and then its application should be continued with patient persistence until a fair judgment can be rendered after a fair trial"

### REFERENCES

- Allen, Edgar and Doisy, Edw A An Ovarian Hormone. Preliminary Report on Its Localization, Extraction and Partial Purification and Action in Test Animals *J A M A*, Chicago, Vol lxxxi, No 10, 819-821
- Anspach, B M *Gynecology*, Lippincott, 1921
- Aub, J C and Taylor, Martha The Effect of Body Tissues Other Than the Thyroid Upon the Basal Metabolic Rate. *Endo*, Los Angeles, Vol vi, No 1
- Bandler, S The Endocrines W B Saunders, 1920
- Barker, L F The Principles Underlying Organotherapy and Hormotherapy *Endo*, Los Angeles, Vol vi, 591-5
- Beck, H G Typophyseal Disorders with Special References to Froelich's Syndrome. *Endo*, Los Angeles, Vol iv, No 14
- Bell, W Blair Intrinsic Dysmenorrhea *J Obst & Gyn*, Brit Emp xxx, 119-161
- Cannon, W B Some Conditions Affecting Thyroid Activity *Endo*, Vol iv, July-Sept. 1920, 386
- Child, Jr, C D Sterility and Conception Appleton, Monograph, 1922
- Cushing, H The Pituitary Body and Its Disorders Lippincott, 1912
- Davis, C H Contribution to Etiological Study of Ovaritis *S G O*, Chicago, Vol xxiii, 1911, 560
- Edmunds, W Further Observations on Thyroid Gland *J Path & Bacteriology*, Cambridge, 1916-17, xxi, 23-7
- Engelbach, Wm Classification of Disorders of the Hypophysis *Endo*, Los Angeles, Vol iv, Serial No 15
- Engelbach, W, and McMahon, A Osseous Development in Endocrine Disorders *Endo*, Vol viii, Jan, 1924, 1-53
- Evans, Herbert M Endocrinology and Metabolism, Appleton, Vol ii, 573-598
- Editorial Patience in Endocrinology *Endo*, Vol viii, Jan, 1924, 120-122
- Falta, W, and Meyers, M K The Ductless Glandular Diseases, 2nd Edition, Blakiston
- Geist, S H The Relation of the Endometrium and Ovary to Haemorrhage. *S G O*, Vol xxiii, 1916, 68
- Geist, S H and Harris, W Experimental Investigation of the Value of the Various Commercial Ovarian Extracts *Endo*, Los Angeles, Vol vii, 1
- Goetsch Emil The Relation of Pituitary Gland to the Female Generative Organs *Surg Gyn & Obst*, Vol xxv, 229-243
- Goodall, J R The Origin of Tumors of Ovary *Surg Gyn & Obst*, Vol xxx, No 3, Mar 20, 1923, 249-264
- Goodall, J R Endocrinology and Metabolism Appleton Vol ii, 601-608
- Graves, W P *Gynecology* W B Saunders Co, 1916
- Hoskins, R G Some Recent Work in the Internal Secretions *Endo*, Vol iv, Sept 1922, 621
- King, Jas E Endocrine Influence *Trans Am Ass Obst Gyn & Abd Surgeon*, No xxxiii, 1920, 40-48
- King, Jessie L Study of Anti Coagulating Substances in Endometrium. *Amer J Physiol*, Oct. 1, 1921, 57 444
- Kingsbury, B T The Endocrine Organs A Point of View *Endo*, Vol viii, Jan 1924, 91
- Krabbe, Knead H The Pineal Gland, Especially in Relation to the Problem on Its Supposed Significance in Sexual Development. *Endocrinology*, Vol vii, 3, 379-405
- Leighton, A P Luteum Extract—A Further Report. *Trans Am Ass Obst Gyn & Abd Surgeon*, No xxxiii, 1920, 209-215
- Lintz, W, and Markow, H Relation of Onset of Menstruation to Environment. *Endo*, Vol vii, No. 1
- Lisser, H Hypopituitarism and Its Treatment *Endo*, Los Angeles, Vol vi, No 1
- Lissner, H L Hypopituitarism. *Endo*, Vol vii, July-Sept. 1920, 403
- Loeb, L The Relation of the Ovary to the Uterus and Mammary Gland from the Experimental Aspect. *Surg Gyn & Obst*, Chicago, July to Dec. 1917, Vol xxv, 300-315
- Leopold-Levi and Rothschild LaPetit Insuffisance Thyroïdienne et son Treatment-Paris O Doin et Fils, Editors, 1913
- Maranon, G The Critical Age A Biological and Clinical Study (La Edad Critica) Madrid, 1910. *Surg Gyn & Obst*, No 3, Vol xxx, Abstract 204-214
- Marine, David The Thyroid Gland in Relation to Gynecology and Obstetrics *Surg Gyn & Obst*, Vol xxv 272-275
- Mason, F Raoul Endocrine Glands Lippincott, 1922
- Matt, F W Changes in Central Nervous System in Hyperthyroidism. *Roy Soc Med Lon Path Soc* 1917, v, 51-59
- McCord Carey Pratt The Pineal Gland. *Surg Gyn & Obst*, Vol xxxv, 250-257
- McIlroy, Louise Some Experimental Work Upon the Physiological Function of the Ovary *Jour Obst Gyn Brit. Empire*, Lond 1912, xxii, 19-26
- Novak, Emil Menstruation and Its Disorders. Appleton, Monograph 1921
- Novak, Emil Endocrinology and Metabolism Vol ii, Appleton, 611-637
- Novak, Emil The Hormone Theory and the Female Generative Organ *S G O*, Chicago, 1909, ix, 344-350
- Novak, Emil Atropine Treatment of Dysmenorrhea. *J A M A*, 1915, lxiiv, 120-2
- Novak, Emil Study of Relation Between Degree of Menstrual Reaction in Endometrium and Clinical Character of Menstruation *J H Hosp Bull*, Balt, 1917, xxvi, 306
- Novak, Emil Infantilism and Other Hypoplastic Conditions of Uterus *J A M A*, Chicago, 1918, lxxiv, 1101-1109
- Novak, Emil An Appraisal of Ovarian Therapy *Endocrinology* Vol v-vi, 599-620
- Novak, Emil Role of the Endocrine Glands in Certain Menstrual Disorders, with Special Reference to Primary Dysmenorrhea and Functional Uterine Bleed. *Endo*, Los Angeles, Vol iv, July-Sept. 1920, 411
- Pappenheimer, Alvin M The Thymus Gland and Its Possible Relation to the Female Genital Tract. *Surg Gyn & Obst*, Vol xxv, 276-283
- Paton, D Noel Regulators of Metabolism. Mac Millan & Co, 1913
- Polak, J O Pelvic Inflammation in Women. Appleton, Monograph, 1921
- Pool, Eugene H The Relation of the Parathyroid System to the Female Genital Apparatus *Surg. Gyn & Obst*, Vol xxxv, 260-271

the patient with a damaged hand or a functioning hand? What value do we place on our own hand? Next to our eyes, there is nothing more important. Treat all wounds of the hand with the greatest respect and apprehensions, especially small wounds that bleed little or not at all—punctures of the finger tips especially. Adequately sterilize after the manner already suggested. In the majority of hand wounds, do not tie the sutures at all until the second or third day, merely inserting the sutures at the first dressing. This is the so-called method of "delayed suture" or "primo-secondary suture" as opposed to "immediate suture" or "primary suture." As time goes on, our practice in most wounds of any region is to adequately sterilize, then to place but not to tie all the sutures, awaiting the lapse of 48 to 72 hours to determine the presence or absence of infection. This principle of wound treatment is exceedingly important in view of the statement previously made that infection due to the causative agency manifests itself in the first three days unless re-infection or secondary infection occurs from contamination due to our own faulty technic. Nothing really is lost by this plan of "delayed suture", on the contrary, many infections are thus prevented. Incidentally, we should not fail to enforce this rule on our ambulance surgeons and the internes in our accident ward.

Many of these hand wounds are associated with fractures, and numbers of them are badly mangled. In these, it is needful to spend a long time in the preliminary cleansing with soap and water, using a grease solvent like benzine, gasoline or kerosene when needed.

We save every bit of attached soft tissue at first, for the hand, like the face, is rich in blood supply and our early conservation may be rewarded by a restoration of function seemingly impossible. Keep the fingers straight. Separate them by a layer of gauze soaked in sterile vaseline or olive oil. Hold them straight by passing a needle and thread through the finger nail, fastening the thread over the end of a splint. A piece of telegraph wire makes an excellent splint when the shaped ends are bound together by adhesive or electrician's tape, and the entire finished splint is then covered by gauze. We must not forget to use Tetanus Antitoxin in any crushing hand wound that may have become soiled by street dirt, garden soil or by contact with any manured location. This applies also to any other anatomical location, especially if a fracture co-exists. We do not fear to use Tetanus Antitoxin because of a possible anaphylaxis. If we inject the antitoxin slowly this reaction will usually not occur, if still we fear it, we have at hand a hypodermic of adrenalin 1/10,000 to ward off the onset of anaphylactic evidences. If there is any one indisputable surgical lesson growing out of our recent war experience it is the demonstration of Tetanus Antitoxin as a sovereign remedy,

practically a specific, in the class with quinine for malaria, mercury for syphilis and insulin for diabetes.

### INFECTED WOUNDS

If the infection appears in a case originally under our care, we immediately open the wound to allow free drainage. We have learned the value of making a smear or culture of the wound and thus early determining whether or not we are dealing with a streptococcus invasion. We fear this organism with a real terror, and once we determine that it is present, we make sure of unusually free drainage very promptly. We do not so much fear staphylococcus infection, or colon infection, and almost with a certainty we can laugh at a pyocyanus or "green bug" infection for this blue or green pus is for us the "laudable pus" of our predecessors—indeed we might call it "laughable pus" because of the joy it seems to produce in the subsequent repair. Some day we will deliberately inoculate our streptococcal or strepto-staphylococcal wounds with pyocyanus and watch the latter battle for our side.

Gas bacillus infection is fortunately rare and in many of these, liberal drainage will prevent amputation. Beware of it when muscle has been much crushed, vessels are injured or a tourniquet has been used.

In already established infections, in those untreated or lightly or improperly treated, we should be guided by the type of the organism and the clinical signs before ruthlessly proceeding with incisions and drainage. Never incise for redness or swelling alone. Incise only for fluctuation, for sharply localized pain, from definite induration. Incise in the direction of the main underlying structures. Rarely cross cut. Make the incision sufficiently long and deep so that the wound edges actually gape apart. Beware the so-called "medical incision" which is generally about half an inch long and an eighth of an inch deep. Get in the habit of declining to incise unless you can use a local anaesthetic or better nitrous oxide, ether or ethyl chloride by the drop method. Never use chloroform in any traumatic case, for it is as dangerous in this class as it is safe in obstetrics, remembering that even in the hands of a trained anaesthetist chloroform is still the most lethal form of narcosis. When draining an infected wound, use rubber bands or rubber tubes unless the bleeding requires gauze. If so, soak the gauze in vaseline, olive oil or sterile soap suds so that it will not adhere. Dress such a wound in the early stages with a hot iodine solution on many layers of gauze. Keep it wet by placing perforated rubber tubes in the gauze, so that these tubes can take up solution injected every three hours if necessary. Splint and elevate an infected wound. Soak off the dressings in running water.

We would revert to some of these in essential detail, having in mind some of the usual or common forms of trauma as witnessed in automobile accidents

### WOUNDS

We now know that antiseptics have only a limited value, however vaunted any one of them may be. As a matter of fact, the washing away, the liquifaction power, the mechanical stimulation, is for any antiseptic an essential element. The germ killing power of an antiseptic is in reality only secondary, inasmuch as the demise of the germ is usually associated with the demise of adjacent normal tissue and thus is of doubtful value. We now know that in any ordinary wound, germ life does not appear until about eight hours after the injury, that at 12 hours thereafter the organisms may be fairly numerous, and that at 24 hours thereafter, they may be almost uncountable. At the end of 36 hours, some of the original colonies die, but new colonies appear often enough to give in some instances that characteristic daily rise of temperature so common in septic cases. We must stand on the fundamental principle that germs live in wounds only when there exists damaged tissue enough to nourish them. Hence the axiom that early sterilization is the key to success, for a clean wound means early healing, a dirty wound means delayed healing. Early or immediate sterilization is possible by two methods only. One is *mechanical sterilization* obtained by sparingly cutting away the bruised, lacerated or otherwise damaged tissue so that only healthy red tissue remains. This is the principle of debridement first used by the French and later universally employed by Allies and foes alike. Strangely enough this very process dates back to the Napoleonic wars, when it was advocated by Napoleon's famous surgeon, Baron Larrey. It is applicable, of course, only to the severer wounds of civil life, practically only to hospital cases or those in which an anæsthetic is necessary.

The second method of wound sterilization is *chemical sterilization* and this is the procedure applicable to the ordinary case. Here we endeavor to wash away all contamination by soap and water, using benzine, gasoline or kerosene to remove grease or tar. Then we flood the wound with an antiseptic of known staining quality, seeking as it were to "fix" the tissues, using the term we remember from our student experience in the histopathological laboratory. What is a good "fixing" agent of reliability for every day use? Not carbolic or bichloride surely. Not a chlorine or other nascent agency. Based on our experience the official alcoholic tincture of iodine is the antiseptic of proven worth. Wisdom dictates the use of one antiseptic only after

we have verified the value of it. If we use seven, that means that we vary our technic by the days of the week more than by the lessons of experience. It is unwise to use an antiseptic because it has advertising propaganda and an attractive label or a pretty name, we use it, because yesterday, today and tomorrow it does what any standard form of therapy does—namely, acts. So then this accidental wound is cleaned by soap and water, it is dried, it has iodine freely poured into it. If it is a punctured wound, we inject the iodine with a syringe or hypodermic.

*Next suturing.* Apply sutures loosely. In some cases, as indicated below, we do not suture at once. Always use interrupted sutures of non-absorbable material. In children and in some adults, a few long attached hairs twined or tied across the scalp wound act as well as sutures. In some cases, adhesive strapping is also efficient.

*Next draining.* Every wound not made with surgical intent is already infected and should be drained. We use for this purpose rubber bands, a rubber tube, or where the wound is small, we insert a strand of our suture material, using a needle to place it. This drain is removed in 24 to 48 hours if all goes well. The only reason for not using a drain is the groundless fear that union is compromised. The contrary is true as a matter of clinical experience, for an adequate rubber drain will not in the least interfere with wound coaptation if it is removed by the end of the second day. We do not use gauze for drainage unless we deliberately plan to use that material as a hemostatic agent, or design to keep wound edges apart. Gauze when saturated by blood or serum acts as a plug or cork and obviously then ceases to function as a vent.

*Next the dressing.* Gauze should always be placed next to the wound, not absorbent cotton or rubber dam. The first few layers of gauze may well be moistened by a mild antiseptic to render sterile the field adjacent to the wound, especially the area about a contused wound. Our experience again favors iodine for a wet dressing, using one dram of the tincture to a pint of normal saline solution. For many years this "iodine solution" has been the vehicle of choice in our practice when a non-irritating antiseptic is demanded for irrigations or wet dressings. In many cases it is wise to splint the wound for the first few days, and this is notably true in hand and forearm wounds. Splint thumb up in hand cases and palm up in forearm cases. Anticipate a tendency to flexion in any wound contiguous to a joint, and splint accordingly.

### HAND INJURIES

There is more mutilating surgery in this group than in any other, especially when infection has begun. We must never forget that our initial treatment may be the essential factor in providing

sary when the fracture line is non-serrated, as in many smooth transverse or smooth oblique fractures. Very rarely attempt to reduce any fracture without anaesthesia unless it is seen within the first few hours. Swelling and muscle spasm will defeat our best efforts after this lapse, to say nothing of the added pain induced by manipulation. Again beware of chloroform, using instead, nitrous oxide, or ether or ethyl chloride given drop by drop.

We should more often attempt the reduction of fractures of long bones by gradual weight traction rather than by quick manual traction. By this we mean to apply adhesive straps or glued straps to a limb, then fastening a weight to these straps so that thus the muscles may be pulled into line, for in reality we set every fracture not at all by setting the bone but by setting the muscles.

A very serviceable non-irritating glue called Lotol is to be marketed by the U S Rubber Company, using their liquid rubber Latex as a base. This has been tried out in my service and I can recommend it as a fixative for traction straps made of adhesive plaster, moleskin or muslin.

A towel or sheet around the ankle or wrist will act as an efficient traction strap until we can apply a more elaborate apparatus composed of a pulley, an overhead set of bars (Balkan frame), or special splints of the Thomas or similar varieties.

If we apply this form of preliminary traction at once, placing the limb in a grooved pillow, we will be gratified to find reduction much easier, perhaps even attained, when we next see the patient after a lapse of eight or more hours.

This applies with great detail to fractures of the lower extremity, and to the dreaded fracture of the neck of the femur in old people. In many of these fractures of the neck of the femur, any fixed apparatus immobilizes the patient as well as the hip and leads to stasis of circulation ending in pneumonia or cardio-renal disaster.

There is no question as to the value of the plaster of Paris spica in selected cases of fracture of the neck of the femur, but we must remember that a fat, flabby abdomen or a retracted cadaverous abdomen in an old person lessens the holding power of the abdominal part of the cast and is likely to press the abdominal contents against the diaphragm to such an extent as to impede thoracic breathing and thus to promote hypostasis, which last is also aided by the enforced recumbency induced by the cast, despite frequent turning of the patient.

As a matter of practice, we never use a circular plaster of Paris casing or cast in any recent case (neck of femur excepted), but do place great reliance and faith in two piece

moulded plaster of Paris splints. Whatever is used, every splint should be first of all safe and next it should be simple and next economic.

There are certain selected fractures demanding open or operative reduction from the outset, conditions permitting. In this group are displaced fractures of the patella, of the olecranon, of the forearm, some of the tibia and some of the os calcis.

Plating, wiring and the introduction of non-absorbable material is needlessly dangerous surgery in the vast majority of cases and it should not be attempted by the occasional operator who, strangely enough, is just the surgeon who is now doing most of it.

Fractures of the shaft of the femur, of the tibia and some of the humerus often demand more traction than is possible by external appliances, and hence skeletal traction is needed either in the form of (1) a nail or pin transfixing the bone (Codivilla-Steinmann method), or, (2) tongs or callipers passed into the cortex of the bone (Ransohoff method), or, (3) a stirrup or loop of wire passed over the bone (Finochietto method). None of these devices should be left long in situ, and they can be removed within two weeks in the majority of cases if a heavy traction weight is used from the outset. They are methods of reduction only and no longer are used by us until union is well advanced, splints or external traction being substituted when the bone is definitely aligned. They are of especial service in compound or infected fractures because they can be inserted at a distance from the site of the trauma.

The ordinary joint fractures, such as those about the wrist (Colles' and Chauffeur's), or ankle (Pott's and variants), or elbow (supra-condylar and condylar) demand more accurate adjustment than shaft fractures if our patient is to escape disability and deformity.

Experience teaches us that children up to 16 years compensate by subsequent growth for even gross post-traumatic bone deformity, especially after fracture of the shaft of the femur. Joint fractures in children, notably if epiphyseal in type, are more likely to prove deforming and disabling than shaft fractures, and this is markedly true of elbow and knee fractures. Irrespective of age then, a joint fracture requires more accurate reposition than a shaft fracture. Prompt reduction under anaesthesia is essential and the first step in reducing any joint or shaft fracture is to increase the original deformity enough to thoroughly mobilize the part. Then traction and manipulation follow until (1) the normal bony landmarks of the joint or shaft are restored, (2) the deformity disappears, (3) pressure does not produce recurrence of the original deformity. When these three "tests of reduction" exist, that fracture is properly set.

and do not pull them off. Let the patient immerse the part in a hot iodine solution two or three times daily for half an hour, and while so immersed see that contiguous joints are moved.

Use a saturated solution of magnesium sulphate for so-called erysipelas cases. I say "so-called," for wound erysipelas is in reality streptococcus cellulitis that needs no special isolation, and certainly needs no ichthyol or any similar nasty smear as a dressing.

Hand infections should be incised, not carelessly, but in a perfectly definite manner, based on the known anatomy and pathology of the process. For finger tip infections of the felon type (a true osteomyelitis), split the pulpy pad of the finger vertically just in front of the nail and insert a rubber band. For hang nail infections, the paronychia group, incise upward from the edge of the nail toward the pad of the finger so that the matrix will be exposed.

For tendon infections of the finger group, make lateral incisions, on each side if necessary, but do not cross the web spaces and do not incise directly along the palmar surface. It is almost never necessary to cut on the back of the hand in any form of hand infection because the swelling in this location is a passive edema, rarely harboring pus in the absence of a definite focus or definite fluctuation.

Infections reaching the palm will occupy one of the three main cavities thereon, namely, the thenar, the hypothenar or mid-palmar space. Use the normal creases of the palm as the guide to these areas, having in mind the distribution of the palmar arches. For infection that spreads beyond the wrist into the forearm, make a lateral incision on the antero-external or antero-internal aspect, or both, and pass the drain across and under the tendons if necessary.

Do not use drains for more than a few days in these hand and forearm cases, for otherwise a slough of tendons or vessels will occur. Teach the patient to keep the fingers and the wrist and the elbow moving, otherwise pitiable and perhaps hopeless contractures will occur.

We must not forget that any infected wound leading to bone may be associated with osteomyelitis which is usually a streptococcus affair and hence will be subject to an exceedingly guarded prognosis as to immediate recovery, a period of latency and a subsequent recurrence. We know, I regret to say, very little more today about the treatment of osteomyelitis than our forefathers knew in Civil War days, and our own soldiers are again proving to us the tragedy of the old adage "once an osteomyelitis, always an osteomyelitis." Be especially careful then in dealing with any infection contiguous to or associated with bone.

The general care of an infected case is very important. When possible, expose the wound

surface to the sun, to the air, to electric light, for all these agencies promote healing. Keep all dressings off a freely draining or granulating wound and cover it instead by a wire mesh or celluloid cage. In such cases, a dressing is often nothing more than a pus poultice. When possible, get sea water for soaking or dressing the wound as this is of all the best to promote free drainage. Feed well an infected case. Plenty of milk and eggs and green vegetables. Give iron and quinine as a tonic where needed.

#### NOW AS TO FRACTURES

There are certain very definite but very simple rules governing our practice, and these are based on the law of averages. First, let us recognize that a fracture is a wound of bone, and like wounds of soft parts we can actually have an incised or slightly separated fracture, and a lacerated or much separated fracture. These non-overlapped fractures we call Type II, the overlapped group fall into Type I. The important thing is that the Type II set require splintage alone to promote healing, but the Type I set require reduction *and* splintage. In other words, we convert Type I into Type II before we splint. Either type can of course be simple or compound. Wounds of the soft parts heal well only when properly coapted and retained by sutures. Fractures act in the same way, the splint acting as an external suture.

The vast majority, yes almost 80 per cent, of joint injuries characterized by deformity and disability are fractures and not dislocations, the shoulder joint being the only exception. Hence in any recent deforming and disabling injury of a joint, this law of averages requires us to think first of a fracture, shoulder joint excepted.

We should acquire the habit of setting the fracture when first seen, using the X-ray to prove the success in our setting more than the success in our diagnosis. Show the patient or some responsible member of the family the X-ray, but always be prepared to state that an absolutely perfect adjustment is impossible in a hidden bone unless open operation is permitted, even then it is often impossible. State also that absolute or anatomical alignment is usually not necessary either as to function nor visible contour. State these things freely and openly, make no positive promises as to the outcome in terms of time, function nor appearance, if we do these things we will not be harassed by lawsuits nor will we be accused of bungling. Get X-rays when possible immediately after setting, and in the case of shaft fractures especially, check up by another X-ray in from seven to ten days, inasmuch as a fracture of the shaft of the arm, forearm, leg or thigh often "slips" after primary or immediate adjustment unless the fragments are well locked. This caution is especially neces-

to cope with the extensive lacerations of brain covering and brain substance that usually involves the inaccessible mid-brain

The after care in all these cases demands great watchfulness to prevent meningitis or other sequelae

#### DISLOCATIONS

A word of caution as to prolonged bandaging or otherwise immobilizing these cases. Dislocations like joint fractures are associated with arthrosynovitis and this is the pathology demanding attention and not the displaced bone, after the latter is set. No joint injury more requires early mobilization than dislocations, and to long immobilize a dislocated shoulder, for example, is to promote atrophy, invite recurrence and perpetuate disability

#### SUMMARY

An attempt has been made to epitomize some of the salient features of the treatment of traumata growing out of automobile accidents. Spe-

cial stress is laid on the necessity for complete sterilization of wounds, thus limiting infection and disability. Fractures are put also into the wound class and are classified in respect to their displacement and treated accordingly. Dislocations and joint injuries generally should be mobilized early. Infections of the hand demand special attention because they are now badly treated.

The time has passed when the juniors of the house staff "get" the accident cases, because many of these injuries are of such an unusual nature as to tax the most experienced of the visiting staff.

Traumatic surgery should be regarded as emergency major surgery far oftener, and the responsibility of the profession is growing because accidents are now much more numerous and much more severe, so that practically every physician, irrespective of his specialty or geographical location, may be suddenly called upon to treat a most important form of trauma in a most important type of individual.

---

### COMMUNITY NURSE\*

By F G METZGER, M D,

CARTHAGE, N Y

**T**HE success or failure of the community nurse depends principally upon three closely related factors

(1) The nurse, herself, is perhaps the most important. She must possess judgment, tact, ability and willingness to work, and a comprehensive knowledge of public health work. She must be impressed with the actual scope of her field of work and never transgress its rightful limitations of authority and medical practice. She should be firm enough to help enforce, impartially, the public health regulations, yet sympathetic in giving nursing care in cases of emergency relief. While the latter is not considered part of the duties of the public health nurse, it will, perhaps more than any other one thing, gain the confidence and support of the community.

(2) The community, once prevailed upon to employ a nurse, should co-operate fully in adequate compensation and financial as well as moral support in the various phases of the work. While the leaders in some communities figuratively belong to the ox-team age, fortunately these are in the minority, and the live, up-to-date governing boards will support any activity which has been proven of merit. This support must include the maintenance of an auto, which will

increase efficiency both in saving valuable time and physical effort, and is purely a business proposition, from the dollars and cents standpoint. A suitable office, centrally located, is very essential in the holding of the various clinics, an established feature of public health. Various clubs should be interested, not only for the financial support which they lend to the work of the nurse, but the members of these clubs, usually representing the influential element of the community feel a personal responsibility which makes for the good of the cause.

(3) The Health Officer should supervise the public health activities of the nurse, and he, alone should be responsible for the success or failure of her work. This applies equally well to the nurse doing school work as to the one doing Public Health only. Where such is not the case, there is bound to be duplication of effort and confusion, for who is or should be better qualified than the Health Officer to direct the Public Health Program. In communities sufficiently large to make this impracticable, it can be taken care of by a Bureau in the Health Department.

In concluding, I would say that the success or failure of the Community Nurse depends on a competent nurse working out a comprehensive Public Health Program in a manner that the community is convinced that its money is well spent.

\*Read at the Annual Meeting of the Medical Society of the State of New York, at Rochester, April 23, 1924

The position the limb should assume after reduction is not altogether answered by the old rule "splint in a direction opposite to the original deformity." We must of course overcorrect the existing malformation, but we must also bear in mind the best functioning position in the event of ankylosis. The following statements as to position after reduction are clinically valuable.

(1) In the supinated upper extremity preserve the carrying angle by aligning the acromion, external condyle and radial styloid in the lateral axis. In the vertical axis, align the coracoid, the middle of elbow, the middle of wrist and the middle knuckle.

(2) Splint wrist fractures in palmar flexion and adduction in the thumb up position. Splint hand fractures with wrist dorsally flexed.

(3) Splint all fractures above the wrist in full supination, with elbow at a right angle.

(4) Splint elbow fractures (olecranon excepted) in hyperflexion, with marked abduction of forearm.

(5) Splint clavicle fractures with a T-splint or other device to keep shoulders in the wearing-a-knapsack position, i.e., with shoulders drawn backward and upward.

(6) Splint ankle and foot fractures in hyperflexion and hyperinversion.

(7) Splint fractures of the leg and thigh to preserve the lateral carrying angle maintained by aligning the great trochanter, external condyle, external malleolus and head of fifth metatarsal. The vertical carrying angle is maintained by aligning the anterior superior spine, the tubercle of the tibia, the middle of the ankle and the base of the second toe. These two measurements we call the seam and crease of the pants lines.

For splintage, prefer always a removable splint permitting inspection and early massage and motion. As to duration of splintage, let us remove half the splint when union is firm ("lead pipe union") and the rest of the splint when union is solid ("iron pipe union"). We splint a joint fracture only about half the period we splint a shaft fracture, neck of femur excepted. There is practically no such thing as non-union in a joint fracture, again excepting neck of femur.

Beware of non-union oftenest in fracture of the lower third of the tibia, next in the radius, next the ulna, next the humerus. Essentially there is only one cause for non-union and that is non-coaptation due to interposition of hard or soft parts. Syphilis seems often to aid rather than retard fracture healing—witness for example the healing rate in tabetics and the insane.

When can I let the patient use the part? Use is permissible when no prolonged reaction (red-

ness, heat, pain, swelling) follows, (1) Rough massage, (2) pounding the part, (3) special tests of the part, (i.e., weight bearing or weight carrying).

These are the "tests for usage" employed by us, and in the lower extremity, crutches are early displaced by the use of walking callipers placed on the limb as soon as union is solid enough to remove the splints.

## HEAD INJURIES

There are three clinical groups usually encountered, and in at least one of these the diagnosis rests as between concussion alone, or concussion associated with laceration or skull fracture.

Group I may be called the mild group in which concussion is the main symptom, plus the associated shock and the succeeding headache, dizziness and perhaps mental confusion. Let us not forget that concussion means immediate temporary unconsciousness usually associated with nausea or vomiting. If the onset is not immediate, it is not true concussion, if it is not temporary, it is not true concussion. These cases usually recover without any special treatment aside from rest and careful supervision.

Group II may be called the moderately severe group of concussion plus vault or basal fracture. If the latter, and bleeding from the ear or nose is moderately free, self-decompression occurs and any later evidences of intracerebral pressure usually indicates serous effusion or infection. Operation is only indicated in this group for the relief of localizable pressure, and pressure in head injuries occurs only from bone, blood or foreign bodies. Decompression for the relief of basal fracture, or any other site of generalized intracerebral pressure, is a procedure now quite generally abandoned because greater relief can be obtained by the spinal tap, which is not only of therapeutic but also of diagnostic value. Relief of intracranial tension can also be obtained by a rectal drip of a 10 or 20 per cent magnesium sulphate solution. Operation for head injury designed to relieve demonstrable pressure from a clinical standpoint is usually demanded or warranted only for depressed fracture of the vault (especially if compounded) and for cortical hemorrhage as from middle meningeal hemorrhage.

The routine performance of trephining for head injury need only be mentioned to be condemned even in the presence of non-depressed extensive fracture. Children rarely require operation.

Group III may be called the severe group in which the cranial contents are so badly damaged that signs of intracranial damage are present from the outset. These cases are fatal in the vast majority of instances as surgery is unable



chairmen and members are expected to be the channels of communication between the Bureau of Legislation of the State Society and the local representatives in the Legislature

It is the conscientious intention of the Committee on Legislation to transmit up-to-date information in legislative matters to the local chairmen and members at the earliest possible moment. This information is sent through the columns of THE NEW YORK STATE JOURNAL OF MEDICINE, and by advance copies of the JOURNAL articles sent to the county chairmen and members of advisory committees

It is to be feared that the legislative columns of the JOURNAL are not always read with care. Many requests are printed in the JOURNAL that members write to their legislators regarding specific bills, but conversations with legislators show that too few letters are sent in response to these general calls to action. It is the intention of the Committee on Legislation to make an equitable division of the work of reaching legislators. When action on the more important bills is desired, the State Committee sends out special calls to the county chairmen, and puts the responsibility of action upon the local societies and their com-

mitteemen and members. But on lesser matters the State Committee on Legislation feels free to act.

If individual members of county societies fail to reach their legislators when they are requested, the work which they should have done must be apportioned among other members of the State Medical Society, and active men of honest convictions must suffer with the indolent and careless in the results of any inimical legislation that may be passed.

It is a reasonable expectation that the aggregate amount of work done by the Legislative Committees and members of the County Medical Societies in informing legislators would far exceed the amount done by the Committee on Legislation of the State Society. The proper division of work is that the Committee on Legislation should gather and distribute the information regarding medical bills, and that the county legislative committees should do most of the work of informing their legislators. This is an equitable division of the work. It is also the most effective, for if it is carried out, it will demonstrate that the practising physicians are sincerely trying to assist their legislators in framing laws for the public good.

J N V V

## THE PHYSICIAN IN PUBLIC HEALTH

Physicians generally are beginning to recognize their direct duties in public health matters, and to seek channels by which they may express their opinions and secure action in accord with their convictions. They are ready to act through their medical societies, and to give time and effort in advising governmental bodies regarding any of their actions which affect public health. It has heretofore been the argument of lay welfare organizations that physicians have not taken part in public health movements. This criticism is no longer true. Physicians are ready and anxious to respond to public health needs, as is abundantly proved by the actions of several County Medical Societies in appointing advisory committees whose services are at the disposal of Boards of Supervisors and other governmental bodies.

An opportunity to recognize the local physicians and give them definite responsibility is afforded by Senate Bill Int. 283 Assembly Int. 399, on which we commented in the editorial columns last week (page 265). This bill authorizes Boards of Supervisors to employ public health nurses at county expense. The Committee on Legislation of the Medical Society of the State of New York believes that the employment of public health nurses by county governing boards is a most excellent idea. The Committee also approves the lines of work which the

nurses may undertake. But it does not approve the machinery under which the nurses will work if the bill should become a law in its present form.

Health officers naturally desire to avail themselves of the services of public health nurses, but primarily health officers are physicians, and on the shoulders of the local physicians must rest the ultimate responsibility for the health of the people of a community. The proposed law will apply principally to rural counties, and in these counties the practising physicians form a group which is the best qualified of all groups of persons to understand public health needs and the methods which are best suited to remedy local conditions. Moreover, the physicians of every county have an efficient organization in an active County Medical Society.

The editorial columns of this Journal have contained many comments regarding the practice of Civic Medicine by County Medical Societies, and the news columns have recorded the official actions of several county medical societies in taking the lead in public health matters. The time is at hand when the State Department of Health, the State Department of Education, local Boards of Supervisors, and lay welfare organizations may expect full co-operation from the official organizations of physicians.

When a new method of action affecting public



# EDITORIALS



The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication.

*Editor-in-Chief*—NATHAN B VAN ETEN, M D,  
New York  
*Associate Editor*—ORRIN SAGE WIGHTMAN, M D,  
New York  
*Executive Editor*—FRANK OVERTON, M D  
Patchogue

### COMMITTEE ON PUBLICATION

E ELIOT HARRIS, M D, *Chairman* New York  
ORRIN SAGE WIGHTMAN, M D New York  
EDWARD LIVINGSTON HUNT, M D New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

*President*—OWEN E JONES, M D Rochester  
*First Vice President*—GEORGE A. LEITNER, M D Piermont  
*Second Vice President*—LUZERN COVILLE, M D Ithaca  
*Speaker*—E. ELIOT HARRIS, M D New York  
*Vice Speaker*—GEORGE M FISHER, M D Utica  
*Secretary*—EDWARD LIVINGSTON HUNT, M D New York  
*Assistant Secretary*—WILBUR WARD M D New York  
*Treasurer*—CHARLES GORDON HEYD, M D New York

### CHAIRMAN, STANDING COMMITTEES

*Arrangements*—FREDERICK H. FLAHERTY, M D Syracuse  
*Public Health and Medical Education*,  
JOSHUA M VAN COTT, M D, Brooklyn  
*Scientific Work*—ANDREW MACFARLANE, M D Albany  
*Medical Economics*—HENRY LYLE WINTER, M D Cornwall  
*Legislation*—JAMES N VANDER VEER, M D Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex President and the Councilors of the District Branches.

*First District*—EDWARD C. RUSHMORE, M D Tuxedo Park  
*Second District*—FRANK H. LASHER, M D Brooklyn  
*Third District*—ARTHUR J. BEDELL, M D Albany  
*Fourth District*—CHARLES C. TREMBLEY, M D Saranac Lake  
*Fifth District*—NELSON O. BROOKS, M D Oneida  
*Sixth District*—GEORGE H. FOX, M D Binghamton  
*Seventh District*—WILLIAM I. DEAN, M D Rochester  
*Eighth District*—HARRY R. TRICK, M D Buffalo

### COUNSEL

GEORGE W. WHITESIDE, Esq., 27 William St New York  
Telephone, Broad 1744

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St New York

### EXECUTIVE OFFICER

JOSEPH S. LAWRENCE, M D 51 Chapel Street, Albany

### SECTION OFFICERS

*Medicine*  
*Chairman*—ROBERT L. LEVY, M D New York  
*Secretary*—L. WHITTINGTON GORHAM, M D Albany  
*Surgery*  
*Chairman*—MARSHALL CLINTON, M D Buffalo  
*Secretary*—EDWARD S. VAN DUYN, M D Syracuse  
*Obstetrics and Gynecology*  
*Chairman*—HAROLD C. BAILEY, M D New York  
*Secretary*—NATHAN P. SEARS, M D Syracuse  
*Pediatrics*  
*Chairman*—JOSEPH C. PALMER, M D Syracuse  
*Vice-Chairman*—ROGER H. DENNETT, M D New York  
*Secretary*—ARTHUR W. BENSON, M D Troy  
*Eye, Ear, Nose and Throat*  
*Chairman*—ARTHUR G. BENNETT, M D Buffalo  
*Secretary*—EUGENE E. HINMAN, M D Albany  
*Public Health, Hygiene and Sanitation*  
*Chairman*—PAUL B. BROOKS, M D Albany  
*Secretary*—ARTHUR D. JACQUES, M D Lynbrook  
*Neurology and Psychiatry*  
*Chairman*—EUGENE N. BOUDREAU, M D Syracuse  
*Secretary*—CLARENCE O. CHENEY, M D Utica

## THE MEDICAL LEGISLATIVE MACHINERY

Last week we commented on the circle of legislative influence which emanates from the Albany headquarters of the Committee on Legislation of the Medical Society of the State of New York. The object of our comments was to inform the members of County Medical Societies regarding their position in the legislative machinery of the State of New York.

The Committee on Legislation of the Medical Society of the State of New York consists of Dr J N Vander Veer of Albany, Dr George R. Critchlow of Buffalo, and Dr Walter H. Conley of New York City, each of whom is experienced in medical legislation. There are thus three centers of influence—one in the western end of the State, one in the southeastern end,

and one in the central part of the State, in close touch with legislative matters. Each committeeman is ready to relay and amplify information to the chairmen of county legislative committees and the members of the Societies. Each committeeman is also ready to supply currents of force which shall activate the officers and members of the county medical societies—and there is great need for such activation.

It is physically impossible for the Committee on Legislation to see the entire group of two hundred legislators in Albany, and so the main dependence for seeing the individual legislators must be placed on the chairmen of the legislative committees of the county medical societies, and on the members of the societies. The local

We dislike to admit that there is any need of a code of ethics for public health nurses, but we sincerely hope that Miss Gregg will formulate a tentative code, and we assure her of the co-operation of the medical profession. But still we cannot help feeling that a public health nurse has missed her calling if she requires a code of ethics to regulate her conduct. We have painful

memories of our attempts to formulate public health nursing rules on one occasion when we drew up two pages of general regulations to fit a particular situation, and then when the nursing staff changed, we threw them into the waste basket and adopted only the principles of politeness and consideration for others for the guidance of future nurses.

F O

---

### LABORATORY DEMANDS CLINICAL DATA OR WILL CHARGE FEE FOR SUPPLIES

The value to the physician of well kept records needs no defense or explanation. Every physician, at some time or other, makes an effort to develop a set of records at least upon the important cases in his practice, but unless he has stenographic service in his office, he, sooner or later, finds that his most interesting records are encountered at the time when he is the busiest, with the result that by the time he has passed the busy period, his records are so far behind that it proves too much of a burden to bring them up to date, and most of them are thus discarded. Nevertheless, this does not detract from the value of record keeping.

The State Department of Health finds it exceedingly important that certain records concerning the clinical findings from patients from whom specimens are to be examined, and, likewise, patients upon whom therapeutic products are to be used, should be filed with them in order that they may co-ordinate their laboratory work with the clinical work of the physician. The majority of the physicians realize this, and have been co-operating in a very encouraging way. There are some physicians, however, who consistently do not supply information requested when submitting specimens for diagnosis, or when requesting therapeutic products for administration. While this number is small, it seems to the Department of Health to be of sufficient importance to warrant their introducing a bill, Assembly Introductory No. 1167, entitled, "An Act to amend the public health law in relation to district laboratory supply stations," which would permit the Commissioner of Health to collect fees from physicians who neglected to supply the information requested concerning the patients in whose use the supplies were withdrawn from the station.

It seems unfortunate that a bill of this character is thought necessary, because it is the State Department of Health's function to protect the public against the spread of communicable dis-

eases, and all of the products implied in this law have to do either with diagnosis or treatment of communicable diseases only.

In the past, the efficiency of the laboratories has largely been attributed to the fact that supplies were furnished without cost to all physicians who applied for them. While originally, the idea was that these supplies were intended only for indigent patients, the importance of protecting the public has long since sanctioned the use of diphtheria antitoxin on every child suffering with the disease, regardless of whether a parent could or would pay for the product. It was considered important that the State, with its product provided by public money, should exert itself to protect the public against the spread of a communicable disease immediately on its appearance that it appeared without debating whether the infected one should pay the State a fee for the benefit he would derive from the use of said products.

It would be regrettable if this bill should result in raising a question as to whether or not a busy doctor should receive products from a supply station because he had failed to file requested information from the last supplies given, and thus the community be endangered of infection, or if he would find it difficult to secure the therapeutic products demanded in cases of emergency, because he had failed to pay the fees exacted for the last products he had secured.

We do not question the importance of the State Department of Health having and collecting accurate records concerning the work it does, but we believe that there is sufficient authority in the law, as it now stands, to enable them to secure such information. The proposed bill is unnecessary, and its disturbing effect on the 98 per cent of physicians who are practising according to the law is greater than the co-operation that will be secured from the 2 per cent against whom it is aimed.

J S L

health in a local community is introduced, it would be expected that the local physicians should be recognized, their advice sought, and their full co-operation secured

The closing paragraph of Senate Bill Int 283 makes a brief reference to physicians in that it *permits* a Board of Supervisors to appoint an advisory committee, one of whom shall be a physician, and one a woman. The Committee on Legislation has suggested that the appointment of an advisory committee be mandatory, that the majority of its members be physicians, and that the physician members shall be chosen, or at least nominated, by the County Medical Society.

There is need that the work of county public health nurses be kept up to certain standards, and the standards which are recognized and are acceptable are those of the State Department of Health. The Committee on Legislation has suggested that the bill be made to read that the qualifications of the nurses and their methods of work shall be in accordance with the standards set by the State Department of Health, and that the State Department of Health may make inspections of the work of the nurses. Permissive inspections rather than supervision is in accordance with the policy of the State of New York in regard to the finances of local communities

and the methods of conducting the various phases of strictly local government.

The proposed bill causes the nurses to serve four masters—the Board of Supervisors, the State Department of Health, the educational authorities both state and local, and the individual attending physician. The Committee on Legislation has suggested that the bill shall provide that the Committee of the Board of Supervisors may assign a nurse to work in a public school or with a local health officer, and that when the nurse is thus working, she shall conform to the directions of the officers and the law of the local body for whom she acts.

The Committee on Legislation feels that this proposed law involves the whole principle of the recognition of the influence of local physicians in the public health affairs of local communities. This principle is more far-reaching than the mere employment of public health nurses. It involves the recognition of local physicians in public health matters, and affords an opportunity to secure the co-operation of physicians in governmental participation in public health work. We are confident that the members of county medical societies will act worthily of the trust bestowed upon them if the bill should pass after it has been amended as we have proposed.

J N V V

## A CODE OF ETHICS FOR PUBLIC HEALTH NURSING

The New York State Department of Health Quarterly for January, 1925, contains an unusual article on the Ethics of Public Health Nursing by Elizabeth Gregg, Executive Secretary of the Association of Tuberculosis Clinics, New York City. Miss Gregg gives a truthful definition of unethical conduct in that she calls it impoliteness and rudeness. We have often puzzled our brains to explain wherein one's conduct become unethical, and now we wonder that we missed the point which Miss Gregg makes clear.

Consideration for all other persons constitutes the essence of the ethics of any profession, and is especially applicable to nurses and physicians. Ethics in public health nursing is simply that the nurses shall have a high regard for the feelings of those with whom they come in contact.

Miss Gregg also discusses *personality*, by which she means the ability to "get on" with people generally, and she asks "What is this right personality but the habit of applying ethical principles in our everyday life? It is the practice of our moral duty to ourselves and to those with whom we come in contact."

Miss Gregg discusses the ethical duties of nurses along five lines: 1, to their superiors, 2, to their fellow-workers, 3, to the public, 4,

to themselves, and 5, to their subordinates. She devotes only a few lines to the ethical relations of nurses to physicians, but she sums up the whole matter in a line that if the nurse herself cannot straighten out a misunderstanding with a physician, she shall refer the matter to her superior, "and then ethics requires that she talk no more about it."

Our experience is that it is not the original misunderstanding that causes trouble, but that the irritation comes from the continual talking in which the nurse is likely to indulge. A "chip on the shoulder" is not the honorable badge of distinction which some public health nurses may seem to think it is. Every physician honors a nurse whom he considers to be a "good loser,"—that is, one who is brave enough to treat a doctor with undiminished cordiality after a misunderstanding with him.

Miss Gregg closes with a suggestion, "A printed code which would outline the ethics of public health nursing would be as needful and beneficial as the handbook on the practical aspects of their work. Ethical duties would be set down as cold facts, and would be received as truths, and not as preaching or moralizing, and would have the force of orders."

We dislike to admit that there is any need of a code of ethics for public health nurses, but we sincerely hope that Miss Gregg will formulate a tentative code, and we assure her of the co-operation of the medical profession. But still we cannot help feeling that a public health nurse has missed her calling if she requires a code of ethics to regulate her conduct. We have painful

memories of our attempts to formulate public health nursing rules on one occasion when we drew up two pages of general regulations to fit a particular situation, and then when the nursing staff changed, we threw them into the waste basket and adopted only the principles of politeness and consideration for others for the guidance of future nurses.

F O

### LABORATORY DEMANDS CLINICAL DATA OR WILL CHARGE FEE FOR SUPPLIES

The value to the physician of well kept records needs no defense or explanation. Every physician, at some time or other, makes an effort to develop a set of records at least upon the important cases in his practice, but unless he has stenographic service in his office, he, sooner or later, finds that his most interesting records are encountered at the time when he is the busiest, with the result that by the time he has passed the busy period, his records are so far behind that it proves too much of a burden to bring them up to date, and most of them are thus discarded. Nevertheless, this does not detract from the value of record keeping.

The State Department of Health finds it exceedingly important that certain records concerning the clinical findings from patients from whom specimens are to be examined, and, likewise, patients upon whom therapeutic products are to be used, should be filed with them in order that they may co-ordinate their laboratory work with the clinical work of the physician. The majority of the physicians realize this, and have been co-operating in a very encouraging way. There are some physicians, however, who consistently do not supply information requested when submitting specimens for diagnosis, or when requesting therapeutic products for administration. While this number is small, it seems to the Department of Health to be of sufficient importance to warrant their introducing a bill, Assembly Introductory No. 1167, entitled, "An Act to amend the public health law in relation to district laboratory supply stations," which would permit the Commissioner of Health to collect fees from physicians who neglected to supply the information requested concerning the patients in whose use the supplies were withdrawn from the station.

It seems unfortunate that a bill of this character is thought necessary, because it is the State Department of Health's function to protect the public against the spread of communicable dis-

eases, and all of the products implied in this law have to do either with diagnosis or treatment of communicable diseases only.

In the past, the efficiency of the laboratories has largely been attributed to the fact that supplies were furnished without cost to all physicians who applied for them. While originally, the idea was that these supplies were intended only for indigent patients, the importance of protecting the public has long since sanctioned the use of diphtheria antitoxin on every child suffering with the disease, regardless of whether a parent could or would pay for the product. It was considered important that the State, with its product provided by public money, should exert itself to protect the public against the spread of a communicable disease immediately on its appearance that it appeared without debating whether the infected one should pay the State a fee for the benefit he would derive from the use of said products.

It would be regrettable if this bill should result in raising a question as to whether or not a busy doctor should receive products from a supply station because he had failed to file requested information from the last supplies given, and thus the community be endangered of infection, or if he would find it difficult to secure the therapeutic products demanded in cases of emergency, because he had failed to pay the fees exacted for the last products he had secured.

We do not question the importance of the State Department of Health having and collecting accurate records concerning the work it does, but we believe that there is sufficient authority in the law, as it now stands, to enable them to secure such information. The proposed bill is unnecessary, and its disturbing effect on the 98 per cent of physicians who are practising according to the law is greater than the co-operation that will be secured from the 2 per cent against whom it is aimed.

J S L.



# LEGAL



By **GEORGE W. WHITESIDE, Esq.**  
Counsel Medical Society of the State of New York

## RE-REGISTRATION AND OTHER FEATURES OF THE KARLE-DUNMORE BILLS

As a citizen you are entitled to vote upon all questions submitted to the electorate, but before you exercise that privilege, you are required to be duly registered each year as such a voter. In the cities you must personally appear before the poll clerks and answer numerous questions and affirm your answers to the questions by signing your name in the roll. This is something of a nuisance, but it also prevents thousands of unqualified or unscrupulous people who are not entitled to vote, from voting, and is a curb upon any individual voting more than once. Such annual registration of voters is regarded now as indispensable to the maintenance of pure elections, and therefore, such annual registration is requisite as a condition to the exercise of the franchise and keeps away from the polls those not qualified to vote.

When you go to a hotel and before you are assigned to a room you are required to register, so that the hotel proprietor may be informed as to the identity of his guests and know to whom he has legal obligation as an innkeeper. You go to your lodge, and before you are admitted you must be identified. When you are called on a panel as a juror, you must each day be registered by the clerk as present before you are permitted to sit on a case. Employees of large, and many small, concerns, must daily register their presence, as well as the time of their arrival and departure by one system or another of registration.

You board a train, and you must register your right to passage by the possession of the necessary ticket which identifies you as one to whom the railroad owes a definite legal obligation. Practically in every form of social or business organization, the first order of business is the calling of the roll in order that each person entitled to membership may be registered and identified.

So examples may be multiplied. Can it be said that any of these laws, regulations or procedures for registration are in the nature of a deprivation of the individual's rights? Are they not, on the contrary, methods and means by which the rights of the individual may be enforced as against those who are not entitled to such rights? And are they not, therefore, procedures by which protection is given to the individual?

For about forty years doctors who are entitled to practice and who have received licenses have

been required, before undertaking any practice, had to record their licenses in the office of the County Clerk of the county in which they intend to practice. Many doctors belong to numerous organizations, and at the time they join they sign the constitution and by-laws and thus register themselves as entitled to membership.

What would you think of an organization that had a membership of sixteen thousand, where the privilege of membership granted an exclusive right of making a livelihood in a definite line of work the preparation for which required years of study, if such organization should permit thousands of others who were not members, and who were not eligible, to enjoy all the fruits of such membership because such organization had never taken the trouble to adopt a method by which it could check up its members and exclude the interlopers? In other words, would you not be in favor, at least once a year, of having the roll called and have each member identify himself for his own protection?

There has never been a roll call of the medical profession of the State of New York for about forty years. Doctors, as far as identifying themselves as entitled to practice, as separate and apart from the many charlatans and quacks who are not entitled to practice, by being recorded once in their lifetime in the office of the County Clerk, might just as well have their names inscribed in the Domesday Book. The County Clerk's record, for all practical purposes, is just as antique and about as useless.

Let us for the next five years have a roll call once a year and let the duly licensed doctors answer. Here, and the first time the roll is called after forty years let us be assured that the man who is answering "Here" is the right man, and not an impersonator of someone else. Let us have him thereafter take oath to that fact and for the following four years, if he is identified with the County Medical Society, let its secretary answer "Here" for him.

Would this procedure be considered by any sensible man as an infringement of his rights and prerogatives as a duly licensed practitioner of medicine? Can any sensible man fail to see the wisdom of such a roll call? It is going to take some money to call this roll for the next five years, to provide the necessary machinery for that purpose. It is going to take some money, after the roll is called, to put out of the meet-

ing a large number of those claiming to exercise the same rights as you do as doctors, and possibly particularly obstreperous ones may have to be safely lodged in jail. Should we stop at merely calling the roll, leaving those who are not entitled to answer "Here" free to exercise all the rights and privileges of membership in the medical profession, or should we not complete what we start when we call the roll and take whatever measures are necessary to exclude the unqualified? Can any man answer other than affirmatively to any of these propositions? Are you willing to pay two dollars a year for five years, or a total sum of ten dollars, to accomplish this result? Can you think of where ten dollars for a period of five years could be better spent? Are you willing to have the man who would like all of the benefits from such a system, but who won't pay the ten dollars, partake of the benefits at your expense? Or are you not willing to equalize this expense by taxing all who are entitled to answer the roll call two dollars a year for five years?

The Karle-Dunmore bills, sponsored by the State Department of Education, seek by their terms to obtain an honest, true list of registered doctors in this State for the first time in forty years. They seek, after obtaining such list, to make it very hard for those who are not entitled to practice, to do as they are now doing and have been doing for many years—practicing without a license. They seek to provide state-wide machinery, after calling the roll of the registered practitioners, to inspect and find out all those who are practicing who are not on the list, and to mete out to them suitable punishment. As it is practically impossible to have this done at the expense of the entire State as it should be, the Karle-Dunmore bills provide that the doctors who are registered, for five years shall pay annually two dollars a year in the cleanup campaign.

It seems hard to take seriously the claims of some doctors that they are opposed to this plan as a matter of principle. How small this principle urged as an objection looms in comparison to the ultimate principle for which the profession must always strive, of restricting the practice of the healing art to the educated and qualified, for the public good! While fighting for the small principle of taxation which involves an expenditure for a period of five years not to exceed ten dollars, by obstructing the Karle-Dunmore bills in their passage in the Legislature, what violence are you doing to this principle for public protection, which has for its purpose and foundation the saving of human lives? Some assert that the present system and present laws are sufficient to vindicate the principle that only the licensed shall practice. The past forty years of history in this State controvert the assertion

Some people have asserted that to permit a registration fee to be imposed for five years upon the doctor would jeopardize his vested interest in his license. The license does not create a vested interest. It does not create a title. It is a mere grant of permission to do certain acts that to the general public are prohibited, and is subject to legislative control, change, amendment, or even abrogation. What is to be gained by fooling one's self as to the nature and legal character of a license? Why lull oneself into a state of false security and self-satisfaction and impregnability based on a false legal premise?

The provisions for registration and the penalties provided for failure to register do not in anywise affect one's license. They are in the nature of ordinances to be complied with and non-compliance does not destroy the license or in fact affect it, but they do subject the non-conformist to certain financial penalties, which are exclusive and the only penalties for non-conformance.

If you have title to a house and lot in a city or town, the municipality has a right to pass certain ordinances with which you must comply or pay certain penalties, such as requiring you to separate garbage from ashes, to keep your sidewalk clear of snow and ice, and the like. Failure to comply with these ordinances does not affect your title or your right to your house and lot. Similarly, non-compliance with the registration features do not affect your right to license, but does subject you to other small penalties, having no relation whatsoever to your license.

Under the present law a large class of persons are exempted from the operation of the Medical Practice Act, whereas when such exemptions were created it was intended only to permit such exempted classes to do certain things. Under these exemptions we see chiroprodists advertising themselves as doctors, we see those engaged in fitting artificial limbs and eyes and glasses holding themselves out as doctors. The Karle-Dunmore bills will put a stop to such acts and create only limited exemptions to those entitled thereto. Criminal and civil penalties are provided to curb the unlicensed practitioner, and the district attorney of each county shall prosecute all offenders, the attorney general may supersede him should he fail in his duty. Fraudulent medical advertising is specifically prohibited. Advertising of fake cures and the cure of incurable diseases, and advertising the use of secret methods of cure are forbidden, so that the ethical man does not have unfair competition from the quack. Patients treated by unlicensed practitioners may sue and recover damages for injuries they suffer, and proof of their case is made very simple under favorable rules of evidence created by the act. The enforcement of the Medical

Practice Act is centralized in the hands of the Regents and the Attorney General, who may employ inspectors to search out and prosecute offenders. The rights of the physician as now existing are preserved and further safeguarded in proceedings directed toward the revocation of his license, and yet the malefactor may be more readily punished.

It is the privilege of every doctor in this State to take a definite stand on these bills and to record his position with the State Society. On March fourth, in the Assembly Chamber at

Albany, the joint committee on public health of the Senate and Assembly will hold a hearing on these bills. The representatives of the State Society will be present to carry out the will of the Society. The Assembly Chamber will be crowded with chiropractors, naturopaths, drug less healers, quacks, and various nondescript fakirs, who will loudly voice their opposition, realizing that the passage of the bills would be the death-knell to the unlicensed practitioner.

"No man e'er felt the halter draw  
With good opinion of the law"

### CLAIMED NASAL OPERATION ON MINOR WITHOUT CONSENT OF PARENT

This action was instituted by the mother, as guardian of her infant child. It was alleged that on the 5th of May a tonsillectomy was performed and that the surgeon was paid for his services, that subsequent to the operation the plaintiff visited the defendant's office pursuant to his direction, that on the 13th of May the infant plaintiff, accompanied by his father, again visited the defendant's office, that on that day without any knowledge on the part of either the father or the infant plaintiff and without their direction or consent, it is claimed that the defendant negligently and wrongfully and by his error performed an operation upon the infant plaintiff's nose and the child was thereby rendered ill and caused to suffer pain in his nose and head. For this they sought money damages.

It appears that the mother of the infant plaintiff had called upon the defendant surgeon for the removal of her son's tonsils. She did not bring the boy for examination, as it was her desire not to interfere with his school hours. Arrangements were then made for the performance of the tonsillectomy and the amount of compensation agreed upon and paid. Upon examination of the boy, the surgeon found a small spur on the cartilagenous septum and told the parents of the condition and that some day he would remove the small spur. No response was made by the father, the surgeon assuming that he understood when spoken to. Arrangements were made for the performance of the tonsillectomy

on Friday, so that the child might return to school on Monday. After the removal of the tonsils, the child returned to the surgeon's office for post-operative examination and treatment. Upon the last of these visits, the child being accompanied at that time by his father, the surgeon stated that he would remove the spur from the septum. The child was prepared for the operation by the surgeon's nurse, she also prepared the necessary instruments and the surgeon, in the meantime, preparing himself for the performance of the operation. A local anaesthesia was applied. The operation was then performed and the spur removed. During all of this time the father remained at the side of his son and observed everything that was done. No objection was made by the father at any time. In fact, he never spoke during the treatment and operation.

The plaintiff's chief contention was that the surgeon had confused the boy in this case with another child, whom he was to operate upon on the same day.

After the prosecution of this action for several years, the examination of the defendant before trial and the taking of the deposition of witnesses, the action finally came on for trial. Because of prejudicial error by plaintiff's counsel, occurring during the trial, the court declared a mistrial. The case was then restored to the calendar for a new trial, at which time the plaintiff's attorney not being ready to proceed with the re-trial a dismissal was had of the complaint.





# LEGISLATION



By JAMES N VANDER VEER, M.D.  
Chairman, Committee on Legislation.

## SPECIAL NOTICE TO COUNTY LEGISLATIVE CHAIRMEN

Joint Conference of Legislative Chairmen of County Medical Societies, with the Officers of the Medical Society of the State of New York, and the Advisory Committee on Legislation, will be held on Wednesday, March 4, 1925, at 9 30 A M, at The Hotel Ten Eyck, Albany, N Y. Registration with presentation of credentials not later than 9 A M.

## INDEX OF LEGISLATIVE BILLS DISCUSSED IN THIS JOURNAL

B—Bill printed.

C—Comment.

Senate Int. No.	Assembly Int. No.	Law	Subject	Page and Date	
115	215	Public Health	THE NARCOTIC BILL	B 80	Jan 23
				C 329	Feb 27
116	216	Insanity	Licensing Institutions for Drug Addicts	B 84	Jan. 23
				C 329	Feb. 27
211	307	Public Health	THE MEDICAL PRACTICE ACT	B 123	Jan. 30
				C 329	Feb 27
228	236	State Charities	Inspection of Children's Institutions	C 329	Feb 27
263		Insanity	Qualifications of Examiners	B 174	Feb 6
				C 329	Feb 27
283	399	County	County Public Health Nurses Ed p 321	B 175	Feb 6
				C 329	Feb 27
302	748	Education	Health Service in Schools	B 176	Feb 6
				C 330	Feb 27
380	570	Workmen's Comp	Injured Employee to Select His Physician	B 177	Feb 6
				C 330	Feb 27
473		Public Health	The Drugless Practitioner Bill	B 232	Feb 13
				C 330	Feb 27
	127	Education	Health Service in Schools	B 86	Jan 23
				C 341	Feb 27
	185		A CHIROPRACTIC BILL	B 87	Jan. 23
				C 277	Feb 20
				C 341	Feb 27
594	301	Workmen's Comp	Choice of Medical Attendants	B 183	Feb 6
				C 330	Feb 27
	422	Civil Practice	Professional Secrets	B 186	Feb 6
				C 278	Feb 20
647	184	Workmen's Comp	Examination After Injury	C 331	Feb 27
671	868	Penal Law	Crippled Children	B 288	Feb 20
				C 331	Feb 27
	649	Public Health	A CHIROPRACTIC BILL	B 278	Feb 20
				C 342	Feb 27
	908	Penal Law	Wood Alcohol	B 294	Feb 20
	925	Public Health	Reciprocity in Licensures	B 294	Feb 20
716	969	Public Health	Rural Hygiene	B 332	Feb 27
				C 277	Feb 20
787	973	Public Health	State Institutions Study Malignant Disease	B 335	Feb 27
				C 295	Feb. 20
743		Mental Deficiency	Expenses for Care of Mental Derectives	B 333	Feb 27
	987	Penal	Birth Control	B 343	Feb 27
755	1018		Prison Clinic	B 334	Feb 27
786	1074	Public Health	Hospital for Crippled Children	B 334	Feb 27
789		Public Health	A Chiropractic Bill	B 336	Feb 27
851	1027	Public Health	Dissecting Material	B 340	Feb 27
	1167	Public Health	Laboratory Supplies	B 343	Feb 27

# SPECIAL ATTENTION

To Chairmen of County Legislative Committees and  
Members of County Medical Societies:

Have you written your letters to, or personally interviewed, your  
legislators on the following legislative bills?

## FAVORING

## AGAINST

Senate Int 115, Conc Assembly Int 215, The Narcotic Bill	
Senate Int 116, Conc Assembly Int 216, Requiring the Licensing of Private Institutions for the Treatment of Drug Addicts	
Senate Int 211, Conc Assembly Int 307, State Department of Education Bill on Medical Practice	
	Senate Int 283, Conc Assembly Int 399, County Public Health Nurses See comments on pages 265, 271 and 321 of this JOURNAL
Senate Int 380, Conc Assembly Int 570, Injured Employee to Select his physician	
	Senate Int 473 The Drugless Practitioner Bill
	Assembly Int 185, Assemblyman Nicoll's Chiropractic Bill
Senate Int 594, Conc Assembly Int 301, Choice of Medical Attendants	
	Assembly Int. 422 Professional Secrets
	Senate Int 647, Conc Assembly Int 184 Examination after injury
Senate Int 671, Conc Assembly Int 868, Crippled Children	
	Assembly Int 649, Assemblyman Esmond's Chiropractic Bill
	Senate Int 789, Senator Bouton's Chiropractic Bill
Assembly Int 908, Control of Sale of Wood Alcohol	
	Assembly Int 987, Birth Control

## SUMMARY OF BILLS INTRODUCED IN LEGISLATURE IN SENATE

### The Narcotic Bill

Senate Int No 115 (conc Assembly Int 215)  
—A bill introduced in the Senate by Senator Morton J Kennedy of New York, concurrent Assembly Int 215, by Assemblyman Morris Weinfeld of New York, would add new article 22, and amend section 4-b, Public Health Law, and repeals section 1746, Penal Law, relative to habit forming drugs

Referred to Public Health Committees of both Houses

Still in committees

*Comment* It must be realized that certain interests are deeply concerned with keeping this bill in the committees, and if the Medical Society is anxious to forward good legislation, here is an opportunity to write and ask the Chairmen of these two committees of Public Health in Senate and Assembly to bring the bill out

### Requiring the Licensing of Private Institutions for the Treatment of Drug Addicts

Senate Int No 116 (conc Assembly Int 216)  
—A bill introduced in the Senate by Senator Morton J Kennedy of New York, concurrent Assembly Int 216, by Assemblyman Morris Weinfeld of New York, would add new section 177, Insanity Law, requiring the licensing of private institutions for treatment of narcotic drug addiction

Referred to General Laws Committee of Senate, and to Judiciary Committee of Assembly

Still in committees

*Comment* This bill is still in the committees and the same comment applies as in the previous bill

### The State Department of Education Bill Amending the Medical Practice Act

Senate Int No 211 (conc Assembly Int 307)  
—A bill introduced in the Senate by Senator John L. Karle of Queens County, concurrent Assembly Int No 307, introduced in the Assembly by Assemblyman Russell Dunmore of Oneida County, would amend Sections 164, 169, 170, 173, 174, and repeal section 171, Public Health Law, relative to practice of medicine, by providing among other things for the registration and licensing of physicians

Referred to Public Health Committees of both Houses

*Comment* Attention of the members of the Medical Society is called to the fact that our *chiropractic bill* (Mr Esmond's Assembly bill, Int No 649) reads almost word for word the same as this Medical Practice Act, and omits the sections which are obnoxious to chiropractors and adds on sections which would permit of their practicing through the legal verbage added on

Extreme caution and precise care must be used by each County Chairman and individual in discussing medical and chiropractic legislation that these two bills may not be confused, as is evidently the intent, and in drawing this chiropractic bill in such a manner to befog the mind of the legislator when ultimate voting comes up

### Inspection of Children's Institutions

Senate Int No 228 (conc Assembly Int 236)  
—A bill introduced in the Senate by Senator J Griswold Webb of Westchester County, concurrent Assembly Int 236, by Assemblyman T C Moore of Westchester County, would amend State Charities Board, among other things, to visit all institutions in which children are received or cared for, and to establish rules therefor

Referred to General Laws Committee of Senate and to Judiciary Committee of Assembly

*Comment* Your Committee on Legislation has no further comment to make on this bill and as no communications have been received from individuals or county societies "for" or "against" the bill, the same will be dropped unless vital changes are made therein

### Qualifications of Examiners in Lunacy

Senate Int No 263—A bill introduced in the Senate by Senator James A Higgins of Kings County, would amend section 81, Insanity Law, relative to qualifications of examiners in lunacy

Referred to General Laws Committee

*Comment* No further comment having been offered and there seeming to be some opposition from other sources to this bill, your Committee on Legislation is inclined to remain neutral in the situation, taking the position that physicians who are now acting as examiners in lunacy and those who may become so later are disinterested to the degree that they wish no further work done on the part of the Committee on Legislation. It would seem that the bill will not pass, and therefore the present position of such officials will remain in statu quo

### County Public Health Nurses

Senate Int No 283 (conc Assembly Int 399)  
—A bill introduced in the Senate by Senator J Griswold Webb of Clinton Corners, N Y, concurrent Assembly Int No 399, by Assemblyman Frank H Lattin of Orleans County, would amend section 12, County Law, by authorizing county supervisors to provide expenses for public health nurses, who shall work under the public health committee or board, providing for appointment of advisory committee of citizens and relative to duties of nurses

Referred to Internal Affairs Committee of both Houses

*Comment* Your Committee on Legislation hopes that a conference is about to be held which may eliminate the objectionable features in the bill as have been outlined by the members of the Society who have been conscientious in offering their thoughts in relation to the bill and as the bill still reads opposition still maintains, but it is almost assured that the thought contained in the bill will be carried out satisfactorily to the members of the Society and to the various parties interested in the question

#### Health Service in Schools

Senate Int No 302 (conc Assembly Int 748)  
—A bill introduced in the Senate by Senator Ernest E Cole of Bath, N Y, concurrent Assembly Int 748, by Assemblyman Irving F Rice of Cortland County, would amend sections 571, 571-a, 572, 575, Education Law, relative to medical inspection and health service in public schools

Referred to Public Education Committee of both Houses

*Comment* It is evident there does not seem to be much interest in this bill as we have received no comments from County Chairmen or individuals and consequently this bill will be dropped unless there be amendments added thereto

#### Free Choice of Physician

Senate Int No 380 (conc Assembly Int 570)  
—A bill introduced in the Senate by Senator Daniel J Farrell of Kings County, concurrent Assembly Int 570, by Assemblyman Gerald F Dunne of Kings County, would amend Section 13, Workmen's Compensation Law, relative to medical and surgical attendance of injured employees by providing employee shall select physician

Referred to Labor and Industry Committees of both Houses

Still in committee

*Comment* No further comment than that the County Chairmen and individual members of the State Society should work for the passage of the bill

#### The Drugless Practitioner Bill

Senate Int No 473—A bill introduced in the Senate by Senator Leonard W H Gibbs of Erie County, would add new article 13-a, Public Health Law, relative to practice of all systems or sciences constructed or developed for treatment of disease and the removal of abnormality, injury or deformity of human beings, except practice of medicine, osteopathy and Christian Science

Referred to Public Health Committee

*Comment* "The Medical Society quite naturally is against the Drugless Therapy Bill, the same as cult practice, and in both instances reference to the past will show without question that we are opposed to any and all special legislation

which would delimit the safeguards even one iota that up to the present have been created in behalf of the health of the public

"The medical profession has learned through the channels of science, in many instances slowly permeating through the profession, that didactic facts had to yield to scientific modification in the treatment of diseases

"We are utterly and absolutely opposed in the medical profession to anyone attempting to practice on the health of the people unless the practitioners have had a thorough ground work in the basic principles involved in the treatment of disease, the same as success only can be brought with the man who studies his business from its very beginning upward, else a prolonged pain and death come to the sick one, the same as sorrow and failure comes to the business man and his associates when he is not familiar with every phase of his business

"The basic law does not forbid of a man transacting business along certain general lines, but it does say he shall not commit forgery, and in most instances shall not be deceitful in his business conduct, and just so in medicine, after a proper education there are only certain restrictions to be thought of as how a patient shall be treated differently from the ordinary accepted view "

Attention of members of the Society is called to the article on page 267, of THE NEW YORK STATE JOURNAL OF MEDICINE for February 20, 1925

Relentless opposition *must* be waged against such a low type grade of bill

#### Inspection of School Children

Senate Int No 586 (conc Assembly Int. 850)  
—A bill introduced in the Senate by Senator Ernest E Cole of Bath, New York, concurrent Assembly Int 850, by Assemblyman Irving F Rice of Cortland County, would amend section 570, Education Law, relative to medical inspection of school children by excepting only cities which were cities of the first class on August 1, 1913

Referred to Public Education Committee  
No further comment

#### Free Choice of Physician

Senate Int No 594 (conc Assembly Int 301)  
—A bill introduced in the Senate by Senator William Love of Brooklyn, N Y, concurrent Assembly Int No 301, by Assemblyman Frank H Lattin of Orleans County, would amend the Workmen's Compensation Law, by permitting injured employees at employer's expense to engage medical or other attendance

Referred to Labor and Industry Committees of both Houses

See comment under Senate Bill Int No 380

### Practical Tests of Injured Persons

Senate Int No 647 (conc Assembly Int 184)  
—A bill introduced in the Senate by Senator Frank E Johnson of Brooklyn, N Y, concurrent Assembly Int 184, by Assemblyman F A Miller of Brooklyn, N Y, would amend section 118, Workmen's Compensation Law, by authorizing physical examinations and practical tests of claimant to determine loss of use and proportionate loss of use of a member, result and test to be a part of record

Referred to the Labor and Industry Committees

*Comment* No communication has been received from Mr Johnson or Mr Miller relative to the letters sent them as to the questions of whether the bill means that a layman shall make the examination, therefore your Committee on Legislation feels that opposition should be voiced to the bill by County Chairmen in the present form in which it now reads, and that communications so sent to the Committees on Labor and Industry of both Houses and to the introducers of the bill should include the suggestion that the bill be amended whereby the examination shall be made by a physician, and to be made perhaps in the presence of the lay deputy

### Physically Handicapped Persons

Senate Int No 671 (conc Assembly Int 868)  
—A bill introduced in the Senate by Senator Ernest E Cole of Bath, N Y, concurrent Assembly Int No 868, by Assemblyman John Boyle, Jr, of Suffolk County, would amend sections 2, 5, 23, Children's Court Act, Sections 130, 132, 136, State Charities Law, Sections 275, 310, 573, 650, 652, 653, 1020, 1200, 1201, 1203, 1204, 1206, 1208, adds new sections 1203-a, 1208-a, Education Law, relative to physically handicapped persons

Referred to Judiciary Committees of both Houses

*Comment* It would seem that the members of the Society by their negations are in favor of this omnibus bill and neglected to note in section 23, Children's Court Act, that the old law allows "a physician or psychologist appointed or designated for the purpose by the court" should in such a bill be amended to read "by a physician duly licensed to practice in this state"

It will be noted that the word "indigent" has been stricken out. Therefore, all children are now included under the court jurisdiction "who are physically handicapped" whether their parents be able to pay for them or not

Section 132 of the State Charities Law, has a new clause introduced whereby the board of managers of the New York State Orthopedic Hospital for Children at West Haverstraw "may

receive or collect from parents, and so forth," which now makes this hospital an institution where physically handicapped children of even wealthy parents may be committed and the parents, guardians, etc, be compelled to pay for the maintenance of that child

Section 136, State Charities Law, by new matter, gives preferential admission to indigent children and provides for records concerning the children upon admission, the treatment given, and the results, condition at time of discharge and the reason for discharge, to which records the State Advisory Committee for physically handicapped persons shall have access at all reasonable times

Section 7, Children's Court Act, which would under this omnibus bill give power to provide education in various schools, even to home teaching, and makes it mandatory on recommendation of the State Department of Health that surgical, medical, or therapeutic treatment, hospital care, crutches, braces and other appliances must be furnished

Section 573, Education Law, is amended so as to make it mandatory upon each principal or teacher of public schools to furnish to the medical inspector the names of all physically handicapped children

Section 13, Education Law, is amended so that the Board of Education of each city is required to furnish educational facilities for these physically handicapped persons

Section 1203, Education Law, is remodeled so that the advisory commission for physically handicapped persons as now so-called, shall be composed of the Commissioner of Education, who shall be chairman, the State Industrial Commissioner, the Commissioner of Health, and there is added the president of the State Board of Charities

Section 1203-a, states the purpose of the commission

1 To rehabilitate persons needing and capable of rehabilitation

2 To stimulate all private and public efforts and to coordinate them with the work and functions of governmental agencies designed to relieve, cure, or educate physically handicapped children

In general your Committee on Legislation can do naught but further such a bill which would help physically handicapped persons

### Dissection of Dead Bodies

Senate Int No 681 (conc Assembly Int 986)  
—A bill introduced in the Senate by Senator Ernest E Cole of Bath, N Y, concurrent Assembly Int 986, by Assemblyman Irving F Rice of Cortland County, would amend sections 2211, 2215, Penal Law, by providing in cases in which

right to dissect dead body is conferred by law, such body may be incinerated, section now requires burial

Referred to Codes Committee in both Houses

*Comment* The bill will be dropped

#### **Amendment for Admission of Foreign Practitioners**

Senate Int No 693 (conc Assembly Int 950)  
—A bill introduced in the Senate by Senator John L. Karle of Queens County, concurrent Assembly Int No 950, by Assemblyman Frank H. Lattin of Orleans County, would amend section 166, Public Health Law, relative to practice of medicine by a bachelor of medicine from a medical school in a foreign country

Referred to Public Health Committees in both houses

No further comment as yet

#### **Revocation of License to Practice Medicine**

Senate Int No 701—A bill introduced in the Senate by Senator Nathan Strauss of New York, would add new section 170-a, Public Health Law, empowering Supreme Court to revoke license to practice medicine

Referred to Public Health Committee

No further comment

#### **Rural Hygiene**

Senate Int No 716 (conc Assembly Int 969)  
—A bill introduced in the Senate by Senator Leigh C. Kirkland of Randolph, N. Y., concurrent Assembly Int 969, by Assemblyman Frank H. Lattin of Orleans County, would add new article 2-b, Public Health Law, establishing provision of rural hygiene in State Department of Health and appropriating \$10,000

Referred to Finance Committee of Senate, and to Ways and Means Committee of Assembly

STATE OF NEW YORK,  
No 748,

IN SENATE, Int 716

February 12, 1925

Introduced by Mr. Kirkland—read twice and ordered printed, and when printed to be committed to the Committee on Finance.

#### **AN ACT**

To amend the public health law, in relation to establishing in the state department of health a division of rural hygiene, and making an appropriation therefor

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to public health, constituting chapter forty-five of the consolidated laws," is hereby

amended by inserting therein a new article, to be article two-b, to read as follows

#### **ARTICLE 2-B**

##### **DIVISION OF RURAL HYGIENE.**

Section 18-d Division of rural hygiene.

18-e Assistants and employees

18-f General powers and duties of the division

§ 18-d Division of rural hygiene There is hereby established in the state department of health, a division of rural hygiene, the object and purposes of which shall be to co-operate with statewide and local organizations in promoting and protecting the health of residents of the rural districts of the state

§ 18-e Assistants and employees The state commissioner of health, within the limitation of appropriations made therefor, may employ, for the work of the division of rural hygiene, a director who shall be a physician qualified in public health administration, and such other assistants as may be necessary Within the amounts appropriated he may also incur such other expenses as may be necessary for carrying out the provisions of this article

§ 18-f General powers and duties of the division The state commissioner of health, through the division of rural hygiene, shall act in an advisory and superadvisory capacity in matters pertaining to the objects and purposes of such division, and shall, in such manner as he deems practicable, co-operate with statewide and local organizations in promoting and protecting the health of residents of the rural districts of the state

§ 2 The sum of ten thousand dollars (\$10,000), or so much thereof as may be necessary, is hereby appropriated for the purposes of this act, out of any money in the treasury, not otherwise appropriated

§ 3 This act shall take effect immediately

*Comment* This bill is not quite as the title would lead one to think and while its powers are broad in definition it would create within the State Department of Health a new "division of rural hygiene"

Attention is called to the breadth of section 18-d which, of course, is where the question lies, and the objects of which would seem to be able to be accomplished by the district state health officer

As the State Department of Health is now constituted the medical profession have nothing to fear from this type of bill, provided that the rules and regulations relative to this provision of rural hygiene may not be drawn so as to exceed the purport of the law

**Mental Deficiency Law**

Senate Int No 743—A bill introduced in the Senate by Senator Charles Hewitt of Locke, N Y, would amend sections 9, 16, 22-b, 25, adds new section 36-a, Mental Deficiency Law, relative to powers of commission providing for reimbursement for care of poor and indigent mental defectives and relative to penalty for certain violations

Referred to Finance Committee

STATE OF NEW YORK,  
No 778

Int 743

IN SENATE,

February 16, 1925

Introduced by Mr Hewitt—read twice and ordered printed, and when printed to be committed to the Committee on Finance.

**AN ACT\***

To amend the mental deficiency law, generally

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section nine of chapter six hundred and thirty-three of the laws of nineteen hundred and nineteen, entitled "An act in relation to mental defectives, constituting chapter seventy-one of the consolidated laws," is hereby amended to read as follows

§ 9 Official visits The commission, or a majority thereof, shall visit every state institution for mental defectives jointly or by a majority of the commission and every such private institution by one member of the commission or a duly accredited representative at least once in each calendar year

The commissioners shall at least once a year at a time to be appointed by the commission meet the managers of such state institutions, or as many of the number as practicable, in conference and consider in detail all questions of management and improvement of the institution, and they or one or more of them, with the managers, shall inspect the institution or such parts thereof as they deem necessary and they shall send to the managers in writing, if approved by a majority of the commissioners, such recommendations in regard to the management and improvement of the state institution as they may deem necessary or desirable All reports of inspections made by regularly accredited agents of the state board of charities and the fiscal supervisor's office, shall be reported in full to the commission for mental defectives

§ 2 Section sixteen of such chapter is hereby amended to read as follows

§ 16 Private institutions No mental defectives shall be cared for in a private institution unless such private institution shall be approved by the commission and shall have been given a license to conduct an institution for mental de-

fectives, and such private institution so licensed shall be under the supervision and subject to the rules and regulations of the commission *The violation of any provision of this section shall constitute a misdemeanor*

§ 3 Subdivision one of section twenty-two-b of such chapter, as added by chapter four hundred and eighty-three of the laws of nineteen hundred and twenty-one and last amended by chapter six hundred and fourteen of the laws of nineteen hundred and twenty-three, is hereby amended to read as follows

1 The institution now and heretofore known as the Eastern New York Reformatory at Nanpoch, with its grounds, buildings, materials, supplies, stocks and equipments, shall hereafter be under the supervision, control and direction of the commission for mental defectives and used for the care, training and treatment of mental defectives over sixteen years of age charged with, arraigned for or convicted of criminal offenses [The commission shall have, with respect to such institution, all the powers of boards of managers as prescribed in section nineteen of this chapter] The superintendent of purchase, as successor to the fiscal supervisor of state charities, shall continue to have fiscal supervision of such institution The commission, by order filed in its office of which a duplicate shall be filed in the office of the state comptroller, shall adopt a name for such institution, to be descriptive of its objects and purposes

§ 4 Section twenty-five of such chapter is hereby amended to read as follows

§ 25 Qualified examiners The certificate of mental defect must show that such person is mentally defective and may be made by two reputable physicians, graduates of an incorporated medical college, and duly licensed to practice medicine in the state of New York who have been in the actual practice of their profession at least three years, or by one such physician and one psychologist who shall have had two full years of post-graduate study in psychology at an incorporated university or college and three years of actual clinical experience Such examiners shall file with the commission for mental defectives a certified copy of the certificate of a judge of a court of record showing such qualifications in accordance with forms prescribed by such commission *The qualified medical examiners in lunacy shall be accepted as qualified examiners in mental defect*

§ 5 Such chapter is hereby amended by inserting therein a new section, to follow section thirty-six, to be section thirty-six-a, to read as follows

§ 36-a Reimbursement for care of poor and indigent mental defectives *The commission may, except as hereinafter provided, secure from the patient's estate and from relatives or friends who are liable or who may be willing to assume*

\* Matter in italics is new matter in brackets [ ] is old law to be omitted.

the costs of support of inmates of state institutions supported by the state, reimbursement at a rate fixed by the commission, in whole or in part, of the money thus expended, either directly or through the superintendents or treasurers of the respective state schools. The commission may, in its discretion waive the whole or a portion of the claim of the state for the cost of the support of a patient against the estate of such patient, whenever the court by which a committee was appointed shall have directed such committee to apply any part of the patient's estate for the maintenance of his family. The commission may appoint agents, whose duty it shall be to secure from relatives and friends who are liable therefor, or who may be willing to assume the cost of support of any inmate of a state school for mental defectives who is being supported by the state, reimbursement, in whole or in part, of the money so expended. The compensation of each agent shall be fixed by the commission on either an annual or per diem basis, provided that the annual compensation shall not exceed twenty-five hundred dollars, nor the per diem compensation eight dollars a day. Each agent shall receive his necessary traveling and other incidental expenses incurred by him, to be approved by the comptroller. The commission shall fix the rate to be paid for the support of an inmate of a state school for mental defectives by the committee of such inmate or by relatives liable for such support or by those not liable for such support, but willing to assume the cost thereof.

§ 6 This act shall take effect immediately

This bill is printed for the information of the members of the Society, and will be dropped

#### Appropriation of Clinic for Mental Diseases at Ossining Prison

Senate Int No 755 (conc Assembly Int 1018)—A bill introduced in the Senate by Senator Thos C Brown of Schenectady, N Y, concurrent Assembly Int No 1018, by Assemblyman Milan E Goodrich of Westchester County, would appropriate \$15,000 for a clinic for mental diseases in State prison at Ossining

Referred to Finance Committee

STATE OF NEW YORK,

Int 755

IN SENATE,

February 17, 1925

Introduced by Mr Brown—read once and referred to the Committee on Finance

#### AN ACT

To provide for the establishing of a clinic for mental diseases in the state prison at Ossining, and making an appropriation therefor

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 There shall be established in the

state prison at Ossining a clinic for mental diseases. The state superintendent of prisons shall appoint, and may at pleasure remove, and shall fix salaries of a psychiatrist to be in charge of such clinic, and such stenographic and clerical assistants as may be necessary for the conduct of such clinic. For the salary of such psychiatrist and for the personal service made necessary by this act, there is appropriated out of any money in the state treasury not otherwise appropriated the sum of fifteen thousand dollars (\$15,000). The moneys hereby appropriated shall be paid out on the warrant of the comptroller and the certificate of the superintendent of state prisons.

§ 2 This act shall take effect immediately

This bill is printed for the information of the members of the Society and will be dropped

#### Giving Health Commissioner Control State Hospital Crippled Children

Senate Int No 786 (conc Assembly Int 1074)—A bill introduced in the Senate by Senator Michael E Reiburn of New York, concurrent Assembly Int No 1074, by Assemblyman A Spencer Feld of New York, would add new article 19-a, Public Health Law, giving health commissioner control of State Hospital for Care of Crippled and Deformed Children at West Haverstraw

Referred to Public Health Committee of both Houses

STATE OF NEW YORK,

No 821

Int. 786

IN SENATE,

February 17, 1925

Introduced by Mr Reiburn—read twice and ordered printed, and when printed to be committed to the Committee on Public Health

#### AN ACT

To amend the public health law, in relation to the supervision and control by the state department of health of the New York state hospital for the care of crippled and deformed children

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," is hereby amended by inserting therein a new article, to be article nineteen-a, to read as follows

#### ARTICLE XIX-A

#### CONTROL AND SUPERVISION OF HOSPITAL FOR THE CARE OF CRIPPLED AND DEFORMED CHILDREN

- |             |  |
|-------------|--|
| Section 352 | Hospital continued                             |
| 352-a       | Board of trustees, supervision of commissioner |
| 352-b       | Fiscal control by commissioner                 |
| 352-c       | Expenditures                                   |



§ 352 Hospital continued The state hospital, known as the New York state hospital for the care of crippled and deformed children established at West Haverstraw, is hereby continued, but hereafter such hospital shall be under the general supervision and control of the commissioner of health

§ 352-a Board of trustees, supervision of commissioner The board of trustees of such hospital, as constituted pursuant to the provisions of article ten of the state charities law, is hereby continued with all the powers and duties conferred and imposed by such article, except as otherwise provided in this article, but the commissioner of health, in the exercise of the general supervision and control of such hospital, may prescribe that any and all of the powers and duties of such board be exercised and performed by such board in a manner to be approved by him

§ 352-b Fiscal control by commissioner The regulation, supervision and control of such hospital, in so far as the same pertains to expenditures of money, shall be vested in the state department of health No such expenditures or disbursements shall be made unless the same be authorized, audited and approved by the commissioner of health

§ 352-c Expenditures All balances of appropriations made for such hospital and remaining unexpended at the time this article takes effect shall be available and expended for the purposes for which such appropriations were made, but such moneys and all sums hereafter appropriated for such hospital shall be paid out by the treasurer on the warrant of the comptroller and the certificate of the commissioner of health All unexpended balances of gifts, legacies, bequests and other donations made to such hospital shall be expended for the objects and purposes for which the same were intended but hereafter such expenditures from such unexpended balances and from gifts, legacies, bequests or donations hereafter made shall require the approval of the commissioner of health

§ 2 This act shall take effect immediately

This bill is printed for the information of the members of the Society and will be dropped

**Giving Control of State Institute Malignant Disease to State Health Department**

Senate Int No 787 (conc Assembly Int 973)  
—A bill introduced in the Senate by Senator Michael E. Reiburn of New York, concurrent Assembly Int No 973, by Assemblyman Julius S. Berg of Bronx County, would amend section 345, Public Health Law, by giving State Health Department fiscal control of State Institute for Study of Malignant Disease

Referred to Public Health Committees of both Houses

No 822

Int 787

IN SENATE,

February 17, 1925

Introduced by Mr. Reiburn—read twice and ordered printed, and when printed to be committed to the Committee on Public Health

**AN ACT\***

To amend the public health law, in relation to the fiscal management of the state institute for the study of malignant disease

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section three hundred and forty-five of article eighteen of chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," as added by chapter one hundred and twenty-eight of the laws of nineteen hundred and eleven, is hereby amended to read as follows

§ 345 Management and control, board of trustees The general management and control of said institute shall be vested in a board of trustees consisting of seven members, one of whom shall be the state commissioner of health, ex officio The remaining members shall, as often as the positions of the several original members constituted by the act of which this article is a part, become vacant, be appointed by and may be removed at the pleasure of the governor Said trustees shall serve without compensation, and said board shall meet quarterly and shall hold an annual meeting in November to receive the annual report of the director and to prepare for transmission to the legislature its report upon the work of the preceding year The board shall [audit the annual expenses of the institute and] appoint the director The board of trustees, *subject to the approval of the state commissioner of health*, shall, within the limits of the annual appropriation made therefor, fix all salaries of officers and employees of the institute [and authorize all disbursements] The board may meet any time on the call of the chairman and shall be allowed necessary traveling expenses in attending the fixed meetings or any special meetings At least two of the trustees shall be residents of Buffalo or vicinity and one of them shall be a member of the medical faculty or of the council of the university of Buffalo *The regulation, supervision and control of such institute, in so far as the same pertains to expenditures or disbursement of money, shall be vested in the state department of health No such expenditure or disbursement shall be made unless the same be*

\* Matter in *italics* is new matter in brackets [ ] is old law to be omitted

*authorized, audited and approved by the commissioner of health All unexpended balances of appropriations made for such institute shall be transferred to the state department of health and shall be available for and expended by such department in carrying out the objects and purposes for which such appropriations were made*

§ 2 This act shall take effect immediately

This bill is printed for the information of the members of the Society, and will be dropped

#### Bouton Chiropractic Bill

Senate Int No 789—A bill introduced in the Senate by Senator Arthur F Bouton of Roxbury, N Y, would define and regulate the practice of chiropractic

Referred to Public Health Committee

No 835

Int 789

IN SENATE,

February 18, 1925

Introduced by Mr Bouton—read twice and ordered printed, and when printed to be committed to the Committee on Public Health

#### AN ACT

To define and regulate the practice of chiropractic  
*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

#### Section 1 Definitions

- 2 The New York State Chiropractic Society, Incorporated
- 3 Board of examiners, organization
- 4 Powers of board
- 5 Present practitioners exempt from examination
- 6 Qualifications of applicants for examinations and license
- 7 Examination of applicants
- 8 Licenses
- 9 Waiver of examination
- 10 Registry of license
- 11 Display of license and evidence of registration
- 12 Rights of licensed practitioners
- 13 Revocations and cancellation of licenses
- 14 Proceeding for revocation
- 15 Compensation of examiners
- 16 Fines and penalties
- 17 Violations
- 18 Statutes repealed

Section 1 Definitions As used in this act, "Regents" means board of regents of the university of the state of New York "Society" means New York State Chiropractic Society, Incorporated

"Board" means the board of chiropractic examiners of the state of New York

"Chiropractic school" means any school, college or department of a university teaching and giving instructions in the subjects required for a proper chiropractic standard as herein defined, which schools, upon making proof of giving such teaching and instruction shall be registered and approved by the regents

"Proper chiropractic standard" means a course of study extending over a period of twenty-four months, during which an aggregate of at least two thousand one hundred hours of sixty minutes each of instruction is given in the following subjects Anatomy including histology and embryology, hygiene and sanitation including bacteriology, physiology, biological chemistry including dietetics, physical diagnosis and symptomatology, pathology, chiropractic analysis, and science and practice of chiropractic

"Practitioner" means one who practices chiropractic

"License" means a license granted and issued by the board of regents of the university of the state of New York under this act to practice chiropractic within this state

"Licensed practitioner" means one who has received a license and is entitled to practice chiropractic within this state under the provisions of this act

The practice of chiropractic is defined as follows A person practices chiropractic within the meaning of this act, who holds himself out as being able to locate and to adjust by hand misaligned or displaced vertebrae of the human spine, for the purpose of relieving nerve pressure caused thereby

§ 2 The society The New York State Chiropractic Society, Incorporated, is continued, and the officers thereof shall be entitled to hold offices until the expiration of their respective terms and the elections and qualification of their successors, but the existence of said society shall in no way affect the validity of this act

§ 3 Board of examiners, organization Within thirty days after this act takes effect, the regents shall appoint a board of examiners consisting of three members The term of office of such examiners shall be one for one year, one for two years and one for three years, the term of each to be designated in his certificate of appointment Before entering upon his term of office such examiner shall file with the secretary of state his oath of office The regents shall annually thereafter appoint one member of such board to fill vacancy caused by expiration of term and may at any time fill vacancies on the board Appointments to the first board of examiners by the regents shall be made from a list of ten candidates nominated by the society Be-

fore the day when the official term of a member of the board shall expire, the regents shall appoint his successor to serve for the term of three years. Such appointment shall be made from a list of five candidates nominated by the society after notice given by the regents to the secretary of the society, or in default of such nomination, from the licensed and registered chiropractors of the state. The regents in the same manner shall also fill vacancies in the board. After the board of examiners shall have issued ten licenses under the provisions of this act, no person shall be eligible for appointment as an examiner unless he be a duly licensed chiropractor. No person shall be appointed or permitted to hold the office of examiner who is an officer or employee of any school, college, or university. Cause being shown before them, the regents may remove an examiner from office on proven charges of misconduct, unfairness, incapacity or neglect of duty.

§ 4 Powers of the board. 1 The board shall organize by electing one of its members president and another member secretary thereof, any member of the board may administer oaths, summon witnesses and compel their attendance, and take testimony concerning any matter within the jurisdiction of the board.

2 The board of examiners shall, by a majority vote of its members subject to the approval of the regents, make such rules and regulations, not inconsistent with law, as may be necessary for the proper performance of its duties.

3 The board of examiners shall have charge of the preparation and grading of examination papers, and shall hold examinations in at least three places in the state during each calendar year.

4 The board shall, after a hearing, upon notice given, recommend to the regents the suspension or revocation of the license of a practitioner and the suspension or annulment of his registration, for any misrepresentation or false or fraudulent statement in his application or examination for a license, for his conviction of a crime involving moral turpitude or for a violation of any of the provisions of this act. Upon such recommendation being made the regents may suspend or revoke such license and may suspend or annul such registration. Whereupon the practitioner must surrender his license to the regents who shall certify the facts to the county clerk of each county in which the practitioner is registered.

5 The board may investigate violations of the provisions of this act and conduct hearings in respect thereto, when, in its discretion, it appears to be necessary, and to bring the same to the notice of any state or county official.

§ 5 Present practitioners exempt from examination. For the period of six months after the

appointment of the first board of examiners, upon application made in writing and the payment of a fee of ten dollars, the regents shall issue a license, without examination by the board of examiners, to such persons certified by the board of examiners to be more than twenty-one years of age, of good moral character and otherwise qualified in any one of the following: (a) Graduates after a resident course in a school teaching chiropractic who continuously during at least three years immediately preceding and at the time of taking effect of this act have been actually engaged in the practice of chiropractic in this state, and (b) graduates after a resident course in a school teaching chiropractic who have had a preliminary education equivalent to a high school course and who continuously during at least one year immediately preceding and at the time of taking effect of this act have been actually engaged in the practice of chiropractic in this state, and (c) applicants determined after examination conducted by the board to possess a working knowledge of the practice of chiropractic and to be qualified to pass an intelligence test equivalent to that required of a high school graduate and who continuously during at least two years immediately preceding and at the time of taking effect of this act have been actually engaged in the practice of chiropractic in this state.

§ 6 Qualifications of applicants for examinations and license. The board shall admit to the examination for license any applicant who shall have paid to the board of examiners an examination fee of twenty-five dollars and submitted satisfactory evidence verified by oath or affirmation that he possesses the following qualifications:

1 That he is more than twenty-one years of age, and

2 That he is a person of good moral character, and

3 That he has a preliminary education equivalent to graduation from a four year high school course registered by the regents, or an education accepted by the regents as fully equivalent, provided such course shall have included elementary biology, elementary physics, elementary chemistry as taught in secondary schools, and

4 That he has actually taken a resident course and graduated from a chiropractic school which maintained, during the time of his attendance, a resident course of study extending over a period of twenty-four months, during which course at least two thousand and one hundred hours of sixty minutes each of actual instructions were given, and which included in its curriculum substantially all of the subjects specified in the next section, provided, however, that the students who prior to the taking effect of this act were engaged

in a resident course of study in a school which was teaching chiropractic and which then maintained a course of study of at least two academic years of at least six months each, after graduation therefrom, and all graduate chiropractors who shall have been in active practice of their profession in this state prior to the passage of this act shall be deemed to possess an equivalent of the qualifications specified in this and the preceding subdivision and be eligible for examination

§ 7 Examination of applicants All applicants for examination for license shall be required to pass a written examination conducted in the English language in the following subjects Anatomy including histology and embryology, hygiene and sanitation including bacteriology, physiology, biological chemistry including dietetics, physical diagnosis and symptomatology, pathology, chiropractic analysis, and science and practice of chiropractic The board of examiners shall submit to the regents, as required, a list of questions for examination in the subjects enumerated From these lists the regents shall select questions for all the subjects To entitle the applicant to a license he must pass the examination with an average of seventy-five per centum

§ 8 Licenses On receiving from the board of examiners an official report that an applicant has successfully passed the examination and is recommended for license, the regents shall issue to him a license to practice chiropractic in this state Every license shall be issued by the regents under seal, and shall be signed by the president and secretary of the board of examiners and by an officer of the regents Before any license is issued, it shall be numbered and recorded in a book kept in the regents' office and its number shall be noted in the license This record shall be open to public inspection and in all legal proceedings shall have the same weight as evidence that is given to a record of conveyance of land Such license shall entitle the holder to use of the degree D C, or doctor of chiropractic

§ 9 Waiver of examination The regents may waive the examination of any applicant for license hereunder who presents satisfactory proof that he has been duly licensed as a practitioner in any other state of the United States, upon such waiver and the payments of the fee of twenty-five dollars the regents shall issue to him a license as provided in section eight of this act

§ 10 Registry of license Every licensed practitioner shall before beginning practice under his license, cause such license to be registered in the office of the clerk of the county in which his practice is to be principally carried on, in a book to be provided by the clerk for such purpose, in which shall be entered the name, residence, place and date of birth, number and date of license and an affidavit signed by such licensed practitioner

verified before such clerk to the effect that he is the person named in the license, and has complied with all of the provisions of this act The clerk shall indorse upon such certificate the date and his name, preceded by the words "registered to practice chiropractic, in the clerk's office of \_\_\_\_\_ county" The clerk shall

thereupon give to the licensed practitioner so registered a certified transcript under his official seal of the entries in the register The county clerk shall be paid a fee of one dollar for registration, affidavit and certificate If the registration of the practitioner be suspended or annulled by the agents, upon receipt of a certificate to that effect the clerk shall stamp upon the record of registry "registration suspended" or "registration annulled" as the case may be, with the date of suspension or annulment If such registration be thereafter reinstated the clerk shall note that fact on the registration record If a registered practitioner remove his office or maintain an office in another county he shall register also in such county and notify the board of such fact He shall present a transcript of registration and pay a fee of twenty-five cents, whereupon the clerk shall indorse thereon "registered also in \_\_\_\_\_ county"

§ 11 Display of license and evidence of registration Each licensed practitioner must at all times keep conspicuously displayed in his principal business office his license and registration certificate and in any office in which he practices chiropractic his county registration certificate. Every unrevoked license with indorsement of registry thereon shall be presumptive evidence in all courts and places that the person named therein is legally licensed and registered under the provisions of this act

§ 12 Rights of licensed practitioners Each duly licensed practitioner who shall have fully complied with all provisions of this act, shall have the right to practice chiropractic within this state and shall be subject to all the disabilities, limitations and restrictions and entitled to the civil rights, privileges and immunities imposed upon and granted to all professional persons by the civil practice act and the judiciary law A licensed chiropractor shall have the right to practice in public or private hospitals and other institutions in the state, when requested so to do by a patient or his natural and lawful guardian or representative or a member of his family

§ 13 Revocation and cancellation of licenses The regents may revoke the license of a practitioner or annul his registration, or both, in any of the following cases

(a) A practitioner who is guilty of any fraud or deceit in his practice, or who is guilty of a crime involving moral turpitude, or who is guilty of any fraud or deceit by which he was admitted to practice, or

(b) To an habitual drunkard or habitually addicted to the use of morphine, opium, cocaine, or other drugs having similar effect, or

(c) Who prescribes or administers drugs, or practices surgery or obstetrics, or

(d) Who undertakes to engage in any manner or by any ways or means whatsoever, to procure or perform any criminal abortion as the same is defined by section eighty of the penal law, or

(e) Who offers or undertakes by any manner or means to violate any of the provisions of section eleven hundred and forty-two of the penal law

§ 14 Proceeding for revocation Proceedings for revocation of a license or the annulment of registration shall be begun by filing a written charge or charges against the accused. Those charges may be preferred by any person or corporation, or the regents may on their own motion direct a member of the board of examiners to prefer said charges. Said charges shall be filed with the secretary of the board of examiners. The board of examiners shall hear and determine said charges. A time and place for the hearing of said charges shall be fixed by said board as soon as convenient, and a copy of the charges, together with a notice of the time and place when they will be heard and determined, shall be personally served upon the accused or his counsel, at least ten days before the date actually fixed for said hearing. Where personal service upon counsel cannot be effected, and such fact is certified on oath by any person duly authorized to make legal service, the board shall cause to be published, in the manner prescribed for the service by publication of a summons, a notice to the effect that at a definite time and place a hearing will be had for the purpose of hearing charges against the practitioner upon an application to revoke his license. At said hearing the accused shall have the right to cross-examine the witnesses against him and to produce witnesses in his defense, and to appear personally or by counsel. The said board shall make a written report of its findings and recommendations and the same shall be forthwith transmitted to the executive officer of the board of regents. If the said board shall find that said charges, or any of them are sustained, and shall recommend that the license of the accused be revoked or his registration be annulled, the regents may thereupon, in their discretion, revoke said license or annul said registration, or do both. If the regents annul such registration they shall forthwith transmit to the clerk of the county or counties in which said accused is registered as a practitioner, a certificate, under their seal certifying that such registration has been annulled and said clerk shall upon receipt of said certificate file the same and forthwith

mark said registration "annulled." Any person who shall practice chiropractic after his registration has been marked "annulled" shall be deemed to have practiced without registration. Where the license of any person has been revoked or his registration has been annulled as herein provided, the board may entertain an application for a new license, in like manner as original applications for licenses are entertained, and upon such new application they may, in their discretion, exempt the applicant from the necessity of undergoing any examination.

§ 15 Compensation of examiners Each member of the board of examiners shall receive a fee of fifteen dollars per day for each day necessarily engaged in the performance of his official duties and in addition thereto shall receive his necessary expenses while so engaged. The secretary shall receive, in addition to the fee of fifteen dollars and expenses above specified, the annual sum of one thousand dollars. The fees and compensation of the secretary shall not exceed in any year the sum of eighteen hundred dollars. The chairman of the board shall audit the expense account of each member, including his own, and certify the same to the regents.

§ 16 Fees and penalties All fees, fines, penalties and other moneys derived from the operation of this act shall be paid into the state treasury that the legislature shall annually appropriate for the department an amount sufficient to pay all proper expenses incurred by them in administering this act, including the salary and expenses of the board.

§ 17 Violations Any person who shall violate any of the provisions of this act shall be guilty of a misdemeanor. Any person not duly licensed under this act who engages in the practice of chiropractic shall be guilty of a misdemeanor.

§ 18 Statutes repealed All acts or parts of acts inconsistent with or contrary to the provisions of this enactment are hereby repealed.

§ 19 In effect This act shall take effect September first, nineteen hundred and twenty-five.

*Comment* This bill also is a cult bill and deserves the greatest opposition on the part of all those who hold the present sciences and their application in regard to health measures in behalf of the health of the public in due regard.

This bill is a special class legislative measure in behalf of the New York State Chiropractic Society, so that it would seem that this society, by its anxiety in introducing two bills, is desirous of controlling their type of cult practice to the exclusion of all others.

Careful perusal of the bill must be made by all and objections must be voiced to the committee on Public Health of the Senate, as from

the number of bills introduced relative to cult practice, it would seem that extreme efforts will be made this year to license those who have practiced medicine illegally, according to their own admission, before the state is awakened to what is necessary in the further protection of the public health

#### Delivery of Cadavers to Medical Colleges

Senate Int No 851 (conc Assembly Int 1027)  
—A bill introduced in the Senate by Senator John A. Karle of Queens County, concurrent Assembly Int No 1027, by Assemblyman Frank H. Lattin of Orleans County, would amend section 316, Public Health Law, relative to delivery of cadavers to medical colleges

Referred to Public Health Committees of both houses

Int 851

IN SENATE,

February 17, 1925

Introduced by Mr. Karle—read once and referred to the Committee on Public Health

#### AN ACT\*

To amend section three hundred and sixteen of the public health law, in relation to cadavers

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section three hundred and sixteen of chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," is hereby amended to read as follows

§ 316 1 *Dissection* The persons having lawful control and management of any hospital, prison, reformatory, asylum, almshouse, morgue or other receptacle for corpses not interred, and every undertaker or other person having in his lawful possession any such corpse for keeping or burial may deliver and he is required to deliver, under the conditions specified in this section, every such corpse in their or his possession, charge, custody or control, not placed therein by relatives [or friends] in the usual manner for keeping or burial, to the medical colleges and universities of the state authorized by law to confer the degree of doctor of medicine and to all other colleges or schools incorporated under the laws of the state for the purpose of teaching medicine, anatomy or surgery to those on whom the degree of doctor of medicine has been conferred, and to any university of the state having a medical preparatory or medical post-graduate course of instruction [No corpse shall be so delivered or received if desired for interment by relatives or friends within forty-eight hours after death, or if known to have relatives or friends without the assent of such relatives or friends,

*or of a person who shall have expressed a desire in his last illness that his body be interred, but the same shall be buried in the usual manner. If the remains of any person so delivered or received shall be subsequently claimed by any relative or friend, they shall be given up to such relative or friend for interment.] No corpse shall be so delivered or received in case the next of kin, within forty-eight hours after death, notifies the person or institution so delivering or receiving the same, that it is desired for interment, or of a person who shall have expressed a desire in his last illness that his body be interred, and in such cases the same shall be buried in the usual manner.* Any person claiming any corpse or remains for interment as provided in this section, may be required by the persons, college, school or university or officer or agent thereof, in whose possession, charge or custody the same may be, to present an affidavit stating that he is such relative [or friend,] and the facts and circumstances upon which the claim that he is such relative [or friend] is based, and that the said relative assumes the cost of burial, the expense of which affidavit shall be paid by the persons requiring it. If such person shall refuse to make such affidavit, such corpse or remains shall not be delivered to him but he shall forfeit his claim and right to the same. Any such medical college, school, or university desiring to avail itself of the provisions of this section shall notify such persons having the control and management of the institutions and places heretofore specified, and such undertakers and other persons having any such corpse in their possession, custody or control in the county where such college, school or university is situated, and in any other county in the state in which no medical college, school or university is situated, or in which no such medical college, school or university desires to avail itself of the provisions of this section, of such desire, and thereafter all such persons shall notify the proper officers of such college, school or university whenever there is any corpse in their possession, custody or control, which may be delivered to a medical college, school or university under this section, and shall deliver the same to such college, school or university. If two or more medical colleges, schools or universities are entitled to receive corpses, under the provisions of this act and shall have given notice as aforesaid, they shall receive the same in proportion to the number of matriculated students in each college, school or university who are pursuing courses of anatomy and surgery at the time of making the apportionment. The professors and teachers in every college, school or university receiving any corpse under this section shall dispose of the remains thereof, after they have served the purposes of medical science and study,

\* Matter in italics is new matter in brackets [ ] is old law to be omitted

in accordance with the regulations of the local board of health where the college, school or university is situated. Every person neglecting to comply with or violating any provision of this section, shall forfeit to the local board of health where such non-compliance or violation occurred, the sum of twenty-five dollars for every such non-compliance or violation, to be sued for by the health officer of such place, and when recovered to be paid over, less the costs and expenses of the action, to such board for its use and benefits.

**2 Autopsies** The person having lawful control and management of any hospital in which a patient has died may order the performance of an autopsy upon the corpse, unless objection is made to such autopsy by the next of kin within forty-eight hours after death. In case of unclaimed bodies, the aforementioned medical colleges,

schools or universities shall have a priority claim to the bodies, for the purpose of teaching anatomy.

**3 Disposal of remains** In all cases in which an autopsy or dissection has been made of an unclaimed body, the provisions of article one hundred and ninety-eight of the penal law requiring the burial of a dead body and punishing interference with or injuries to it, shall apply equally to the remains of such body as soon as the lawful purposes of such autopsy or dissection have been accomplished, except that the persons having possession of the dead body may, in their discretion, cause it to be either buried or cremated, or may retain parts of such body for scientific purposes.

§ 2 This act shall take effect immediately.

No comment. The bill will be dropped.

## IN ASSEMBLY.

### Requiring Employers to Furnish First Aid in Factories

Assembly Int No 120—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would add new section 213, Labor Law, requiring employers to furnish first aid service in factories, mercantile and other establishments.

Referred to Labor and Industry Committee.  
This bill will be dropped.

### Appointment of Physicians, Dentists and Nurses in Schools

Assembly Int No 127—A bill introduced in the Assembly by Assemblyman Joseph Reich of Kings County, would amend sections 570, 571, Education Law, by providing that boards of education and trustees shall appoint physicians and dentists and may employ nurses for service in schools.

Referred to Public Education Committee.

**Comment** This bill has been amended by adding at the end of the first paragraph "subject to the consent of the parents or guardians."

This change makes the bill less objectionable, but its provisions still are such as to keep it an undesirable measure although the consent of the parent or guardian is provided for it is quite evident that this would not work out in practice to give the family physician any more opportunity because the school physician would be in a position to bring pressure to bear upon the parents which would in a majority of instances result in the parents giving their consent to the school physician or nurse because they had sought it.

Medical men realize very keenly that medical and surgical attention to children when demanded, can rarely be completely administered without continuing the care of the child outside of the school hours, and if the school physician does not intend to follow the child to its home with his attention, and it is expected that the family physician shall supplement him, the situation produced would be undesirable to both physicians and often of a serious injury to the child.

### Practical Tests of Injured Persons

Assembly Int No 184 (conc Senate Int 647)—A bill introduced in the Assembly by Assemblyman F A Miller of Kings County, would amend section 118, Workmen's Compensation Law, by authorizing physical examinations and practical tests of claimants to determine loss of use and proportionate loss of use of a member, result and test to be part of record.

Referred to Labor and Industry Committee.

See concurrent Senate Int 647 for digest and comment.

### Nicoll Chiropractic Bill

Assembly Int No 185—A bill introduced in the Assembly by Assemblyman William Nicoll of Schenectady County, would define and regulate the practice of chiropractic.

Referred to Public Health Committee.

**Comment** It is to be hoped that the opposition to this vicious form of legislation has continued and will be kept up until absolute defeat of the bill is assured.

This bill has been amended from the old reading which was as follows:

"Sect 5 Present practitioners exempt from examination For the period of six months after the appointment of the additional member of the State Board of Medical Examiners as provided by this act "

and it now reads

"Sect 5 Present practitioners exempt from examination For the period of six months after this act takes effect, upon application made in writing and the payment of a fee of ten dollars, the regents shall issue a license, etc "

It will therefore be seen that another hole is punched in the provisions of the bill, opening the door still wider for the admission of practitioners without license and purely upon their "say-so" as to qualifications for practice

#### **Narcotic Bill**

Assembly Int No 215 (conc Senate Int 115)  
—See concurrent Senate Int 115 for digest and comment

#### **Providing Rate of Wages of Public Employees**

Assembly Int No 216 (conc Senate Int 116)  
—See concurrent Senate Int 116 for digest and comment

#### **County Supervisors for Children of Retarded Development**

Assembly Int No 229—A bill introduced in the Assembly by Assemblyman A Spencer Feld of New York County, would add new section 579-a, Education Law, providing for county supervisors to supervise education of children with retarded development

Referred to Public Education Committee

No further comment

#### **Inspection of Children Institutions**

Assembly Int No 236 (conc Senate Int 228)  
—See concurrent Senate Int 228 for printed bill and comment

#### **Free Choice of Physician**

Assembly Int No 301 (conc Senate Int 594)  
—A bill introduced in the Assembly by Assemblyman Frank H Lattin of Orleans County, would amend section 13, Workmen's Compensation Law, by permitting injured employees at employer's expense, to engage medical or other attendance

Referred to Labor and Industry Committee

See concurrent Senate bill and Int 594 for digest and comment

#### **The State Department of Education Bill Amending the Medical Practice Act**

Assembly Int No 307 (conc Senate Int 211)  
—See concurrent Senate Int 211 for digest and comment

#### **County Public Health Nurses**

Assembly Int No 399 (conc Senate Int 283)  
—See concurrent Senate Int 283 for digest and comment

#### **Disclosure of Confidential Communications**

Assembly Int 422—A bill introduced in the Assembly by Assemblyman Samuel Rosenman of New York County would amend section 352, Civil Practice Act, by providing physicians and nurses may disclose professional information as witnesses in action to annul marriage on ground of fraud

Referred to Codes Committee

*Comment* It is again asked if the County Chairmen have written to the Assembly Codes Committee as requested in opposition to the bill

#### **Free Choice of Physician**

Assembly Int 570 (conc. Senate Int. 380)—  
See concurrent Senate Int 389, for digest and comment

#### **Esmond Chiropractic Bill**

Assembly Int 649—A bill introduced in the Assembly by Assemblyman Burton D Esmond of Saratoga County would amend sections 164, 169, 170, 173, adding new article 8-b, Public Health Law, relative to the practice of medicine, and to chiropractic

Referred to Public Health Committee.

*Comment* Attention of the members of the Medical Society is called to the fact that this chiropractic bill reads almost word for word the same as the Department of Education bill amending the Medical Practice Act (Senate Int. 211, conc A 307), and omits the sections which are obnoxious to chiropractors and adds on sections which would permit of their practicing through the legal verbiage added on

Extreme caution and precise care must be used by each county legislative chairman and individual in discussing medical and chiropractic legislation that these two bills may not be confused, as is evidently the intent, and in drawing this chiropractic bill in such a manner to befog the mind of the legislator when ultimate voting comes up

#### **Health Service in Schools**

Assembly Int 748 (conc Senate Int 302)—  
See concurrent Senate Int 302 for digest and comment

#### **Inspection of School Children**

Assembly Int 850 (conc Senate Int. 586)—  
See concurrent Senate Int. 586 for digest and bill printed

#### **Physically Handicapped Persons**

Assembly Int 868 (conc Senate Int 671)—  
See concurrent Senate Int 671 for digest and printed bill



**Forbidding Sale of Wood or Methyl Alcohol Except as Methanol**

Assembly Int 908—A bill introduced in the Assembly by Assemblyman Frank H Lattin of Orleans County, would add new sections 416, 447, 447-a, Penal Law, forbidding sale of wood or methyl alcohol except as methanol, and making it a felony to sell food or drink or medicinal or toilet preparations for internal use in which there is methanol

Referred to Codes Committee

*Comment* No further comment

**Reciprocity in License to Practice Medicine**

Assembly Int 925—A bill introduced in the Assembly by Assemblyman Edward J Coughlin of Brooklyn, N Y, would amend section 169, Public Health Law, relative to licenses to practice medicine who have received the licensee in another state

Referred to Public Health Committee

No further comment as yet

**Rural Hygiene**

Assembly Int No 969—(conc Senate Int 716)—See concurrent Senate Int 716 for digest

**Control of State Institute for Malignant Disease by State Department of Health**

Assembly Int No 973 (conc Senate Int 787)—A bill introduced in the Assembly by Assemblyman Julius S Berg of Bronx County, would amend section 345, Public Health Law, by giving State Health Department fiscal control of State Institute for Study of Malignant Disease

Referred to Ways and Means Committee.

See concurrent Senate Int 787 for digest and comment

**Dissection of Dead Bodies**

Assembly Int No 986 (conc Senate Int 681)—See concurrent Senate Int. 681 for digest

**The Birth Control Bill**

Assembly Int 987—A bill introduced in the Assembly by Assemblyman John Boyle, Jr, of Suffolk County, would amend section 1145, Penal Law, by permitting use of instruments for contraceptive treatment of married persons

Referred to Codes Committee

No 1041

Int 987

IN ASSEMBLY,

February 16, 1925

Introduced by Mr Boyle—read once and referred to the Committee on Codes

**AN ACT\***

To amend the penal law in relation to physician's instruments

\* Matter in *italics* is new matter in brackets [ ] is old law to be omitted

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section eleven hundred and forty-five of the penal law is hereby amended to read as follows

§ 1145 Physician's instruments An article or instrument, used or applied by physicians lawfully practicing, or by their direction or prescription, for the contraceptive treatment of married persons or for the cure or prevention of disease, is not an article of indecent or immoral nature or use, within this article The supplying of such articles to such physicians or by their direction or prescription, is not an offense under this article

§ 2 This act shall take effect immediately

*Comment* Why this bill should recur year after year is a question which interests the medical profession and those who believe in the dictates of a Divine Being

The bill is useless if it is for practical purposes since the law is being controverted quietly by many and moreover it is detrimental to the best interests and welfare of the inhabitants of this State Such a question has long since been passed upon as not moral and harmful to unknown degrees

Those who are in favor of it advance time worn and hackneyed argument but your Committee on Legislation urges the county chairman to register their disapproval to the measure

Assembly Int No 1005 (conc Senate Int 743)—See concurrent Senate Int 743 for digest and comment

**Providing That Those Using Laboratory Supplies Shall Furnish Clinical Data, Etc.**

Assembly Int No 1167—A bill introduced in the Assembly by Assemblyman Frank H Lattin of Orleans County, would amend section 5, Public Health Law, by providing institutions and persons using laboratory supplies shall furnish clinical data and report or pay market prices and fees therefor

Referred to Public Health Committee

Int No 1167

IN ASSEMBLY,

AN ACT\*

Introduced by Mr Lattin to amend the public health law, in relation to district laboratory supply stations

Section 1 Section five of chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," as added by chapter six hundred and

\* Matter in *italics* is new matter in brackets [ ] is old law to be omitted

twenty of the laws of nineteen hundred and twenty and last amended by chapter six hundred and thirty-seven of the laws of nineteen hundred and twenty-three, is hereby amended to read as follows

§ 5 LABORATORY SUPPLY STATIONS The state commissioner of health or his authorized representative may establish stations, to be known as district laboratory supply stations, for the distribution of laboratory supplies furnished by the state department of health *Institutions, physicians and all other persons using these supplies shall furnish the clinical data and reports required by the laboratory of the state department of health and laboratories approved by the commissioner of health, or pay the market prices and fees for such laboratory services and supplies as shall be established from time to time by the state commissioner of health All such fees and charges made by the laboratory of the state department of health shall be paid into the state treasury [He] The state commissioner of health may designate districts to be served by [such] the district laboratory supply stations (remainder same as old law)*

§ 2 This act shall take effect immediately

*Comment* This would write into the law possibly under the rules and regulations to be devised, the divulging of confidential communications between patient and physician as well as to open the liability to penalty in case the information could not be furnished in full as would be required by the law Immediate comment is requested from the County Legislative Chairmen. (See editorial, page 323)

**Appropriation for Mental Disease Clinic at Ossining State Prison**

Assembly Int. No 1018 (conc. Senate Int. 755)  
—See concurrent Senate Int 755 for digest and comment

**Relative to Delivery of Cadavers to Medical College**

Assembly Int No 1027 (conc. Senate Int 851)—See concurrent Senate Int 851 for digest and comment

**Giving Health Commissioner Control of State Hospital for Crippled Children**

Assembly Int No 1074 (conc. Senate Int. 786)—See concurrent Senate Int 786 for digest and comment



# State Department of Health



## COUNTY JUDGE JUSTIFIES MENTAL EXAMINATION OF CRIMINALS.

At the December term of the Greene County Court, Judge William E Thorpe's disposition of ten criminal cases was one which should be of especial interest to members of the medical profession

Judge Thorpe directed the district attorney to call in Dr C P McCord, a psychiatrist of Albany, to make a mental examination of each of the ten defendants. This was done in the presence of the court. Considerable adverse criticism developed, chiefly because of the expense involved. In a statement issued subsequently, Judge Thorpe said

"Having been present at each one of these examinations, having carefully noted the degree of detail and the numerous branches of medical, mental and psychological research adopted by the expert, it was readily apparent to me, and demonstrated beyond the peradventure of any doubt, that without this examination there would have been one of the most serious and regrettable dispositions of each of these cases that had ever happened within the confines of a County Court in this County"

\* \* \* \* \*

"If we went to the doctor's office and informed him that one of the members of our family was ill, and he should respond by saying 'Give him a dose of paregoric,' we would consider the doctor was either grossly negligent, unwilling to perform the duties of the position he occupied in society, or lacking in sound common sense and good judgment. Yet, on the other hand, the tax-paying public are asking the judicial officers before whom criminals are arraigned and who have the power of disposition as to their future, to not diagnose the disease but to furnish the remedy for a disease that they do not know the character of and which in instances of this kind there can be but one remedy for, and that is reformatory or prison. The assuinity of such a method of performance is clearly apparent when we wouldn't have a doctor treat without *any*

diagnosis. On the one hand, it is the health of the individual that will be affected, while on the other hand, where the judge enters into the situation, it means the future of the criminal and his relation to society, and the peace and harmony of the society in which he shall later mingle, all of which are in the hands of the judicial officer, and the public have heretofore demanded or expected disposition of these cases on his part without any knowledge of the disease"

\* \* \* \* \*

"The procedure adopted here in Greene County perhaps is among the first, if not the first adopted in any Court of this kind in the entire United States, particularly true, perhaps as to New York State, but it has been recommended a long time since by the American Bar Association, and prominent criminal lawyers all over the country are repeatedly rallying to the standard whose insignia is no longer 'An eye for an eye and a tooth for a tooth,' but is rather that justice shall be tempered with mercy, and that no prescription shall be given in the way of a sentence until the disease calling for the prescription shall have been thoroughly diagnosed and a perfect analization made so that there may be chance of a recovery or at least full protection to society from the future crimes of these same individuals"

\* \* \* \* \*

"While the first expense incurred for examinations of this kind may seem large, I feel sure in saying that this expense which saves the criminal to society is infinitesimal as compared with the expense that the taxpayers will incur in taking care of him and his progeny after he shall have been treated *without* diagnosis, committed to an institution, permitted to associate with criminals, absorbing their ideas and their suggestions, and allowed to propagate and bring up offspring which shall become a menace to society and a disgrace to civilization generally"

## MONROE COUNTY HEALTH COMMITTEE ADOPTS NEW PROGRAM

The County Health Committee of the Tuberculosis and Public Health Association of Rochester and Monroe County has adopted the following health program

1 The extension of nursing service and the promotion of pre-school health examinations, with the assistance of Sheppard-Towner Funds

2 Demonstrations of the Nutrition Class in

certain towns where request for this service is made

3 A close cooperation with the Monroe County Tuberculosis Sanatorium, and all agencies here present, in order that our combined work may attain maximum effectiveness in health

4 A consideration of the individual problems of each community, so far as is possible, com-

bined with the offer of the Association's facilities in solving them

5 The extension of health education from every angle

6 The examination for tuberculosis of high school pupils and others who are leaving school for work

7 The endorsement of the campaign for the eradication of bovine tuberculosis now being conducted by the Monroe County Farm Bureau

8 The distribution of these resolutions to all agencies participating in this conference

9 The promotion of health examinations for adults by local physicians

## THE PROGRESS AND PRESENT STATE OF MEDICINE—IN 1792

Officers and other members of the County Medical Societies will be interested to read a quotation given below, from a pamphlet in the State Library, entitled "The Rise, Progress and Present State of Medicine"—a discourse delivered before the Middlesex Medical Association by Dr Benjamin Waterhouse, in 1792. Middlesex County includes Cambridge, Massachusetts, where Dr Waterhouse was Professor of the Theory and Practice of Medicine. It will be remembered that it was he who first introduced into America the Jennerian method of vaccination against smallpox.

As an introduction to the "Discourse," there is printed an abstract from the Constitution of the Middlesex Medical Association, and then there appears the following

Queries put to each Member at the opening of every meeting

1 Have you met with anything in any medical

author, since our last meeting, suitable to be communicated to this association?

2 What was the last epidemic that visited the district where you reside, and what were its remedies particularly serviceable in it?

3 Do you know of any instance, since our last meeting, of the resuscitation of any one apparently dead, and the method pursued?

4 Is there any difficult point in the theory or practice of physic, which you would gladly have discussed at this time?

5 Do you know of any deserving beginner in the practice of physic, too young to become a member, whom this association can in any way serve or encourage?

6 Have you any weighty affair in hand as a physician, in which you think the advice of this association may be of service?

7 Do you think of anything at present in which this association may be of service to mankind, to their country, or to themselves?

## ANOTHER TYPHOID CARRIER DISCOVERED

Recently in one of the cities of the State a case of typhoid fever in a child three years of age was investigated. It was suggested to the attending physician that the cook in the household might be a carrier. This cook, who is 60 years old, had previously denied a history of typhoid fever, but evidently had misunderstood the questions, as she had inferred that they applied to the immediate past. Later she admitted that she had typhoid fever about 35 or 40 years ago.

The attending physician had been somewhat misled by the first history and by the fact that two previous occupants of the house had had the disease, so that he was inclined to attribute the source to house infection due to defective

plumbing. However, at the suggestion of the district state health officer, fecal specimens from the cook were examined. The results proved her to be a carrier.

This experience illustrates the futility of as signing defective plumbing or the like as the source of infection, which, of course, must originally have come from a patient or carrier. It also illustrates the need of very careful inquiry before concluding that a suspected carrier has not had typhoid fever. In this connection it may be noted that it is not uncommon to find that a suspect who reveals no history of typhoid fever, even on the most careful questioning, proves to be a carrier.

## REMOVAL OF TONSILS CURES DIPHTHERIA CARRIERS

As a result of a small outbreak of diphtheria in one of the Granville Schools, a number of pupils became diphtheria carriers, some of these being contacts and others recovered clinical cases.

At the instigation of Dr D. C. McKenzie, Health Officer of Granville, eleven of these carriers attended a clinic in Granville on November 10, and had their tonsils and adenoids re-

moved. Of the eleven, four had had clinical diphtheria, three of the four gave positive cultures for nine weeks, and the remaining one for twelve weeks.

Eleven days after the operation, cultures for release were taken with negative results in all cases. Second cultures taken from all the carriers two days later were also negative, and the children were released from quarantine.

# Medical Society of the State of New York

## REFERENDUM ON THE MEDICAL PRACTICE ACT

The members of the Medical Society of the State of New York have had an opportunity to read and consider the proposed Practice of Medicine bill which was introduced in the Senate on January 20, 1925, and was printed on page 123 of the January 30 issue of this Journal

This bill is essentially the same as the bill which was introduced in the Senate on February 11, 1924, and which was printed on page 214 of the February 22, 1924 issue of this Journal. However, this year's bill embodies a few changes which clarify some of the provisions of the former bill

On March 4th the Committees of the Senate and Assembly will hold a hearing on all the bills relating to the practice of medicine. Specifically the bills to be considered are the Practice of Medicine bill, the Drugless Therapy bill, and the two bills legalizing chiropractic practice

The unanimous desire of the physicians of New York State for the enactment of the bill would be considered by the legislators to have great weight in their decisions. Unfortunately there is some opposition which appears to be largely sectional, and therefore the Council of the Medical Society of the State of New York at its meeting on February 18, authorized a referendum vote of the members of the House of Delegates. The ballot is in the following form

### MEDICAL SOCIETY OF THE STATE OF NEW YORK

WHEREAS, There has been introduced in the Senate by Mr. Karle a bill, introductory number 211, see Journal, January 30th, 1925, page 123, entitled "An Act to Amend the Public Health Law in relation to the practice of medicine" and a similar Act by Mr. Dunmore in the Assembly, known as introductory number 307, and a hearing on these bills is to be held in the Assembly Chamber, before a joint committee on Public Health, of the Senate and the Assembly, on March 4, 1925, and

WHEREAS, These bills are sponsored by the Department of Education of the State of New York and provide for amendments to the Medical Practice Act, providing for an accurate official list of licensed physicians by means of annual registration, the clarifying of the exemptions of different classes of persons under the Act so as to limit such exemptions and make the Act more effective, providing for adequate, civil and criminal penalties for the practice of medicine by the

unlicensed practitioners, prohibiting the use of the title "Doctor" by those not legally entitled to the same, curtailing improper medical advertisements, providing for recovery of damages against unlicensed practitioners for injury to those treated by them, simplifying the procedure for revocation and annulment of registration of physicians, and providing for state wide inspection and prosecution of illegal practitioners, and

WHEREAS, That at the hearing on March 4, 1925, by the Joint Committee, it is desirable that the Medical Society of the State of New York should officially record its position on said measures

*Therefore, Be It Resolved*, That the Council hereby approves said measures and recommends the passage of the same subject to a favorable referendum vote of the House of Delegates of the Medical Society of the State of New York confirming said action

*Further Resolved*, That pursuant to Section 24 of the By-Laws of the Medical Society of the State of New York, a referendum vote of the said House of Delegates be, and is hereby ordered, and said vote shall be completed by mail on or before the 5th day of March, 1925, and that the question submitted for such vote shall be as follows

The Medical Society of the State of New York hereby endorses the said Karle and Dunmore bills and urges their passage by the Legislature

Vote by marking X in blank space

Yes ☐ No ☐

Signed, Officer or Chairman, Standing Committee, or Delegate from County of the Medical Society of the State of New York

\*Note A majority vote before March 4th is necessary to be of any value. *Vote and return at once to the Secretary*

New York City, February 18, 1925

By order of the Council Edward Livingston Hunt, Secretary

A copy of this ballot has been sent to every member of the House of Delegates

There is need that the members send their votes immediately in order that the results may be available for presentation at the legislative hearing

F O



# NEWS NOTES



## OCCUPATIONAL HAZARDS IN PERIODIC HEALTH EXAMINATIONS

By LOUIS I HARRIS, M D,  
NEW YORK

Abstract of the fifteenth lecture in the Symposium on Periodic Health Examinations conducted by the Medical Society of the County of New York, given January 29, 1925

Occupations often have definite effects on the health of workmen. Those who practice industrial medicine are trained to recognize the early signs of occupational diseases and to guard against their development into crippling conditions. The subject is exceedingly broad. I will point out only a few of the more evident conditions which are likely to come to the attention of any physician who makes periodic health examinations, and will consider some of the more common pre-clinical symptoms of disorders due to occupations.

*Eyes*—1 The eye is an organ which is often affected by occupational conditions. This is because of the strains from poor lighting and from unusual positions. A typical example is the nystagmus of miners which develops from poor lighting and from the miner working in an unnatural posture.

2 Those who work in excessively hot places, such as foundries and boiler-rooms, are sometimes subject to cataract due to the heat.

3 Dimness of vision may be due to the scars which are the result of flying pieces of metal or stone in the process of grinding or surfacing. The danger to vision from this cause is indicated by the frosting of the protective glasses worn by stone workers after a few hours of labor.

*Nervous and Mental Conditions*—1 Fatigue produces far-reaching mental and nervous conditions, among them being mental irritability, liability to accidents, and decreased output of product.

2 The constant use of a set of muscles may produce painful conditions, such as the cramps of writers and typists. Three elements leading to fatigue are hurry, piece-work, and the constant repetition of a monotonous motion.

3 Nervous conditions are often found among highly skilled workmen, such as goldsmiths and engravers, who are under mental strain and feel a keen responsibility for valuable products.

Poisoning by substances used in industries is common and may produce nervous symptoms. We will discuss only a few of these.

a Mercury poisoning often occurs in hat-making and the fur industry. The earliest signs

are usually irritability known as erethism, a slight tremor, or spongy gums and ptyalism.

b Carbon bisulphide, which is largely used in the rubber industry and for extracting oils from seeds or degreasing, produces headache which is felt at the root of the nose and spreads to the temples or appears at the vertex and radiates to the shoulders.

c Headache is also one of the earliest signs of lead poisoning. Paralysis is usually a late sign of fully developed poisoning by lead.

d Carbon monoxide poisoning is becoming increasingly common owing to the exhaust automobile gases. Its first manifestation is usually headache. It often produces anemia in those who are subject to mild poisoning day after day.

*Skin and Color*—1 The skin is often affected by some of the chemicals introduced into modern industrial processes. Jaundice may result from handling and from the tetra-chlorethane used to varnish airplane wings. The jaundice is due to the destruction of red blood cells.

2 Eczema is an early sign of local poisoning by various irritating chemicals, such as turpentine and aniline. It frequently follows the use of paraphenylenediamine which has lately been introduced into hair-dyes.

3 Ulcers and boils are often produced by the local action of arsenic, mercury, hydrofluoric acid, and chromic acid. Perforation of the nasal septum is a peculiar result of chromic acid derivatives.

*Nose and Throat*—The nose and throat are often seriously affected by fumes and dusts.

Noise which is intense and long continued often dulls the hearing to the point of deafness. Over half of the workmen in one establishment were made deaf by the excessive noise of machinery.

This is but an introduction to points that should be kept in mind in making a routine periodic health examination. Time does not permit of the completion of the pre-clinical conditions that are frequently encountered in the examination of those employed in industry.

## MEDICAL SOCIETY OF THE COUNTY OF KINGS

The following report of the Legislative Committee of the Medical Society of the County of Kings was unanimously accepted at the Stated Meeting of the Society held on February 17, 1925. It was moved, seconded and carried that a copy of the report be transmitted to all the County Societies in the State of New York, and also that a copy of the report be sent to the NEW YORK STATE JOURNAL OF MEDICINE for publication.

Ten days after the January meeting of the Medical Society of the County of Kings your Legislative Committee held a meeting to consider the 1925 Medical Practice Act, sponsored by the State Department of Education, and known as the Karle-Dunmore Bill, Senate Introductory 211, Assembly Introductory 307.

Pursuant to the request of the Society, the Committee was advised by counsel for the Society, Judge John G. Dyer.

Judge Dyer took up with the Committee a calm, cold analysis of the new matter in the bill line by line. After the Judge had finished his analysis a lengthy discussion was entered into by the Committee. The good points in the bill were brought out. The reasons why we might support the bill are as follows:

1 In union (with the State Society) there is strength.

2 The penalties imposed would have a healthful effect on illegal practitioners.

3 Under existing law the work of the Committee on Illegal Practice of the Medical Society of the County of Kings is voluntary and might not always function. Also, the activity of the District Attorney of Kings County is exceptional.

4 The added protection to the title of "Doctor" is good.

5 The State Department of Education would have what it wants, viz., a check-up on all doctors practising today.

The objections to the bill are as follows:

1 We are opposed to registration in principle. The principle of law applying in dentistry and podiatry is as follows:

"Any dentist (nurse, optometrist, or podiatrist—Pars 199 and 201, 251-a, 278-a, 304, of the

Public Health Law) whose name does not appear in the registry on or before the first of January of each year may have his license revoked or suspended by the State Board of Regents."

While the Karle-Dunmore Bill does not contain this provision, it could all too easily be amended after registration was once a law—as has occurred in the case of the nurses and podiatrists.

2 Section 170-d, which has to do with the use of contraceptive measures, should be restored to the bill.

3 The penalties are objectionable, too severe, give arbitrary power, and in our opinion, are for contumacy only.

4 The bill is unnecessary, unremedial, uncalled for. Our present laws are sufficient. We should go slowly about any change in the Medical Practice Act as physicians in general are not acquainted with such proposed changes.

5 We should reject anything covered by existing law. We believe we would be making more laws without enforcing the present ones.

6 While calling for registration of all honest physicians with payment of a fee, etc., for five years, and then registering annually for the rest of our natural lives without payment of a fee, it does not register cults.

7 We believe the public health is better protected today than ever before. This bill empowers the attorney-general to deprive the district attorney of the right to prosecute—an unwarranted centralization of power.

8 We have a vested interest in our state license as practitioners of medicine which should not be jeopardized by even the color of discretionary power.

9 In our opinion, this bill would be an entering wedge for compulsory health insurance and other forms of State Medicine.

10 The only good that might presumably be obtained now would be to prosecute cults at the cost of great personal inconvenience.

About midnight your Committee cast one vote in unanimous opposition to the Karle-Dunmore Bill.

(signed) JOSEPH A. DRISCOLL, M.D.,  
Chairman, Legislative Committee



# THE DAILY PRESS



Oysters and typhoid are occupying less and less of the space in the daily papers, and yet the most important part of the situation is just starting, and that is the constructive remedy. The *Elmira Advertiser*, February 1, says editorially:

"Dealers are coming to understand that they must bring their business up to a standard approaching that followed by the meat industry of the country. It was learned, many years ago, that a number of diseases may be carried and distributed through the careless handling of food products, and pretty nearly everything from lemons to sides of beef are fairly well protected, although in instances, carelessness will creep in. Oysters should be handled with as much care as milk, and the source of supply should be as carefully inspected, graded and scored, as are the dairies of the country, which furnish milk to cities and towns. But it has not been done, if reports of investigations are to be believed, and so the reckoning had to come. The oyster industry has been hard hit for a season, and the country has been deprived of an excellent food."

"Results have already been realized, and improvements must continue in the future. The state of New York has also something to do along this line. There are extensive oyster beds along the shores of Long Island."

In line with this optimism has been the action of some of the Boards of Health on the South Shore of Long Island where a great quantity of some of the finest oysters in the land are grown. The co-operative attitude of the local Boards of Health and people was publicly commended by State Commissioner of Health at a recent hearing on the sewage pollution of oyster grounds. This desire to construct sanitary sewer systems is reflected in the *Patchogue Advance* of February 19, which describes the action of the Village Board on February 17, when its members unanimously voted to take a radical step to secure the immediate formation of a sewer district and the construction of a disposal plant. The account reads:

"At a special meeting of the village board Tuesday night the sewer question was discussed at length in executive session behind closed doors, and while various ideas were put forth as to how best to handle the sewer question and what the possibilities are for passing a sewer proposition if the board offers one, it was decided that something must be done, and in order to have as wide scope for action as possible it was agreed to seek an amendment to the law which would permit forming a small sewer district within the village, which could have the use

of and stand the cost of a mere uptown sewer at first."

"This follows the idea outlined at the State Health Commissioner's hearing. The board directed its counsel to go to Albany and work out such a bill. Such a district, if authorized, might, as a minimum temporary expedient to meet the State's demand for purification of the river and bay, establish a disposal plant and take over the present private sewer. Or it might lay the first unit of a comprehensive system. There is a heavy demand for the commencement of a real general sewer system."

The law to which reference is made is that part of the Village Law relating to the formation of sewer districts and the construction of sewers. The present law has two difficult requirements, first, that before a public sewer can be constructed in a village, a comprehensive plan for a sewer for the *entire* village must be made, and second, the plan must be submitted to a vote of the taxpayers of the entire village. If it is adopted, the Village Board may construct any part of the system that may be needed.

Patchogue needs a sewer in only that small area which is occupied by the congested business blocks. The owners of the block are willing and anxious to form a sewer district, but the great mass of taxpayers living outside that area have no immediate need of a sewer and have voted down the sewer proposition.

The law which is proposed would be a *general* law applying to any village. It would be *permissive*, and would allow the residents of a small area to form a sewer district by petition, as the Town Law permits the residents of a small community of a town to do. The passage of such a law will lead at once to the abatement of greatest source of pollution of the oyster grounds, as well as be of great benefit to the people of several villages.

The *Newburgh News* of February 11 contains a report of the Health Officer regarding the prevalence of communicable diseases and says:

"That there is an improvement in the local situation as regards both diphtheria and scarlet fever is indicated by the fact that from January 19 to January 24 inclusive eight cases of diphtheria were reported, as compared with three cases from February 1 to February 9. From January 1 to January 10 inclusive twenty-one cases of scarlet fever were reported, as compared with eleven during the first nine days in Febru-



ary Dr Burke says the danger is not yet over, and that parents should use every precaution against exposing their children to any possible indirect contact with either disease, and to segregate children suffering from either

"The situation here at no time approached an epidemic, although the number of cases of scarlet fever reported during January was sixty-nine"

Reading between the lines, it would seem that there has been an excess of scarlet fever cases in the city and that the cause is largely the indifference or ignorance of the people themselves. One familiar with epidemics knows that people generally expect that scarlet fever comes plainly labeled, and believe that, if a child has only a little sore throat and nausea and a slight transient redness of the skin, the case is not scarlet fever, it is not kept from school, and is not reported to the health officer

The school authorities working with the compulsory education law, have efficient machinery for discovering and controlling cases. The principle is to *account for every child every day*. This requires the co-operation of the health officer, the school teachers, the school medical inspector, and the parents of the children, and the time to institute such a system is at the beginning of the epidemic

The Patchogue *Advance*, February 19, contains an account of the adoption of the principle at the beginning of an outbreak, and says

"Some children were found slightly ill over the week-end and on Monday, and by Monday afternoon a plan of action had been established which included the inspection of every pupil in the schools daily, and the sending of a warning and informative circulars to every pupil's home. They were mailed out promptly and reached the people on Tuesday"

The following circular was prepared by the health officer and a copy was given to every pupil to take home

"The officers of the schools of Patchogue are trying to find the cases of scarlet fever from which several children have caught the disease. They will see, or hear from, every child every day

"Be sure to send your child to school, for there the medical inspector, the nurse, and the teachers will observe it. If any child shows signs of sickness, it will be sent home before it can do harm to others. School is the safest place in which your child can be

"Look for signs of scarlet fever in your child before you send it to school. The signs are those

of a cold or sore throat, with some loss of appetite or vomiting

"If your child appears to be sick in any way, send for your doctor, or you may telephone to the school nurse (Telephone, Patchogue 800) and a doctor or nurse will come to your house without cost to you

"If you keep your child home from any cause, a school officer will call you up to see if the child is sick

"Some children have had scarlet fever, and their skins are now peeling. These children will be kept out of school until they are well

"It is up to parents to help the school officers to find the mild cases of scarlet fever that are dangerous to well children"

The method adopted was that every pupil who comes to school is inspected carefully daily for signs of beginning sickness, and that the health teacher and two assistants check up on the absentees by home visits or telephone

The result is that every child with a sore throat is discovered and isolated until the nature of the disease is determined

The happy result of the system is that parents feel safe in sending their children to school, absences are few, and the epidemic is aborted

Some parents think there has been unnecessary expense and publicity, but the great majority of the people heartily approve the action of the officials of the school and the health department

---

The Avon *Herald*, February 12, contains a column description of a child welfare clinic conducted in Avon with the co-operation of the State Department of Health. The description was written by Dr George W Squires, a local physician, whom we quote

"At the pre-school age clinic recently held at the Legion Room the importance of the activities and services of the Iowa nurse, Miss Wirth was demonstrated. She was an absolute necessity and some appreciation of her services to the community understood

"Mrs W Schanck, chairman of the Child Welfare Board of the county, spent time and valuable assistance toward the success of the clinic. Dr Zilmer and Dr Dean with Mrs White, experts in children's diseases, pleased both parents and children in the tact and interest they showed with little patients and mothers

"Those of the visiting public who comprehended the value and privilege of these State Clinics and "went and saw," are unanimous in their appreciation and zeal for the success of their efforts"



# BOOK REVIEWS



**HOSPITAL ORGANIZATION AND OPERATION** By FRANK E CHAPMAN Octavo of 270 pages with illustrations New York, The Macmillan Company, 1924 Cloth, \$3.50

To the experienced hospital executive the whole book and every part of it gives evidence that the author has learned his story in the field of experience and practice.

The book is full of good things, of value to hospital workers in general, and while we cannot all agree on detail the author has been able to communicate many methods of work in a pleasing manner. Hospital executives will surely find this book pleasant and profitable reading.

R. E. S.

**HANDBOOK OF SKIN DISEASES** By FREDERICK GARDINER, M.D. Second Edition. 12mo of 248 pages, with illustrations. New York, William Wood and Company, 1924.

This is a small book of about 250 pages containing 46 black and white cuts, as well as 12 colored plates.

The introduction deals briefly with the anatomical structure of the skin, clinical pathology, and a general outline of treatment. This is followed by short but accurate descriptions of the more common skin diseases, which are classified according to similarity of appearance, or because they occur in the same region. Finally a few pages are devoted to Tuberculosis and the Tuberculides, also to Syphilis and the Syphilides.

The work is well written, the illustrations are good, and the publishing itself is in keeping with the whole.

E. ALMORE GAUVAIN

**WHAT DOES YOUR CHILD WEIGH?** By EDITH B LOWRY, M.D. 12mo of 187 pages. Chicago, Forbes & Company, 1924.

The text and mission of Dr. Lowry's book are much more than the title would lead one to expect. It is really a treatise of the whole subject of Nutrition in children and the question of weight and height is merely an introduction.

As the writer truly says weighing and measuring children not only attracts attention to undernutrition, but it also attracts the child's attention to himself, his habits, his diet, and his home environment and hygiene. The causes of underweight are given as, 1, Faulty diet, 2, Faulty hygiene or health habits, 3, Over exercise, 4, Defects and disease, and lastly, Environment.

Very sensible ideas and advice quite in keeping with our newer knowledge of nutrition are set forth in the pages of the book. The subject is vitally important, its author is skilled both in the science of pediatrics and in the art of simple, sensible writing, consequently the combination and its product are both effective.

WM. HENRY DONNELLY

**MANUAL OF THE DISEASES OF THE EYE FOR STUDENTS AND GENERAL PRACTITIONERS** By CHARLES H. MAY, M.D. Eleventh Edition, revised. Octavo of 445 pages, with illustrations. New York, William Wood and Company, 1924.

The worth of this manual is told in the number of editions it has run through, this being the eleventh, and the number of foreign languages in which it is being published. These include French, Spanish, Italian, Dutch, German, Japanese, and to these has lately been added Chinese.

For the last twenty-four years this little book has remained a standard of its kind, and has only been changed sufficiently to keep it abreast of the times, the size and arrangement varying but little from that of the first edition.

As in all other editions this latest exactly meets the need for which it was intended—that of a compact, brief, but complete and modern exposition of diseases of the eye for students and general practitioners.

E. CLIFFORD PLACE.

**THE MEDICAL DEPARTMENT OF THE UNITED STATES ARMY IN THE WORLD WAR. Volume V. Military Hospitals in the United States.** By Lieut. Col. FRANK W. WEED, M.C., U.S. Army. Washington, Government Printing Office, 1923.

This volume includes a sketch of the evolution of the military hospital and a description of the development and organization of the military hospitals in this country during the war. One example of each type of military hospital is described in considerable detail, the other hospitals being disposed of in brief sketches of their physical surroundings and construction, with statistical tables covering the personnel and numbers of patients. This information includes as much as could be conveniently published in one volume. Detailed information concerning all of the hospitals is on file in the Surgeon General's Office, and it was thought that the volume furnished as much as would be desirable to those interested in the subject of military hospitals.

T. H.

**PARENCHYMATOUS KERATITIS. INTERSTITIAL KERATITIS. UVEITIS ANTERIOR.** The Gifford Edmonds Prize in Ophthalmology. By W. T. HOLMES SPICER. Octavo of 63 pages. London, Geo. Pulman & Son, Ltd., 1924. (British Journal of Ophthalmology Monograph Supplement 1.)

This essay is a most complete and exhaustive resume of the subject, copiously supplied with unusually beautiful illustrations. The reader will be well repaid for the time spent in perusing it.

E. CLIFFORD PLACE.

**A PRACTICAL MEDICAL DICTIONARY** By THOMAS LATHROP STEDMAN, A.M., M.D. Eighth Edition. Octavo of 1145 pages illustrated. New York, William Wood and Company, 1924. Leather, \$7.00.

The first edition of this dictionary was published in 1911, and in the space of thirteen years seven editions have been disposed of. Few medical books of any kind reach an eighth edition, and to have accomplished this feat is an achievement of no little merit. From its first appearance it has been on the table of the present writer, and each new issue has confirmed and increased the good opinion originally formed of the value of the work. The book is accurate and comprehensive, after a somewhat critical use of this dictionary, extending over its whole career, we have been able to detect but few omissions (none of real importance), and still fewer mistakes. The present issue contains several new words, including many dental terms, entries regarding the mineral springs have been omitted, and (as in the previous edition) the plates have been relegated to the end of the volume. As it now stands the dictionary is thoroughly up to date, and medical readers and writers will find it entirely adequate for their needs.

R. J. E. SCOTT

**ETUDES MEDICO-RADIO-CHIRURGICALES SUR LE DUODENUM** Par PIERRE DUVAL, JEAN-CHARLES ROUX, HENRI BECLERE. Masson et Cie, Editeurs, Paris, France. 1924

This interesting study of the diseases affecting the duodenum is an example of the collaboration of Internist, Radiologist and Surgeon, rather more common in French medical literature than in our own. It has certain advantages but we may expect one of the factors to dominate in the best balanced team.

In this volume the radiologic side is somewhat more in evidence than the others although all have a share.

The first chapter is devoted to the Duodenum in Cholelithiasis and discusses, with some fulness, the relation of peri-duodenal adhesions to calculous cholecystitis and to cholecystectomy.

The second chapter on Essential Stenosing Periduodenitis, much less satisfactory, is preoccupied with the study of bands and adhesions to the point of ignoring the pathology of the duodenum itself.

Chapter three discusses the Chronic Compression of the Third Portion of the Duodenum by the Root of the Mesentery. A most interesting chapter, well illustrated and in which the authors show how much they have been influenced by American opinion.

Chapter four describes and discusses the operation of Duodeno-Jejunostomy and should be read and digested.

The concluding chapters on Duodenal Ulcer and on Duodenal Intoxication emphasize the authors' views on duodenal obstruction and the operative measures, especially duodeno-jejunostomy, indicated for its relief.

The book is well printed on good paper. The X-ray reproductions are particularly clear. J. E. J.

**GASTROPATIAS DE ORIGEN RENAL, ESTUDIO CLINICO Y PATOGENICO.** Por el DR. JUAN RAUL GOYENA, Profesor suplente de Clinica Medica, de la Facultad de Medicina de Buenos Aires Medico de Sala del Instituto Modelo de Clinica Medica. "La Semana Medica," Imp de Obras de E. Spinelli, 2254 Cordoba, Buenos Aires. 1924

This monograph consists of a clinical and pathological study of gastric disorders due to renal diseases. It is a small book, well written and in plain Spanish. It sums up a subject so often neglected by the textbooks on Medicine and Surgery. Of special interest is the author's studies on nephritic patients with retention and increased chlorides and blood urea. He found that retained chlorides are practically always excreted through the gastric mucosa, which in turn irritate and then cause congestion of the mucosa, which produce so called symptoms of indigestion, whereby the physician may be misled in treating a gastric disorder when in reality it is primarily a Nephritis, unless he has been careful in making a thorough physical, urine analysis and blood examination. In cases where the blood urea is high and constant he describes four forms of gastric disorders seen in his hospital and private practice, viz.

- 1.—Attenuated form (migrainoid, gastric catarrh dyspepsia)
- 2.—Intermittent or paroxysmal form (Gastralgia, gastric crisis incorrigible vomiting)
- 3.—Erosive form (ulceration)
- 4.—Prolongated form (pseudo cancer of stomach)

He cites numerous cases, going into them quite thoroughly affected by the above forms of gastric disorders due to renal diseases. It is a book well worth reading because it makes one more cautious when examining patients to bear in mind that gastric diseases at times may be a manifestation of renal diseases.

GAETANO DE YONANA

**MEDICAL GYNECOLOGY** By SAMUEL WYLLIS BANDLER, M.D. Fourth Edition, thoroughly revised. Octavo of 930 pages with 157 original illustrations. Phila. & London, W B Saunders Company, 1924. Cloth, \$8.00

If there is one outstanding merit of this book it is that it emphasizes the value of office treatment as against operation. This book is not dogmatic and offers many courses to follow, should some previous method tried, been found wanting.

The work is brought up to date and the newer remedies, physical and chemical, are thoroughly reviewed and their value properly appraised. This book is of value for the general practitioner as well as the specialist. G W P

**THE PATHOLOGY AND TREATMENT OF DIABETES MELLITUS** By GEORGE GRAHAM, M.A., M.D. 12mo of 188 pages. London, Henry Frowde & Hodder & Stoughton, New York, Oxford University Press, 1923. Cloth, \$2.00 (Oxford Medical Publications)

The book consists of two parts. Part one contains an account of the physiology of the metabolism of sugar and part two, a description of the different types of Diabetes Mellitus and the treatment of the disease. In the appendix there is a description of the ladder diet of St. Bartholomew's Hospital, tables of food values, laboratory methods and a discussion of the ketogenic-anuketogenic ratio.

The work embodies the Goulstonian Lectures by the author on glycaemia and glycosuria. The blood sugar renal threshold is discussed at some length. The usual figure is believed to be about 0.18 per cent, but the threshold may be raised in cases of severe diabetes. It is stated that the blood sugar may be raised in pneumonia and nephritis without sugar being excreted, figures up to 0.28 per cent being reported.

Two days of fasting at the beginning of treatment are still favored by the writer, only tea, coffee, meat extract and water being allowed. Whether or not the patient is sugar free he is not allowed to fast more than two days at a time. The ladder plan is then followed. This is a form of under nutrition and the author favors this rather than the method by which carbohydrate tolerance is determined early in the treatment by adding carbohydrates other than in vegetables.

The book is well written and is an interesting exposition of methods slightly different than those in use in many clinics in this country. W E. McCOLLOM

**EPIDEMIC ENCEPHALITIS** By ARTHUR J. HALL, M.A., M.D., F.R.C.P. London, New York, William Wood & Company, 1924, 229 pp, 12 illustrations, 8 vols cloth.

This volume represents the collected Lumleian Lectures delivered before the Royal College of Physicians at London in 1923 on the subject of Epidemic Encephalitis.

The extensive literature of this disease which has grown to such enormous proportions since the original reports of Cruchet, Moutier and Calmette, and that of Von Economo has been thoroughly reviewed, material assistance being afforded the author, however, by the compilation previously made by the Ministry of Health of Great Britain and presumably that of Achard in his earlier presentation of the same subject. These accumulated facts comprising more than 75 pages of bibliography the author has succeeded in condensing to form a concise orderly presentation of our present knowledge of this new disease.

The average reader will find this book instructive and will be surprised by the information which has already been accumulated on the subject. The student of epidemic encephalitis will save much time in his literary research work by consulting this publication.

J. C. REGAN

RECENT ADVANCES IN MEDICAL EDUCATION IN ENGLAND  
A Memorandum addressed to the Minister of Health  
by Sir George Newman, KCB, MD Octavo of  
195 pages London, His Majesty's Stationery Office,  
1923 Paper, 1s.3d net

Recent advances in Medical Education in England is a memorandum addressed to the Minister of Health and published by His Majesty's Stationery Office, and contains an account of the Medical Education in England and a brief history of the circumstances of which that position is the outcome

This book contains chapters on the teaching of the Preliminary Sciences and the various definitions of the Medical Curriculum

The chapter on Preventive Medicine in Medical Practice tells what kind of knowledge is necessary for the general practitioner to vitally appreciate the part played by this branch

Of special interest is the Chapter on the Association of Research with Education This gives in detail the principal subjects in which research has been undertaken Worthy research requires a prepared mind, experience, leisure, imagination, learning and high technique. It is not for the inexperienced undergraduate with other tasks on hand, but there is here, nevertheless something vital for him which has heretofore been gravely neglected in our national schemes of Medical Education and that is to learn to love research, to know its methods, to be moved by its spirit, to appreciate its stupendous achievements, to recognize that in it alone can the future be secured This is what we have neglected to teach the medical student It has not been explained to him that all knowledge comes by scientific investigation and research, clinical as well as other Moreover, the teacher who is not imbued with the spirit of research is unable to wisely teach and thus it comes about that an inspired teacher and a seeing student are the two desiderata.

Listen to the inspiring words of Sir Clifford Allbutt in the concluding chapter—

"At this moment it is revealed to us that Medicine has come to a new birth What is then the new birth, this revolution in medicine? It is nothing less than its enlargement from an art of observation and empiricism to an applied science founded upon research, from a craft of tradition and sagacity to an applied science of analysis and law, from a descriptive code of surface phenomena to the discovery of deeper affinities, from a set of rules and axioms of quality, to measurements of quantity"

The book is very interesting and should be read by everyone interested in Medical Education

DIET FOR CHILDREN (AND ADULTS) AND THE CALORIE KIDS By LULU HUNT PETERS, A.B., M.D., author of Diet and Health, With Key to the Calories Pediatrician Los Angeles County Hospital Dodd, Mead and Company, 1924 Price \$2.00

Dr Peters has written a book for mothers who, after all, have the immediate care and responsibility of feeding children

In her preface she very truly says, "The proper diet for your growing children is practically the foundation diet for yourself and the other adult members of your family"

Such great advances have been made in the last decade in nutrition that any publication which presents the newer knowledge of this all important subject in a simple fashion for the mother in the home must be cordially welcomed Physicians and especially pediatricians are at present laying such stress on preventive measures as opposed to curative methods, that it is only logical that such measures should begin in earliest childhood

The various constituents of a well balanced diet are simply enumerated and explained and then a full set of menus is given for the preparation of meals for children, which will observe the cardinal principles of nutrition.

There are chapters on the Malnourished Child, the Fat Child, on Bedwetting, on Acidosis, Rickets, Convulsions and other important subjects The style is simple, as it should be for lay readers, and the subject matter quite in keeping with our present knowledge of essential foodstuffs and the prevention of deficiency disease Such a book cannot fail to be of great service, especially to the young mother who is often confused by the conflicting views and advice of friends and relatives who mean well but who are not familiar with true food values  
WILLIAM HENRY DONNELLY

FIGHTING FOES TOO SMALL TO SEE. By JOSEPH McFARLAND, M.D., ScD, Professor of Pathology, Medical Department of the University of Pennsylvania. 64 engravings F A Davis Co., Phila., 1924 Price, \$2.50 net.

This book is a compilation of lectures delivered by the author to a gathering of lay people on the subject of Microbiology In spite of the fact that the subject has so technical a sound, the author has well succeeded in very interesting and fascinating reading matter

Here the author speaks to lay people, in terms of lay language in the origin of micro-organisms, the ancient conception of spontaneous generation of life, etc. And then the author fully and simply explains the modern views of infection and immunity, prevention and transmission of disease, illustrating the material with drawings and photographs

To the practicing physician this book illustrates how a technical subject can be successfully put to lay people in lay language.  
S J COHEN

INCOMPATIBILITY IN PRESCRIPTIONS AND HOW TO AVOID IT By THOS STEPHENSON, D.Sc., Ph.C New Edition Octavo of 32 pages Edinburgh, "The Prescriber" Office. 1924 Paper 1/6d net.

This is a typical British booklet—paper, cover, advertisements on cover pages and typographically The subject matter is well presented, authentic and up-to-date. The author disposes of the old aspirin-quinine incompatibility by saying it "is untrue—there is no such incompatibility", and he is probably correct One wonders why anyone should wish to combine quinine and aspirin To those not familiar with prescription incompatibilities this little booklet will prove a real aid. It is brief, accurate and readable.

THE PRINCIPLES AND PRACTICE OF OBSTETRICS By JOSEPH B DELEE, A.M., M.D Fourth Edition, thoroughly revised Large octavo of 1123 pages with 1128 illustrations Phila. and London, W B Saunders Company, 1924 Cloth, \$12.00

A lengthy review of this book is not at all necessary as in the reviewer's opinion it is one of the best books on Obstetrics, written in the English language.

It is profusely illustrated and the bibliography is full Dr DeLee has the happy quality of writing so that the material written is clearly understood, not ambiguous

If there is any criticism that the reviewer feels forced to make it would be on the scant dismissal of Dr Potter's work Very few agree on the indications of Dr Potter but he has surely taught the Obstetrical specialist a new art in his method of version

Prophylactic forceps is still a very fertile field for disagreement  
G W P

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

Vol. 25, No. 8

NEW YORK, N. Y.

March 6, 1925

## THE TREATMENT OF LOBAR PNEUMONIA WITH PNEUMOCOCCUS ANTIBODY SOLUTION \*

By RUSSELL L. CECIL, M.D.,  
NEW YORK CITY

TWO years ago, Cecil and Larsen<sup>1</sup> reported the result of their experience in the treatment of lobar pneumonia at Bellevue Hospital with polyvalent solution of pneumococcus antibodies prepared according to the method of F. M. Hinton<sup>2</sup>. This agent, usually spoken of as pneumococcus antibody solution, is an aqueous extract of the protective substance in polyvalent anti-pneumococcus serum. By an ingenious device, Hinton succeeded in removing the immune substance from the serum and resuspending it in water. Cecil and Larsen treated 424 cases of pneumococcus pneumonia with intravenous injections of pneumococcus antibody solution with a death rate of 21.4 per cent. 410 control cases under observation at the same time, and treated, except for antibody injections, in a similar way showed a death rate of 28.3 per cent. In other words, antibody treatment seemed to have brought about a reduction of approximately 25 per cent in the death rate. The most striking results were obtained in Type I and Type IV infections. In the former group, the death rate in treated cases was only 13.3 per cent, while the controls show a death rate of 22.2 per cent. In the Type IV group, the treated series yielded a death rate of 16.4 per cent, against 24 per cent for the untreated cases. Still better results were obtained with antibody solution, when it was administered early in the disease. In a series of 114 cases treated intravenously during the first two days of the disease, the death rate was only 13.1 per cent, whereas in 157 early control cases the death rate was 26.7 per cent. Again the most striking difference was noted in the Type I and Type IV cases. In Type I pneumonias treated early, the death rate was only 8.9 per cent, as compared with 23.5 per cent for early Type I controls.

About the same time Conner<sup>3</sup> reported equally favorable results on a series of 116 pneu-

mococcus pneumonias treated with antibody solution in the wards of the New York Hospital.

At the time our first report was made, we felt convinced that in pneumococcus antibody solution we had a new and valuable specific agent for the treatment of pneumococcus pneumonia. One of the chief advantages of the agent was its almost complete freedom from horse protein. This eliminated the danger of anaphylactic shock and the possibility of serum sickness. Another great advantage of the antibody solution was its polyvalency. The statistics on our original series showed the effectiveness of antibody solution in the treatment of Type I, Type II, and Type IV pneumonia. No particular benefit could be demonstrated experimentally or by statistics in the treatment of Type III pneumonia with antibody solution.

In our previous report it was pointed out that the intravenous injection of 50 or 100 cc of antibody was, in most instances, followed by a rather characteristic reaction. Thirty to forty-five minutes after the injection the patient usually had a chill, which was accompanied by a rapid rise in temperature, often amounting to two or three degrees. Sometimes even higher shoots were observed. Following this sudden rise, there was a rapid fall in temperature, accompanied by profuse perspiration.

The following case (Fig. 1) shows the typical reactions which occur when antibody is injected intravenously in a patient with lobar pneumonia.

This patient, infected with pneumococcus Type I pneumonia, received his first injection of antibody on the second day of the disease. Following the administration of 50 cc of antibody solution intravenously, the patient had a chill and his temperature arose from 105° to 106.7°. The temperature then began to drop rapidly and on the following morning had reached 100°. A second intravenous injection of 50 cc of antibody solution was then administered. The patient again had a chill, the temperature rose to

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester April 23, 1924.

RECENT ADVANCES IN MEDICAL EDUCATION IN ENGLAND  
A Memorandum addressed to the Minister of Health  
by Sir George Newman, KCB, MD Octavo of  
195 pages London, His Majesty's Stationery Office,  
1923 Paper, 1s 3d net

Recent advances in Medical Education in England is a memorandum addressed to the Minister of Health and published by His Majesty's Stationery Office, and contains an account of the Medical Education in England and a brief history of the circumstances of which that position is the outcome

This book contains chapters on the teaching of the Preliminary Sciences and the various definitions of the Medical Curriculum

The chapter on Preventive Medicine in Medical Practice tells what kind of knowledge is necessary for the general practitioner to vitally appreciate the part played by this branch.

Of special interest is the Chapter on the Association of Research with Education This gives in detail the principal subjects in which research has been undertaken Worthy research requires a prepared mind, experience, leisure, imagination, learning and high technique It is not for the inexperienced undergraduate with other tasks on hand, but there is here, nevertheless something vital for him which has heretofore been gravely neglected in our national schemes of Medical Education and that is to learn to love research, to know its methods, to be moved by its spirit, to appreciate its stupendous achievements, to recognize that in it alone can the future be secured. This is what we have neglected to teach the medical student It has not been explained to him that all knowledge comes by scientific investigation and research, clinical as well as other Moreover, the teacher who is not imbued with the spirit of research is unable to wisely teach and thus it comes about that an inspired teacher and a seeing student are the two desiderata.

Listen to the inspiring words of Sir Clifford Allbutt in the concluding chapter—

"At this moment it is revealed to us that Medicine has come to a new birth What is then the new birth, this revolution in medicine? It is nothing less than its enlargement from an art of observation and empiricism to an applied science founded upon research, from a craft of tradition and sagacity to an applied science of analysis and law, from a descriptive code of surface phenomena to the discovery of deeper affinities, from a set of rules and axioms of quality, to measurements of quantity"

The book is very interesting and should be read by everyone interested in Medical Education

DIET FOR CHILDREN (AND ADULTS) AND THE CALORIE KIDS By LULU HUNT PETERS, A.B., M.D., author of Diet and Health, With Key to the Calories Pediatrician Los Angeles County Hospital Dodd, Mead and Company, 1924 Price \$2.00

Dr Peters has written a book for mothers who, after all, have the immediate care and responsibility of feeding children

In her preface she very truly says, "The proper diet for your growing children is practically the foundation diet for yourself and the other adult members of your family"

Such great advances have been made in the last decade in nutrition that any publication which presents the newer knowledge of this all important subject in a simple fashion for the mother in the home must be cordially welcomed Physicians and especially pediatricians are at present laying such stress on preventive measures as opposed to curative methods, that it is only logical that such measures should begin in earliest childhood

The various constituents of a well balanced diet are simply enumerated and explained and then a full set of menus is given for the preparation of meals for children, which will observe the cardinal principles of nutrition

There are chapters on the Malnourished Child, the Fat Child, on Bedwetting, on Acidosis, Rickets, Convulsions and other important subjects The style is simple, as it should be for lay readers, and the subject matter quite in keeping with our present knowledge of essential foodstuffs and the prevention of deficiency disease Such a book cannot fail to be of great service, especially to the young mother who is often confused by the conflicting views and advice of friends and relatives who mean well but who are not familiar with true food values  
WILLIAM HENRY DONNELLY

FIGHTING FOES TOO SMALL TO SEE. By JOSEPH McFARLAND M.D., ScD, Professor of Pathology, Medical Department of the University of Pennsylvania. 64 engravings F A Davis Co, Phila., 1924 Price, \$2.50 net.

This book is a compilation of lectures delivered by the author to a gathering of lay people on the subject of Microbiology In spite of the fact that the subject has so technical a sound, the author has well succeeded in very interesting and fascinating reading matter

Here the author speaks to lay people, in terms of lay language in the origin of micro-organisms, the ancient conception of spontaneous generation of life, etc. And then the author fully and simply explains the modern views of infection and immunity, prevention and transmission of disease, illustrating the material with drawings and photographs

To the practicing physician this book illustrates how a technical subject can be successfully put to lay people in lay language.  
S J COHEN

INCOMPATIBILITY IN PRESCRIPTIONS AND HOW TO AVOID IT By THOS STEPHENSON, D.Sc., Ph.C New Edition Octavo of 32 pages Edinburgh, "The Prescriber" Office 1924 Paper 1/6d net.

This is a typical British booklet—paper, cover, advertisements on cover pages and typographically The subject matter is well presented, authentic and up-to-date The author disposes of the old aspirin-quinine incompatibility by saying it "is untrue—there is no such incompatibility", and he is probably correct. One wonders why anyone should wish to combine quinine and aspirin To those not familiar with prescription incompatibilities this little booklet will prove a real aid. It is brief, accurate and readable

THE PRINCIPLES AND PRACTICE OF OBSTETRICS By JOSEPH B DELEE, A.M., M.D Fourth Edition, thoroughly revised Large octavo of 1123 pages with 1128 illustrations Phila. and London, W B Saunders Company, 1924 Cloth, \$12.00

A lengthy review of this book is not at all necessary as in the reviewer's opinion it is one of the best books on Obstetrics, written in the English language.

It is profusely illustrated and the bibliography is full Dr DeLee has the happy quality of writing so that the material written is clearly understood, not ambiguous

If there is any criticism that the reviewer feels forced to make it would be on the scant dismissal of Dr Potter's work Very few agree on the indications of Dr Potter but he has surely taught the Obstetrical specialist a new art in his method of version

Prophylactic forceps is still a very fertile field for disagreement  
G W P

third day, after two injections of antibody had been given, the patient's blood showed considerable protection, and on the morning of the fourth day still more immune substance was present in the circulating blood. On this day the temperature of the patient reached normal.

Fig. 4 illustrates a pneumococcus Type II pneumonia in which subcutaneous treatment with antibody failed to stop the infection. Treatment was started on the second day of the disease and daily injections were given, until the seventh day, when the patient died. None of the subcutaneous injections caused any general reaction, nor was any clinical effect on the course of the disease demonstrable. On the fifth day, the blood cultures became positive, in spite of much antibody treatment, and the number of bacteria in the blood increased daily, until death occurred.

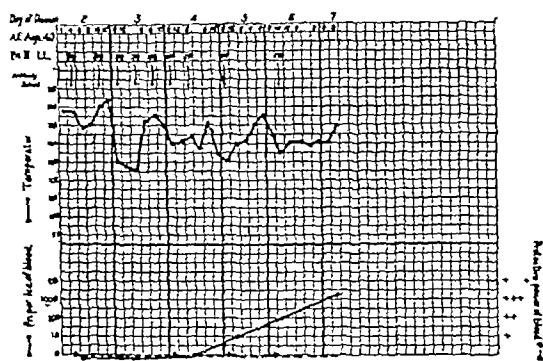


Fig. 4

The results during the winter of 1922-23 were fairly satisfactory. Altogether, 52 early cases of pneumococcus pneumonia were treated subcutaneously, with a death rate of 21.1 per cent. In 59 control cases admitted during the first 48 hours of the disease, the death rate was 40.6 per cent, almost twice as high.

In the fall of 1923, it was decided that all cases of lobar pneumonia, both early and late, should be included in the experiment. Every other case throughout the twelve medical wards was treated subcutaneously with pneumococcus antibody solution, the alternate cases being reserved for controls. The results during the past winter were not so good as in 1922-23. Between November 15, 1923, and March 1, 1924, 92 cases of pneumococcus pneumonia were treated subcutaneously with pneumococcus antibody solution, with a death rate of 32.6 per cent. Ninety-five alternate cases that were not treated with antibody showed a death rate of 37.8 per cent. When the early cases were filtered out of the 1923-24

series and added to the early pneumonias treated during the winter of 1922-23, the antibody series showed some advantage (see Table I). Seventy-nine early cases of pneumococcus pneumonia were treated subcutaneously with antibody, with a death rate of 21.5 per cent. Whereas 94 control cases showed a death rate of 36.1 per cent. As in the case of intravenous treatment, the best results were obtained in Type I and Type IV infections.

After two years' experience with the subcutaneous administration of antibody in the treatment of pneumonia, we have reached the conclusion that, while certain of the earlier cases of Type I and Type IV pneumonia were apparently benefitted by subcutaneous antibody injections, there are several reasons why this form of treatment is not practical. The dosage required for subcutaneous treatment is too large. Pneumococcus antibody solution is expensive and the results obtained are not sufficiently striking to justify such a procedure. Furthermore, there is considerable local discomfort in many cases following the subcutaneous injections.

TABLE I  
DEATH RATE FOR ALL PNEUMOCOCCUS PNEUMONIAS TREATED SUBCUTANEOUSLY DURING FIRST 48 HOURS OF DISEASE, COMPARED WITH CONTROLS ADMITTED DURING FIRST 48 HOURS OF DISEASE. A COMBINATION OF 1922-23 AND 1923-24 SERIES

Type	TREATED CASES			CONTROL CASES		
	Cases	Deaths	Death Rate %	Cases	Deaths	Death Rate %
Pn. I	23	4	17.3	23	6	26.0
Pn. II	13	5	38.4	25	13	52.0
Pn. III	6	3	50.0	21	9	42.8
Pn. IV	37	5	13.5	25	6	24.0
Total	79	17	21.5	94	34	36.1

During the last few months we have returned to the intravenous method of administering antibody solution. Through the kindness of Dr. Huntoon, we have been able to obtain several lots of antibody which give no chill or other untoward symptoms, when injected directly into the vein. In cases treated with these particular lots of antibody, there has been a slight rise of temperature following the injection, followed by a rapid fall and profuse perspiration. Only a few cases have been treated with these new lots, but the therapeutic effect appears to be just as good as with the chill-producing lots. If the substance which causes chills can be effectually eliminated from pneumococcus antibody solution, there is no reason why this agent should not be injected directly into the veins of any case of pneumococcus pneumonia.

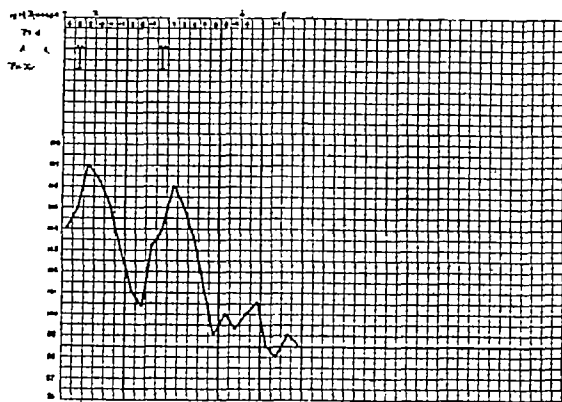


FIG 1

104°, then dropped rapidly to normal, where it remained permanently

Fig 2 shows how ineffective intravenous injections of antibody may prove in some cases of Type III pneumonia. This patient received an enormous quantity of antibody intravenously, but in spite of this treatment the blood culture became positive, the patient developed pneumococcus Type III meningitis and died on the eleventh day of the disease

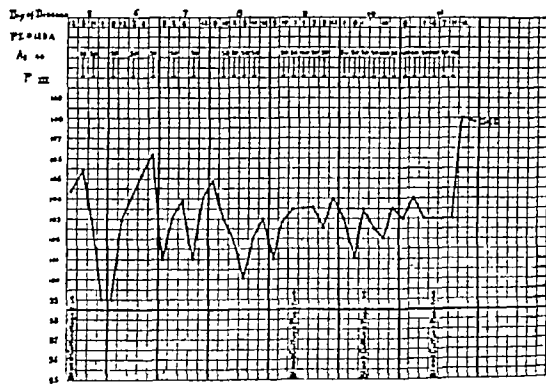


FIG 2

In some cases, where the rise in temperature was excessive, the patient became delirious, and with the fall in temperature symptoms of shock developed, occasionally so pronounced as to endanger life

In view of these severe reactions, it was felt that some modification in the method of preparation or administration of antibody was necessary before this agent could be made applicable in the general practice of medicine. Accordingly, in the fall of 1922, we undertook with Dr H S Baldwin to study the effect of pneumococcus antibody solution when administered *subcutaneously* to patients with lobar pneumonia. During the winter of 1922-23, all cases of early pneumonia admitted on six of the medical wards were treated subcutaneously with pneumococcus anti-

body solution. In the other six wards, no antibody was administered

In the studies of Cecil and Larsen, antibody solution was administered intravenously in doses of 50 to 100 c c. Larger doses were employed for subcutaneous treatment. In ordinary cases, 100 to 200 c c was the initial dose, repeated in ten or twelve hours. If necessary, two more injections of about the same amount were given on the following day. By the third day, the treatment could usually be limited to one injection. In severe cases, the initial dose was 200 to 300 c c, repeated in ten or twelve hours, and continued every day until the temperature came down to normal. The average total dosage per case was about 650 c c

The antibody solution, when given subcutaneously, was injected into the loin or lateral aspect of the anterior abdominal wall. Subcutaneous injections of even large amounts of antibody failed to excite constitutional reactions. Occasionally, there were slight chilly sensations, but the hard, shaking chill observed after intravenous injections never occurred. At the point where the antibody was injected, the skin became moderately red and tender over an area which varied in proportion to the amount of fluid injected

Fig 3 shows the effect of subcutaneous injections of antibody on a case of Type I pneumonia. The patient was admitted to the hospital on the first day of his disease. On the second day, two large doses of antibody were administered subcutaneously. The patient showed no constitutional reaction whatever, but the temperature dropped from 105° to 102° on the morning following. Two more subcutaneous injections were given and on the morning of the fourth day the temperature had dropped to 101°. By the afternoon of the fourth day the temperature was normal and remained so. The dotted line below the temperature curve indicates that development of protective bodies in the patient's serum. No protective substance was demonstrable on the second day of the disease before treatment with antibody was started. On the morning of the

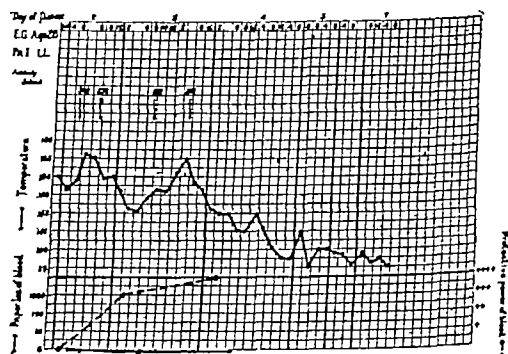


FIG 3



largely on the character of the infecting organism and the resistance of the infected tissues

Similar wound inoculation may occur in tears of the pelvic floor, the vagina and cervix. At first this wound infection is a local process which stimulates a local tissue reaction in the surrounding structures, and whether it remains a primitive local infection, or becomes a consecutive infection, is due to the multiplication of bacteria and extension through the surrounding lymphatics or blood vessels, depends on these three factors

*First* the local resistance of the tissue,

*Second* the general resistance of the patient,

*Third* the virulence of the strain of the infecting organism

It is a well-known clinical fact that local tissue resistance is lowered by injury, and that during delivery the cervix sustains continued trauma. If it be inspected at the termination of labor it may be seen to hang as a flaccid, ecchymotic, mulacerated rim, presenting little or no power of local resistance—if we add to this instrumental or digital trauma, and the cervix becomes a lacerated wound—which, all surgeons will tell you, will not heal until the superficial areas slough and a granulation zone is established, the soil is more favorable for infection.

The one point which must be kept constantly in mind by the obstetrician is that the repair and the pathology of the cervical or uterine wound is in nowise different to that of a contused or lacerated wound on the surface of the body—save that the lymphatics and blood vessels are all enlarged, and that the incidence of infection is infinitely greater.

The general resistance of the patient may be lowered by hemorrhage, complicating toxemia and general ill health, and thus favors infection, therefore, in the presence the lowered resistance from obstetric trauma and the diminished individual tissue reaction from antepartum or postpartum bleeding or toxemia—pyogenic bacteria may gain entrance to the wound and spread through the lymphatics before the natural local barriers have been established.

Pathological observation has shown that the more virulent the strain of bacteria, the less local barrier is developed, illustrated by the occurrence of spreading purulent peritonitis and bacteremia in puerpera showing little or no defensive pathology.

Definite pathological lesions which are due to infection of the puerperal wound may be grouped under the following head

1 Puerperal ulcers result from bacterial inoculation of wounds in the perineum, vagina and cervix—these ulcers may remain as local lesions with well-defined surrounding tissue reaction, or become the foci for the development of

consecutive lesions by the multiplication and spread of bacteria through the surrounding lymphatics

2 Puerperal endometritis—a bacterial inoculation of the great uterine wound, with its mass of detritus, decidua and blood clots

3 Infection of the sinuses of the placental site, with their thrombi producing a thrombophlebitis of the uterine and pelvic veins

4 Invasion of the parametrial tissues—either by direct extension from a cervical wound, or by extension through the uterine wall by way of the uterine lymphatics

5 Bacteremia or blood stream infection—in this condition the bacteria reach the blood stream either by way of the lymphatics or directly through the blood vessels, and multiply within the blood, producing their toxins and destroy the corpuscular elements

Finally puerperal peritonitis—pyogenic bacteria reach the peritoneum and produce a local or general peritoneal reaction. The organisms may reach this tissue by way of the lymphatics and produce a fatal peritonitis without the presence of organisms in the blood.

What is of interest to us in this discussion is the answer to the question—which of these lesions require surgical treatment?

Certainly the puerperal ulcer, whether it be on a wound of the vulva, perineum, vagina or cervix, demands nothing more than wound cleanliness, removal of sutures and drainage—active treatment by the use of cauterants and strong chemical disinfectant during the acute stage of an ulcer is no more justified in the ulcer of the genital tract than in ulcers in other locations.

When the primary focus is a saprophytic endometritis, there is a certain definite train of characteristic symptoms which result from nature's effort to limit the extension of the infection by the formation of a leucocytic barrier in the basal membrane of the endometrium which in turn produces a superficial tissue necrosis—the lochia is profuse, bloody and fetid, and is frothy from an admixture of gas bubbles—the after pains continue, and from time to time a clot is expelled by painful uterine contractions, which are evidences of a relaxed uterus, there is fever from the absorption of the toxins produced by the superficial tissue necrosis and uterine involution is retarded.

On examination, the uterus is large, tender and more or less relaxed—the cervix is open, swollen and eroded, and if the gloved finger is passed into the uterine cavity, clots and necrotic debris are encountered and the interior of the uterus is found rough and shaggy.

In closing, I wish to emphasize once more the importance of early treatment in the application of any form of specific therapy for pneumonia. Pneumococcus infection travels very rapidly through the lymphatics of the lung and easily spreads from one lobe to another. Finally, the blood stream becomes involved and then the problem of controlling the disease becomes very difficult. The process must be stopped in its in-

ciency, if success is to be achieved in the severer forms of infection.

#### REFERENCES

- 1 Cecil, R. S. and Larsen, N. P. Clinical and Bacteriologic Study of One Thousand Cases of Lobar Pneumonia. *Jour. A. M. A.*, 1922, LXXIX, 343-348.
- 2 Hinton, F. M. J. *Immunol.*, 1921, VI, 117.
- 3 Conner, L. A. Treatment of Pneumonia with Antibody Solution, *Am. Jour. Med. Sc.*, 1922, CLXIV, 832.

## WHAT TYPES OF PUERPERAL INFECTION REQUIRE SURGICAL TREATMENT? \*

By JOHN OSBORN POLAK, M.D.

BROOKLYN, N. Y.

**B**EFORE attempting to answer this question, one should review the immunity which the average parturient has against septic invasion, as well as become conversant with the pathologic steps of consecutive infection.

During pregnancy, the cervical mucus plug, the unruptured membranes—and later in the 1st and 2nd stages of labor, the rupture of the waters with their downward rush, the rotary descent of the child through the birth canal, all have a controlling influence on the invasion of bacteria from the vagina, while after delivery, the anti-bacterial quality of the lochia, the contraction and retraction of the uterus, and the development of the leucocytic wall or zone in the basal membrane, prevent the easy entrance of bacteria to the uterine lymphatics.

Normally, the bacterial flora within the vagina is kept under control during pregnancy, by the acid reaction of the vaginal secretion, though this acidity is somewhat weakened during pregnancy by the addition of an increased amount of cervical mucus. After labor, these same bacteria rapidly multiply in the retained lochia in the vagina.

Bacteriological studies of the content of the puerperal uterus, at varying periods after labor, have shown that pathogenic organisms of the same type and strain as those in the vagina are present in the uterus, as early as 24 hours after labor—and are found at the placental site within 48 hours. Furthermore, it has been shown that these bacteria which are present in the normal puerperal uterus, are the same as those found in the uterus of the woman suffering from fever—hence it must be deduced that infection does not depend so much upon the character of the organism, as upon the condition and resistance of the tissues of the birth canal. We know that a long continued dry labor predisposes to the rapid increase of bacterial growth—both in the vagina

and in the uterus, and also that it distinctly lessens the resistance of the maternal tissues.

The fundamental requisites to all infection, wherever it may occur, are

- (1) the presence of an infecting organism,
- (2) of an avenue of entrance,
- (3) a soil for development—granting this to be the fact, all infection is primarily a wound infection, or an inoculation of a wound by pathogenic bacteria, and the local and general symptoms produced thereby are due to their development and the production of their toxins in such a wound.

In the genital tract of the puerperal woman, we have the pathogenic bacteria constantly present—or being carried into it by hand, instrument or other vehicle.

The puerperal woman offers the avenues of entrance in the form of lacerations of the vulva, vagina and cervix, the open uterine cavity and the relaxed placental site, while all of the blood vessels and lymphatics are immensely dilated. It seems remarkable therefore, that more parturient women are not infected, than actually become subjects of puerperal fever.

While there is no question that autoinfection is a possibility, and that it does sometimes occur, most infections are conveyed to the uterus by the attendant (a) by unclean hands, (b) through an unclean vulva, (c) by unsterilized instruments into a wounded and traumatized birth canal.

Admitting this to be a fact, one can readily appreciate the value of routine rectal examination, and realize the importance of detailed surgical cleanliness in making vaginal examinations, and in performing all obstetric operations.

The uterus during involution, should be considered as a puerperal wound undergoing the normal process of repair healing by granulation, and its inoculation will produce either a toxemia or a definite inflammatory reaction—depending

\* Read at the Annual Meeting of the Medical Society of the State of New York, at Rochester, April 23, 1924.

Metro-thrombophlebitis or suppurative pelvic phlebitis, begins as an infection of the thrombi in the placental site. This type of infection is always preceded by a relaxed uterus, persistence of a red lochia, and the occurrence of cramp-like uterine pains.

The bacteria multiply within the clot—they liquefy it and escape to the blood stream, only to be shut off again by the formation of a more extensive clot. The liquefaction of the clot escape and reisolation of the bacteria produce the clinical syndrome of chill, fever, sweat and remission which makes the diagnosis.

It has been stated that pelvic phlebitis is always fatal, in spite of the conservation of nature's forces of resistance. To this statement I cannot subscribe—but I will admit that the majority of fatal puerperal infections will show a thrombophlebitis at autopsy.

The lesions may be found in the uterine sinuses or in the veins of the upper uteroovarian or inferior hypogastric pedicles, and the diagnosis is made on the following signs:

The appearance of chills occurring in the second week—usually between the eighth and twelfth days, which become more and more frequent, followed by sharp rises and marked remissions in temperature—and an absence of any febrile reaction between the chills.

The pulse runs a course parallel to the temperature—up when the temperature is up, and down when the temperature is low. The general condition of the patient in the interval between chills and temperature exacerbation is extremely good—the blood cultures are negative, for the bacteria are confined within the clot only when embolus develops with lung complications is the facial and physical appearance alarming. Pulmonary complications may develop between the eighth and twenty-eighth day after the beginning of the infection. Dyspnea and asphyxia dominate the clinical picture.

It has been suggested that these cases of metro-phlebitis be treated with hysterectomy, and that in pelvic phlebitis the veins (ovarian and hypogastric veins) should be ligated.

The question is, when to operate—for could we remove the uterus, before spread of the lesion has taken place in every potential infection, the

source of bacterial supply might be controlled, but when the infection has spread beyond the uterus, hysterectomy gives a mortality of 100%—so too, in pelvic phlebitis if the operation is performed too late or too early, as before the fifteenth or after the twenty-fifth day, the mortality is very high.

If it is done at all—it should be done in the third week, the veins should be tied, but not excised—as manipulation tends to disseminate the infection.

In peritonitis of puerperal origin, the lesion is either the result of an extension through the myometrium to the perimetrium with an exudate thrown out by the serous coat of the uterus, in which case, the lesion results in adhesion or abscess—and with the aid of posture becomes localized, or the peritoneum is reached by a direct invasion through the lymphatics—in which case we have a spreading peritonitic exudate with cell death, and the formation of pus.

These cases always show the clinical syndrome of a spreading peritonitis, distension, tenderness, intestinal colic and vomiting, with rise in pulse and temperature and a polymorphonucleosis.

All forms of operative treatment have been used with the same fatal result—and we must fall back on simple stab-wound incision drainage and injection of ether into the peritoneal sac.

It stands to reason that in bacteremia, a condition in which the bacteria are circulating in the blood and are rapidly overcoming the immunizing substances in the cellular elements—as shown by the rapid destruction of the red corpuscles and leucocytes, that no surgical treatment can be of any avail—for the bacteria are rapidly multiplying and producing their toxins in overwhelming quantities, irritating the kidneys, disturbing the intestinal and liver function, and poisoning the heart muscle.

Hence we must come back to the basic principle, that the treatment in puerperal infection, depends on the pathologic diagnosis and that because of nature's protective processes it must be expectant and supportive—rather than surgical.

Finally, that surgical measures have their only field in the incision and drainage of parametric abscesses and in local spreading peritonitis.

It will naturally be inferred that the prognosis in this type of infection depends on the establishment of proper uterine drainage, by firm retraction and contraction of the uterus, if this can be maintained, a passive hyperemia is produced which favors the formation of a wide protective barrier consisting of leucocytes and small round tissue cells, which is impenetrable to the lower types of pyogenic organism, this protective wall separates the lymphatic from the infected necrotic endometrium

As late as 1922 Bumm urged that in febrile puerpera the genitalia should be left alone—for wound fever in the majority of cases is due to lochial stasis, which can be combated with drainage and uterine contraction

Only in the presence of relaxed, misplaced uterus will it be necessary to aid these natural processes—and here, such aid may be given by the judicious use of the Ill tube, repeated alcohol irrigations, and the iodoform wicks—when these are employed and placed in the cavity of the uterus, drainage and retraction are stimulated and these cases of lochial stasis clear up promptly and the infection remains confined within the uterus

With every puerperal endometritis, there is always an associated metritis—this is a defensive reaction on the part of the myometrium and the intermuscular lymphatics against the infecting cocci. Metritis is a more definite pathological entity in coccal endometritis than in the saphrophytic form owing to the greater penetrability of the pyococci. When the endometrial infection is due to the streptococcus pyogenes the lochia has no fever—is diminished, serosanguineous or seropurulent in character, and the interior of the surface of the uterus is usually smooth and not deeply necrotic. The layer of granulation tissue in the leucocytic zone is developed but not so extensively, as in the saphrophytic type, but as a rule this granulation zone suffices to limit the infection to within the uterus, unless nature's beneficent processes are disturbed by the meddling of the accoucheur—hence, we can lay down the principle in the treatment of puerperal endometritis, that surgical methods have no place, for posture, an ice bag over the fundus and hypodermatic employment of oxytocic drugs will stimulate uterine contraction and retraction which offers the greatest barrier against further bacterial invasion

The lower segment of the uterus is surrounded by cellular connective tissue—bacteria may reach this structure through lacerations of the cervix which lead directly into it, or from an extension of an endometritis to the myometrium and intermuscular lymphatics which lead into the peri-uterine cellular structures

The majority of the cases of cellulitis are due to infection by streptococci—these bacteria invade the lymph channels, and by their presence and the presence of their toxins excite a hyperemia in the surrounding cellular tissue, this is followed by an effusion of protective serum, and a hurried migration of leucocytes into the connective tissue surrounding the blood vessels and lymphatics

This tissue in turn, produces a small round cell reaction which further increases the size of the exudative mass—the rapid increase of this swelling, distending the folds of the broad ligament or parietal peritoneum and limiting motion causes pain, while the cell activity accounts for the temperature and leucocytosis

These parametritic exudates because of their location, intimately blend and are continuous with the uterine mass, efface the vaginal fornix and obliterate the line of demarcation between the cervix and surrounding tissues—the uterus is displaced upward and toward the opposite side of the pelvis. The formation of this exudate must be considered as a conservative process on the part of nature—an attempt to limit the advance of the bacterial invader, therefore, one can readily see that any form of surgical intervention can do nothing but harm until there is abscess formation. An exudate poured into the cellular tissues of the pelvis may be absorbed, leaving no trace except a slight shortening of the broad ligament on one side, and varicosities of the pelvic veins—these always result from the venous engorgement necessary for the production of a protective exudate

If the infection is long continued, organization will take place and scar tissue will be substituted—this is a common sequel, the shortened, thickened broad ligament distorts the position of the pelvic organs, compresses the blood vessels and ureters and is frequently the cause of ureteral stricture and premenstrual hydroureter

Abscess formation occurs in parametrial infection (in about 7 cases out of the 100), these localized collections of pus are easily recognized by the characteristic evening rise in temperature, the polymorphonuclosis and the physical evidence of a fluctuating mass

In the presence of such a lesion—incision and drainage is demanded. This may be done through the vagina, or by an extraperitoneal incision just above Poupart's ligament between the folds of the broad ligament

Broadly speaking, it may be stated therefore, without fear of contradiction, that surgical measures employed to combat puerperal septic infection are only efficient when the infection is localized

the mucous and amniotic fluid which may have gathered in its mouth is removed. Slowly deliver the nose and brow until the head is completely over the perineum. During this time the patient is in the modified Walcher position and deeply asleep. Care should be taken at this stage to deliver the child in the direction of the birth canal and not up over the mother's abdomen as that position will break the child's neck.

After the baby is delivered it is placed upon the mother's abdomen, care being taken to keep the baby on its right side. It should not be spanked or held up by its feet or shaken in order to hasten the establishment of respiration. So long as the heart beat is strong and the child has a good blue or red color there is no cause for anxiety (Perlman, of St. Louis, says chest breathing). If, however, the breathing of the child is delayed resuscitation may be necessary. Our method is the use of a small soft rubber catheter introduced directly into the larynx and blowing air into the lungs and expelling it by pressure upon the child's chest.

The cord is severed after pulsation has ceased and the patient given one cc of obstetrical pituitin to aid in the completion of the third stage of labor. The pituitin is given after the child leaves the uterus. It is never given when the child is in the uterus.

In applying this operation one must not be in too great a haste. At no stage should the operator hasten delivery unless the child's condition is serious. Twenty-four minutes have been taken to deliver the baby after the umbilicus has appeared.

Secondly. The patient should be completely anesthetized. This is necessary until the version is completed, in other words, until the knees appear at the vulva. The choice of anesthetics may be left to the operator. In our experience we have obtained the best results with chloroform.

Thirdly. The cervix must be completely effaced and the os dilated or easily dilatable before version is attempted. The failure of this operation in many respects is due to the fact that these precautions are not observed.

Fourthly. The birth canal should be thoroughly dilated, and this is accomplished by first obtaining the relaxation of the perineum through a gradual increase of the number of fingers of the hand employed. After the perineum is dilated the vagina is prepared in the same manner. This dilation is essential and should not be started until the patient is asleep. The best lubricant to use upon the hand is sterile green soap.

Keeping these essential points in mind one

will be able to facilitate his work in the employment of this operation. In order that the indications and the applications of this operation may be more definitely defined I have selected one hundred cases which I have delivered by version that reveal the different obstetrical complications. The larger number of the cases in this group comprise those of mal-position. The left occiput posterior was the one most frequently encountered. Sixty of these cases on examination proved to be of this type, four of which were complicated with prolapsed hand, five associated with pendulous abdomens, two had had a previous Gilliam operation.

The next position most frequently encountered was the right occiput posterior. Twenty of the cases come under this classification.

The left occiput anterior was encountered in eight cases, and the right occiput anterior occurred in seven cases.

A face presentation was seen in two cases, while there are three cases on the transverse type. Maternal complications associated with these positions were four cases of cardiac disorder in the mother. Three cases of mitral regurgitation and one case of mitral stenosis. Five of these cases had eclampsia and placenta previa was encountered in six cases, two of which were the central placenta previa and four were marginal, with the os easily dilatable.

Oedema of the cervix, due to long labor without any progress, one case. Inertia, due to fibroid, one case. Inertia, due to pendulous abdomen, and inertia due to previous operative procedures on the uterus, such as the shortening of the ligaments, two cases. Prolapse of the cord occurred in four cases and we divide these cases into the concealed and non-concealed types.

Premature rupture of the membranes occurred in twenty cases without engagement of the head. One should always expect a mal-position when this occurs.

Contraction of the pelvis was encountered in ten cases, three were primipara with an external conjugate of seventeen centimeters or less. Hydramnios was encountered in three cases. The membranes were ruptured high up in an attempt to allow the fluid to escape slowly. One of the babies of this group was accrania, the other a hydro-cephalus in which it was necessary to perforate the after-coming head in order to deliver. The third case was one of spina-bifida.

I have grouped these cases to show the field of the application of version in the different obstetrical complications. In cases of mal-position there is a considerable saving of labor.

## A MODERN APPLICATION OF VERSION\*

By HUGH C McDOWELL, M D,

BUFFALO N Y

THE operative practice of the obstetrics has been limited in the past to certain routine operative procedures. The foremost being the use of forceps, the advantages and disadvantages of which are well known, secondly, the major operation of Caesarian section which has its limited field.

Within the last ten years there has been brought forth by Dr Potter and placed in prominence an operative procedure previously known but not generally applied, and that is the obstetrical operation of version. The technique which he has developed and uses as his armamentarium is the one that is being followed by many who routinely or occasionally make use of this operative procedure. In this series of cases this method was employed, a short description of which will be made at this time.

The patient should be prepared in the following manner. After the first stage of labor is completed the perineum is shaved and washed off with sterile water. This may be followed with a one to five thousand lysol solution. The patient should not be given an enema within an hour before delivery, because frequently the contents of the lower bowel will be expelled during delivery. A quart of warm water may be allowed to run into the vagina, washing out any mucous or blood which may be there. The patient after preparation is anesthetized to the surgical degree and the perineum is ironed out manually until the vagina admits the hand readily, the patient having previously been catheterized. The bladder must be empty before any attempt is made at delivery. The perineum and the vagina having been dilated manually, the left hand is introduced into the uterus. The uterine cavity is now explored, the position of the child is noted, the location of placenta is ascertained, the position of the feet and hands should be noted, and if the arms are not folded across the chest they should be placed in that position before going further. That will prevent in elective cases the complication of the extended arm.

Note the position of the cord. Ascertain whether it is around the neck or any one of the extremities. The hand is now further introduced into the uterus between the uterine wall and membrane, care being taken not to rupture the amniotic sac if rupture has not already taken place. As the hand approaches the fundus it comes into contact with one or

more of the lower extremities of the child. Care must be taken at this time to prevent the premature rupture of the amniotic sac. Ascertain the position of the feet. When this is done, the sac may be ruptured high up in order to maintain sufficient amount of amniotic fluid to facilitate the turning of the child. Both feet are brought down together if possible by a grasping of the ankles between the first and second fingers of the operator. Slight traction is made downward and the head is pushed upward from the outside with the right hand. The downward traction is continued until the knees appear at the vulva, when the version is completed. At this stage the anesthetic should be lessened somewhat so that the uterine contractions may assist in the continued rotation of the child's body, thus avoiding too much traction. The buttocks of the child rotates to the hollow of the sacrum, the buttocks being delivered by lifting the feet upward over the symphysis, after which the tension on the anterior foot is increased with a view of bringing the back of the child transversely across the outlet of the mother in contra-distinction to the old method of delivering the hips anterior-posterior. Gentle traction is now made until the scapula and the posterior axillary fold appear and the scapula is free from under the symphysis pubis. With the index finger of left hand pressure is applied upward on the spine of the scapula or in the posterior axillary fold with a resulting rotation of the shoulder under the symphysis pubis and the delivery of the child's arm and forearm are accomplished. The body is now rotated until the other shoulder appears under the pubic arch. No traction is made upon the arms themselves and there will be necessity in grasping them in order to effect their delivery. With the arms free it is now necessary to see that the head is fully flexed and this flexion should be maintained by following the head downward with gentle pressure over the occiput, through the abdominal wall with the free right hand. The abdomen and chest of the child are now resting on the operator's left forearm. The index finger of the left hand is now inserted into the mouth of the child and pressure exerted above upon the occiput, bringing down the flexed head to the perineum, with the neck of the child under the symphysis and the mouth delivered. One may ordinarily take as much time as necessary to deliver the after-coming head. With the mouth of the child delivered the child can now breathe and by stroking the trachea gently

\* Read at the Annual Meeting of the Medical Society of the State of New York Rochester, April 22, 1924

previa This is done as a routine in these type of cases

The period of involution was considerably shortened, as shown by the lessening of the vaginal discharge

The foetal mortality consisted of two still-born monsters and three cases known to be alive before delivery, the cause of death in the latter being due to a torn tentorium as revealed by post-mortem One case of spina bifida, which lived five days and died from sepsis

None of these cases had any fractures of the extremities or fracture of the skulls

In this series of cases twenty were seen in consultation either on hospital services or outside and had been previously examined or attempts made at delivery.

It has been my privilege to briefly outline my conception of the Potter version and its various indications in the hope that you may extend the application of this procedure

## THROMBOSIS OF THE RETINAL VEINS

By MACY L LERNER, M D, M MED SC,  
ROCHESTER, N Y

**T**HERE is still room for investigation as to the real etiology of this affection, as there is no means of distinguishing clinically what lesion is present in any given case. Although it is nearly forty years since V Michel published the first case, there is still need for collection of fresh material"

These words were sounded recently by such well known men in ophthalmology as Edward Jackson and Alan Greenwood Dr Jackson's plea for recording additional cases of this group of affections stimulated me to report my case and review some aspects of this important subject

Three possible factors may be considered in the production of thrombosis of the retinal veins

- 1 Infection, either bacterial or possibly a toxin bacterial in character or a product of metabolic changes

- 2 Change in the vessel wall favoring thrombus formation

- 3 Alteration of the blood elements

- 4 Combination of any of these conditions

*Etiology*—These cases occur usually in elderly people Among 60,000 patients in Haab's clinic there were 20 cases of thrombosis of the main venous system, of whom 15 were between the ages of 50 and 80 years

There is evidence of widespread vascular disease The peripheral vessels are thickened, cardiac hypertrophy is associated and in many of these patients nephritis is present It seems, therefore, probable that the wall of the central retinal vein is thickened, possibly obliterated, from an endarteritis or maybe a thrombus is lodged in its lumen

We must keep in mind that infection or toxemias during a life time may hasten all these changes in the vessel wall and therefore we must always look for the infectious origin

Influenza seems to be a factor in favoring thrombosis of the retinal veins Jackson's cases were probably due to the influenzal infection Leyden and Gutman, among 186 cases of influenza presenting ocular lesions, classified 32 per cent as retinal lesions and 27 as glaucoma The latter must have followed the thrombosis of the central retinal vein

Focal infection undoubtedly plays an important part in many of these cases of thrombosis of obscure origin Hillard Wood believes that focal infection from the tonsils or sinuses may explain many cases of thrombosis of the retinal veins His case had no evidence of any vascular changes in the body nor in the eye

According to F A Williamson, a toxic influence is responsible for the thrombosis of the vessels He believes this toxin acts on the delicate macular choroidal capillaries, causing degeneration of their walls and in this way increasing permeability to fluid and consequent edema The fluid then diffuses or osmoses through into the potential space between the rods and cones and the pigment epithelium, preventing the access of nutrient materials from the choreocapillaries, so that the adjacent retina degenerates and forms a hole This explains the association of a hole in the macula with thrombosis of the veins in the same case.

Frost mentions stagnation of the blood current as a cause of thrombosis, phlebitis extending from the orbital veins is also given as a cause

Heart disease is considered as a cause by Haab, because he believes that it tends to produce early arteriosclerosis Hard and strenuous work in a stooping posture favor in the production of the affection All Haab's cases were peasants who engaged in hard work

The most important fact in the production of thrombosis of the retinal veins is probably that simultaneously with general or local arteriosclerosis, the circulation of the eye is disturbed

\* Read at the Annual Meeting of the Medical Society of the State of New York Rochester April 22, 1924

for the mother when this procedure is used. It is the operation of choice where there is a prolapse of the hand or where the hand is encountered alongside the head. In delivering these cases one should be sure to replace the hand upward and fold it across the chest before an attempt at version is made, thus avoiding an extension of one or both arms.

In face presentations the majority of the cases are extremely difficult to convert into an occiput. One can more readily push the head out of the pelvis and do a version.

In transverse presentation the better method is in bringing down the feet. A procedure which I have tried recently in several cases where the back was anterior was to place the hand along the back of the neck and push the child upward into the fundus until the feet presented the inlet. The hand is then released from the occiput and brought down until it encounters the feet and extraction is performed in the usual manner. With the back of the child posterior the procedure of obtaining the feet is much less difficult.

*Cardiac Cases*—Where compensation is not broken cardiac lesions occurring in pregnant women should not be a counter-indication to this procedure. These patients tolerate an anesthetic with a short delivery more readily than they do a long labor without an anesthetic. Three of these cases were given a chloroform anesthetic, one case being that of a mitral-stenosis. I have one case which had a complete heart block which was given an anesthetic at the time of delivery, although she was not delivered by version. (How was she delivered?)

Pendulous abdomen is occasionally encountered in the primiparae. But more frequently we see it in those women who have borne a large number of children. In the latter type there is usually a history of increasing difficulty at each child-birth. We find that these cases have a long first stage without any engagement. They are particularly the type of case that is helped by a version.

In the placenta-previa cases delivery should not be attempted until the cervix is completely dilated, the reason being that a tear of the cervix in these cases is more or less serious. The method of dilation may be either by the use of the Champederives balloon or by packing the cervix with gauze. After the complete dilation the hand is introduced between the placenta and the lower uterine segment gently peeling the placenta from its attachment, until it is completely freed. It is then delivered and the hand is re-introduced into the uterus and the version and the extraction of the child performed. I believe that with the stripping off of the placenta first and the subsequent

delivery of the child, that there is less blood lost and the birth canal is not obstructed by the placenta. A live child may be delivered with the placental circulation shut off for a considerable time.

I have left the discussion of the contracted pelvis for the last because this type of case usually gives us our greatest trouble. Often we have an early rupture of the membranes with escape of the amniotic fluid. The rupture of the membranes should not be a counter-indication in doing a version. The only advantage that the retained fluid has is in facilitating the turning of the child. In the contracted pelvis, version is indicated except in the extreme flat or funnel type. The generally contracted pelvis affords a delivery more readily with an after-coming head than an on-coming head providing the disproportion is not too great. Three of the cases of contracted pelvis were primiparae with an external conjugate of seventeen centimeters or in one case where it was necessary to apply less. They afforded no difficulties excepting the forceps on the after-coming head. It is reasonable to suppose that the POTTER VERSION has a distinct advantage in this group and particularly in those of the border-line type. In certain types of rachitic pelvis one may more readily bring the after-coming head through the diagonal conjugate than the on-coming head.

For every procedure there must be some contra-indications, and in the case of version the following are noted:

- (1) A generally contracted and a flat pelvis with a large child.
- (2) Uterus in the stage of tetany tightly contracted around the child with the membranes ruptured and fluid drained away.
- (3) Bandl's ring present which is tightly contracted and does not relax under surgical anesthesia. This rarely occurs in the lecture version.
- (4) A long cervix which encircles the head and does not thin out during labor.

It is highly important that every operator have his own assistant for administering the anesthetic.

*Conclusions*—In this series of cases there was no maternal mortality and the maternal morbidity was less than twelve per cent.

The lacerations of the maternal soft parts consisted of two cases of second degree tear that were repaired and three cases with abrasions which did not need suturing. There were no cases of third degree laceration.

One case showed surgical shock, for which treatment was necessary. The uterus was packed in six cases. These were all placenta



fortable thirteen inch or reading distance Urine report Acid sp gr 1015, no albumin, no sugar, sed neg Blood chem Total nonprotein, N 300 mg %, blood sugar, 012 Wasserman negative Nose and throat Tonsils were embedded but clear No evidence of infection in nose Ear drums were retracted X-ray of sinuses were negative Blood count 3,700,000 reds, 3,600 whites, 91% hemoglobin, color index, 1.2, neutrophils, 76, lymphocytes, 22, large mononuclears, 2 There was slight anisocytosis, otherwise the red cells appeared normal

*Physical Examination*—Chest symmetrical and emphysematous No rales present Heart slightly enlarged and sounded somewhat weak No murmurs Abdomen did not show anything abnormal Extremities showed varicosities on both legs

July 9th—O D Vision Counts fingers at 25 inches Disk made out plainly Margins clearing up Hemorrhages absorbed in many places except in the inferotemporal region where they still have a flame-shaped appearance Veins still very tortuous and engorged

July 23d—Disk outlined fairly well and margins could be made out distinctly for the first time Hemorrhages throughout on the temporal side including macular region, while the nasal side has cleared up completely

August 6th—Vision Counts fingers Tension slightly increased about +1 Nerve head round well outlined Color grayish white Central cupping present Few hemorrhages in the periphery, a few deep hemorrhages in the macular region

September 21st.—Patient complained of sharp pain in right eye radiating to right temple and forehead and to nose Examination showed a very congested eyeball, no ciliary injection Anterior chamber shallow Cornea steamy Pupil oval and moderately dilated Reacts to light very sluggishly Tension by finger about +++ Vision can make out flash lights at two inches Ophthalmoscopically Fundus unobtainable Diagnosis Acute congestive glaucoma, secondary to thrombosis of retinal vein She was given eserine sulphate gr I to 1 oz gtt 1 q 1 hr, sod salicylate, gr 5 q 3 hr and ordered hot compresses Six hours later pupil was contracted, but pain did not subside Tension registered by McLean was 100

September 22d—Pupil contracted Tension same Iridectomy was suggested for relief of pain, but not promising any sight Also explained to patient that enucleation may be the only relief if eye remains painful Patient welcomed the latter and did not care for palliative surgery Enucleation was done under general anaesthesia Specimen forwarded to Army and Navy Medical Museum where it was sectioned and then sent to Dr Verhoff of Boston for further study and confirmation His report follows

*Pathological Report*—The specimens for examination consist of two horizontal sections of the globe, one of which includes the optic nerve The cornea is normal The anterior chamber is obliterated, the iris being compressed against the cornea by the lens, which is in contact with the cornea in the pupillary area The iris shows fibrosis and ectropion uveae The ciliary processes have undergone hyaline change The lens shows slight cataractous changes in the peripheral cortex The vitreous is markedly infiltrated with serum The retina and choroid are greatly compressed as a result of imperfect fixation The retina shows numerous punctate hemorrhages and contains here and there endothelial cells filled with blood pigment. The blood stains poorly, so there were probably more hemorrhages than are apparent in the section There is only slight edema in the retina The retinal ganglion cells are well preserved in the macular region The retinal vessels show marked sclerosis The optic disc shows very slight cupping On the surface of the disc there are actively proliferating capillaries The central retinal vessels are seen cut longitudinally The artery is practically normal The central vein shows endophlebitis of long duration with subendothelial proliferation of connective tissue In the longitudinal section it is impossible to tell whether or not it was completely obstructed by the proliferation, but apparently it was completely obstructed just behind the lamina cribrosa The optic nerve and disc show active neuroglia proliferation with beginning formation of cavernous spaces

Diagnosis Complete obstruction of central vein due to endophlebitis Marked secondary glaucoma

Thrombosis of the veins in the young is rare, and when it does occur, it is very difficult to explain. Wagenmann considers hemorrhagic retinitis and glaucoma as independent of one another but are both dependent on a common cause—arteriosclerosis, the vascular changes which in the posterior half of the eye resulted in hemorrhages, in the anterior half of the eye resulted in impaired drainage and glaucoma

V Graefe observed 22 cases in which glaucoma followed upon hemorrhagic retinitis In the cases of Weinbaum, Purtscher and Würdemann in which hemorrhagic retinitis followed by glaucoma occurred in young patients Since these could not have been due to angiosclerosis they must undoubtedly be looked upon as a sequel of the retinal hemorrhages

According to Jackson, in most of these cases of thrombosis of the retinal veins the arteries are also involved When it comes to prognosis a distinction must be drawn between the cases that are essentially obstruction of the artery or its branches and those that are obstruction of the central vein and its branches The blood current

and to this is added a weak cardiac action that favors venous thrombosis. My patient, I believe, belongs to this group of cases as her symptoms of cramps in her legs were present for a number of years and she also has evidence of myocarditis with hypertrophy.

"Without simultaneous arteriosclerosis, thrombosis of the retinal veins seems out rarely to occur."—Norris and Oliver

**Diagnosis**—There are a number of points of importance in making a diagnosis of thrombosis of the central retinal vein.

- 1 Arteries—caliber normal or slightly diminished
- 2 Veins are tortuous
- 3 Veins are turgid and appear interrupted from being buried in the retina
- 4 Venous pulsation on pressure
- 5 Extensive retinal hemorrhages

The striking feature in thrombosis of the vein is that the blood usually extravasates into the fiber layer and is mostly around the disk over an area having a radius of about two disk diameters. Towards the periphery there are numerous hemorrhages, but they tend to be more scattered.

**Pathology**—I will summarize briefly the pathological changes put forward by most authorities on this subject in explanation of the clinical picture of thrombosis of the central retinal vein.

- 1 Thrombus in the central retinal vein (It was found in 11 out of 22 cases)
- 2 Occlusion of the central vein by proliferation of the intima but without thrombosis
- 3 Multiple thrombi in the retinal veins, but without a thrombus in the central vein
- 4 Multiple emboli or perhaps thrombi in the retinal arteries
- 5 Changes in the retinal vessels, hyaline thickening, endarteritis endophlebitis, sometimes amounting to occlusion, but not the result of either thrombosis or embolism
- 6 Hemorrhage into the substance of the optic nerve

Usually the favorite seat for the lodgment of thrombi is either at the lamina cribrosa or a short distance behind it. The place where the central vein makes its exit from the nerve is also stated by V. Michel to be a favorite place from the obliquity of the course of the vessel in this position.

With all these explanations as to the pathology of thrombosis of the retinal veins we cannot explain yet many cases either clinically nor at sections. Coates, in one of his cases, cut the eye in serial sections transverse to the nerve and stated "at no point is the vein completely obliterated, nor is any laminated or organized thrombus to be found within it."

**Report of Case**—A D, age 69, widow

**Family History**—Father died from old age, mother from post-operative peritonitis, husband died from apoplexy, has two living daughters who are in good health. No history of miscarriages.

**Past History**—Does not recall any infectious diseases, was operated upon for hemorrhoids twice and has had all her teeth extracted.

**Present Trouble**—May 14, 1923, patient complained that she could not see well with right eye, has worn glasses for six years without having them tested during this period, attributing her poor vision therefore to the glasses. She also complains of a sensation as if the blood were rushing to her head, has had many spells of dizziness, and fainting attacks are of common occurrence. Another distressing symptom elicited in the history was cramps in the calves of the legs.

**Vision**—O D Without glasses, 6/60; with glasses, 6/30. O S Without glasses, 6/9+2, with glasses, 6/9+2. External adnexa did not show anything abnormal. Tension was normal in both eyes by palpation.

**Ophthalmoscopically**—O D Media showed fine vitreous opacities, disk margins were poorly outlined. There was central physiological cupping. Numerous flame shaped hemorrhages were observed in the retina along the course of the vessels. Arteries appeared considerably narrower in proportion to veins, the latter being tortuous and engorged. In many places there was practically obliteration of the arteries. O, S, Media clear. Nerve head well defined with central physiological cupping. Arteries narrower in proportion to veins and pressing hard upon latter at crossings. No lesions were observed in the macula or periphery.

May 21, 1923—Right eye showed same picture as described above. Arteries practically obliterated.

May 28th—Flame-shaped hemorrhages more numerous. Veins much engorged and interrupted by edema at places. Disk margins more obscured. Fresh hemorrhages seen.

June 1st—Entire fundus hemorrhagic. Veins more tortuous and engorged near the papilla, their further course hidden and buried in the edematous tissue. Arteries could not be made out. At the place where the disk is supposed to be there is a small whitish area from which the engorged veins appear to emerge, the whitish area evidently pointing to the existing physiological cupping. Left eye showed clear media and a few degenerative punctate exudates in the macular region. Nerve head was somewhat grayish and arteries showed moderate sclerosis.

June 8th—Vision in right eye, counts fingers at nine inches. Left eye + 50 sph + 50 cyl X 180 V 6/6. Add + 300 for near, gave com-

These are anatomical operations, where the patient was operated upon repeatedly on the same region, it is not indicated. The actual number of operations which these patients underwent is really much greater.

The futility of nose and throat operations is clearly indicated, as none of the operated cases benefited.

It is rarely that a patient who suffers from any form of allergy such as asthma, hay-fever, eczema, hives, angio-neurotic-oedema, migraine, frequency, etc., but who at one time or other presents gastro-intestinal symptoms, such as abdominal pain, cramps, distention, nausea, vomiting, diarrhea, constipation, etc.

Table II shows the various combinations of the different forms of allergy as they occurred in our series of 300 consecutive office patients.

TABLE II		Allergy of the			
	No Cases	Asthma	Hay Fever	gastro-intestinal tract	Allergy of the skin
Asthma	237		56	49	59
Hay-Fever	82	56		33	26
Allergy of G I Tract	95	49	33		59
Allergy of Skin	104	59	26	59	
Asthma only—118					
Hay-Fever only—6					
Allergy G I Tract only—11					
Allergy of Skin only—4					

From this table it may be readily seen that the various forms of allergy such as asthma, hay-fever, skin and gastro-intestinal manifestations rarely occur alone, but usually in combination with the other forms. The underlying disease is allergy.<sup>2</sup>

Usually these patients give a definite history that during an attack of asthma they have cramps, abdominal pain, diarrhea, nausea or vomiting. Milk frequently gives these patients loose bowels. The temperature as a rule is normal, and when increased is but slightly so. These symptoms are of allergic origin,<sup>3</sup> and may precede, accompany or follow the above mentioned manifestations. On the other hand, they may occur by themselves.

It is evident that these same symptoms are also quite frequently the symptoms of appendicitis. These cases are very often diagnosed not only as chronic but sometimes even as acute appendicitis. The physician urges appendectomy, and a good number are actually operated. Out of 300 cases of allergy, 17, or 6 per cent, had appendectomy performed. Twenty-nine out of sixty other cases had marked tenderness over McBurney's point and were advised appendectomy, but refused. None of the 17 cases were benefited by the appendectomy. Six per cent of appendectomy in allergy is a higher incidence than is found in other diseases. Since none of them were helped by appendectomy, it is perhaps safe to account for them on the ground of mistaken diagnosis.

In order to obtain successful results in these cases of gastro-intestinal allergy, the procedure is not appendectomy but entirely different. You must treat these cases the same as you would any other form of allergy, such as asthma, hay-fever, etc., ascertaining by skin tests what produces the symptoms, and remove the allergin, or if this is impossible, desensitize the patient. The allergic agent in these cases is nearly always a food. The following is one out of many typical cases of gastro-intestinal allergy, who has been repeatedly advised appendectomy, absolutely cured by following the principles mentioned above.

E G, female, 9½ years of age, was suffering for the last 7½ years from severe abdominal pain, aggravated by eating. She was nauseated and vomited when the pain was severe. Constipation was marked. The above symptoms were getting worse, and for the past six months she suffered daily attacks of severe abdominal pain. She has frontal headaches, chilliness, and frequency in urination. Previous history. She had measles, chicken-pox, suffered frequently from colds, itching of eyes, hives, attacks of diarrhea, with mucous in stools, had tonsils, adenoids, and large cervical glands removed, suffered from enuresis until 1½ years ago. Family history. Father was suffering for years from diarrhea, skin troubles. One aunt had bronchial asthma, another psoriasis, and cousins, skin disease and gastro-intestinal allergy. On physical examination everything was negative with the exception of a diffusely tender abdomen, which was especially marked over McBurney's point, there was no rigidity. Appendectomy had been repeatedly advised as the only means of relief. Skin tests revealed strongly positive reactions to peas, barley and rice, weakly positive to eggs, potatoes, cheese, salmon, veal and beef.

**Discussion**—This patient was repeatedly urged to undergo appendectomy. She was freed from all symptoms immediately, the moment allergic foods were eliminated from the diet, and has remained so for the last 2½ years. The presence of the earmarks of allergy in the patient and in the family history, and the absence of abdominal rigidity are great aids in diagnosing these cases.

Rectal hemorrhage is cited as a rare occurrence in appendicitis. Recently I have described blood in the feces and gastric contents as not an infrequent finding in all forms of allergy.<sup>4</sup> This is in accordance with the canine anaphylactic experimental work of Mannwaring<sup>5</sup> who found from slight to very profuse intestinal bleeding. The following allergic patient presented profuse rectal hemorrhage for which appendectomy was performed, but nothing but a congested appendix was found.

G Y, 43 years of age, weighing 157 lbs, suffered for years from abdominal pain, belching,

in the artery carries the obstruction from the arterial wall through the larger lumen into the smaller, increasing the obstruction. In the vein, the blood current carries the obstruction away from the smaller vessels to the larger, and therefore, there is a better chance for partial or complete recovery. Dr Jackson mentions two cases under his care which made good recoveries, one regaining standard vision and the other 20/100.

Dr Arnold Knapp states in his discussion of Dr Greenwood's paper on this subject, that many conditions with a different pathology are grouped under the clinical picture of thrombosis of the retinal veins. Most of his cases examined after enucleation showed an endophlebitic process. Cases where a complete recovery occurred seem to me to belong to some other classification than thrombosis. This view is held by such well known pathologists as Feingold. Massage of the eyeball, nitrites and other treatment would be useless in pure cases of thrombosis where endophlebitic changes are existing.

#### CONCLUSIONS

1 Thrombosis of the retinal veins should not be confounded with other hemorrhagic affections of the retina.

2 Thrombosis of the retinal vein is due unquestionably to some definite etiology not established yet.

3 Infection must play a part in producing thrombosis of the retinal vessels in a patient whose vascular system shows sclerotic changes.

4 Cases that are classed as thrombosis of the retinal veins and reported as recovered as to vision and integrity of the eye should be carefully studied as to whether they do not belong to some other group of diseases of the eye.

5 This subject should be given more stimulus as far as reporting cases of this nature and study of its pathology.

#### BIBLIOGRAPHY

- J Herbert Parsons *Pathology of the Eye*, p 1275.  
 Norris and Oliver *System of Diseases of the Eye*, Vol 4, 1908, p 515-577.  
 Allen Greenwood *Trans-Sections of Sect of Ophth.* A M A, 1923.  
 Edward Jackson *A J O*, Vol 3, No 12, p 855-857.  
 Hillard Wood *A J O*, Vol 6, No 5, p 400.  
 F. A. Williamson *British J Ophth*, Vol 6, No. 2, p 67.  
 C Adams *Ophth Diag*, translated by M. L. Foster, p 117-153.  
 W Adams *Frost Fundus Oculi*, 1901, p 189.

## APPENDICITIS IN 300 CASES OF ASTHMA AND OTHER FORMS OF ALLERGY

WILLIAM LINTZ, M D

BROOKLYN, N Y

The diagnosis of chronic appendicitis is still shrouded with obscurity and the results of treatments, both medical and surgical, are unsatisfactory. Charles Gibson has recently published the results for six years of chronic appendicitis operations in the New York Hospital. The number of unsatisfactory results amounted to 30 per cent. Very frequently a diagnosis of chronic appendicitis is made without considering the grounds to justify such a conclusion. These cases as a class are very poorly worked up. In a recent study of 58 patients out of 700 who complained of gastro-intestinal symptoms, unrelieved by appendectomies, who were operated upon by surgeons generally and not in any one hospital, Barclay and MacWilliams<sup>1</sup> have demonstrated

that a more thorough study before operation would have spared these patients unavailing surgery. Therefore, any light that can be shed on this subject needs no apology for its introduction.

In a study of 300 consecutive office patients suffering from allergy, I find that as a class they are operated upon more than any other class of individuals, some of the members of this group were operated upon as high as thirteen times (I prefer the term allergy, rather than anaphylaxis, because the former terminology indicates the inherited character of the condition, while the term anaphylaxis does not imply this).

Table No I shows those operated out of our series of 300 consecutive cases.

TABLE I

	Total No of Cases	300
Operations performed —		Throat, tonsils, adenoids
Appendectomy	17	Nose
Miscellaneous	29	Angio-Neurotic-Oedema
Female generative organs	13	
Total number anatomical operations	121, or 40%	Combined operations
Total number patients operated upon	104 or 34.4%	

# EDITORIALS

The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication.

**Editor-in-Chief**—NATHAN B VAN ETEN, M.D.,  
New York  
**Associate Editor**—ORRIN SAGE WIGHTMAN, M.D.,  
New York  
**Executive Editor**—FRANK OVERTON, M.D. Patchogue

### COMMITTEE ON PUBLICATION

E. ELIOT HARRIS, M.D., *Chairman* New York  
ORRIN SAGE WIGHTMAN, M.D. New York  
EDWARD LIVINGSTON HUNT, M.D. New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

**President**—OWEN E. JONES, M.D. Rochester  
**First Vice President**—GEORGE A. LEITNER, M.D. Piermont  
**Second Vice President**—LUZERN COVILLE, M.D. Ithaca  
**Speaker**—E. ELIOT HARRIS, M.D. New York  
**Vice-Speaker**—GEORGE M. FISHER, M.D. Utica  
**Secretary**—EDWARD LIVINGSTON HUNT, M.D. New York  
**Assistant Secretary**—WILBUR WARD, M.D. New York  
**Treasurer**—CHARLES GORDON HEND, M.D. New York

### CHAIRMAN, STANDING COMMITTEES

**Arrangements**—FREDERICK H. FLAHERTY, M.D. Syracuse  
**Public Health and Medical Education**  
JOSHUA M. VAN COTT, M.D., Brooklyn  
**Scientific Work**—ANDREW MACFARLANE, M.D. Albany  
**Medical Economics**—HENRY LYLE WINTER, M.D. Cornwall  
**Legislation**—JAMES N VANDER VEER, M.D. Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer) the ex President and the Councilors of the District Branches.

**First District**—EDWARD C. RUSHMORE, M.D. Tuxedo Park  
**Second District**—FRANK H LASHER, M.D. Brooklyn  
**Third District**—ARTHUR J BEDELL, M.D. Albany  
**Fourth District**—CHARLES C TREMBLEY, M.D. Saranac Lake  
**Fifth District**—NELSON O BROOKS, M.D. Oneida  
**Sixth District**—GEORGE H FOX, M.D. Binghamton  
**Seventh District**—WILLIAM I DEAN, M.D. Rochester  
**Eighth District**—HARRY R. TRICK, M.D. Buffalo

### COUNSEL

GEORGE W WHITESIDE, Esq., 27 William St. New York  
Telephone, Broad 1744

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St. New York

### EXECUTIVE OFFICER

JOSEPH S LAWRENCE, M.D. 51 Chapel Street, Albany

### SECTION OFFICERS

#### Medicine

**Chairman**—ROBERT L. LEVY, M.D. New York  
**Secretary**—L. WHITTINGTON GORHAM, M.D. Albany

#### Surgery

**Chairman**—MARSHALL CLINTON, M.D. Buffalo  
**Secretary**—EDWARD S VAN DUYN, M.D. Syracuse

#### Obstetrics and Gynecology

**Chairman**—HAROLD C. BAILY, M.D. New York  
**Secretary**—NATHAN P SEARS, M.D. Syracuse

#### Pediatrics

**Chairman**—JOSEPH C. PALMER, M.D. Syracuse  
**Vice-Chairman**—ROGER H DRYNITT, M.D. New York  
**Secretary**—ARTHUR W BENSON, M.D. Troy

#### Eye, Ear, Nose and Throat

**Chairman**—ARTHUR G BENNETT, M.D. Buffalo  
**Secretary**—EUGENE E. HINMAN, M.D. Albany

#### Public Health, Hygiene and Sanitation

**Chairman**—PAUL B BROOKS, M.D. Albany  
**Secretary**—ARTHUR D JACQUES, M.D. Lynbrook

#### Neurology and Psychiatry

**Chairman**—EUGENE N BOUDREAU, M.D. Syracuse  
**Secretary**—CLARENCE O CHERNEY, M.D. Utica

## DRUGLESS THERAPY

Those who have seen the inner workings of the Albany headquarters of the Committee on Legislation of the Medical Society of the State of New York are deeply impressed with the flood of healing cultism that threatens to overwhelm the Legislature at every session. The Committee on Legislation stands at the neck of the funnel through which passes every form of cult for curing human ills—and there are at least fifty-five varieties of them, according to an official list published on page 230 of the February 22, 1924, issue of this Journal.

There are many periodicals published by the cult practitioners. We printed a series of studies in Chiropractic periodic literature in this Journal during 1924, and supposed that no system could

be less scientific. But, while the chiropractic system is based on a principle which is at least logical, there are other cults in whose basis of ridiculousness there is no room for logic.

There must be numerous followers of the fifty-five varieties of "pathies" and cults, for many of them have national organizations, who hold conventions and have pictures taken of their members sitting at banquet tables in evening clothes. When a conscientious physician sees the stacks of literature of these cults he gets an idea of the immensity of the task which confronts the committee on Legislation of the Medical Society of the State of New York.

We were interested in one of the periodicals which promotes the drugless therapy bill which

nausea, and vomiting, cramps and burning in the abdomen. She suffered from rheumatism, severe headache, frequency and weakness. On four different occasions she had had profuse bleeding of bright red blood from the rectum. Mother had bronchitis and coughed all her life. Has three children, one is suffering from bronchial asthma, another from frequent diarrhea, and a third is weak minded, has diarrhea and bloody stools. Her husband is perfectly well. On physical examination she showed slight abdominal tenderness especially over McBurney's point, no hemorrhoids or fissures. Proctoscopic examination was absolutely negative. A gastric analysis showed a subacidity, otherwise it was negative. An X-ray examination pointed to inflammation of the gall bladder, everything else was negative. She was operated upon, the gall bladder and all the other organs were found perfectly normal and a congested appendix was removed. The pre-operative diagnosis was chronic appendicitis.

*Discussion of Case*—Four years after the operation the patient still has gastro-intestinal symptoms, although no more rectal bleeding has occurred. In view of the negative abdominal pathology, after a complete exploratory laparotomy, to account for the intestinal bleeding, the continuance of the gastro-intestinal symptoms after appendectomy, the definite allergic history, it is safe to conclude that the bleeding most probably came from the appendix, but was allergic rather than inflammatory in nature, since the appendix merely was congested. I have seen another patient with profuse rectal bleeding, where allergy was apparently the established cause, X-rays, gastric and feces examinations and all the other clinical investigations were all negative. She was helped by treatment along anaphylactic principles. Having benefited by the experience of the first patient, I did not subject her to an appendectomy.

May it not be wise to look out for allergy as the real cause when rectal bleeding is a prominent symptom of appendicitis? If rectal hemorrhage is caused by appendicitis we have a right to expect it more often.

#### DISCUSSION AND CONCLUSION

In allergic patients, before diagnosing appendicitis and resorting to appendectomy, one has to rule out anaphylaxis as the true etiology, a condition hardly thought of in connection with appendicitis. When there is a continuance of the symptoms for which appendectomy was resorted, anaphylaxis should be thought of. Even anaphylactic patients may temporarily be improved following appendectomy, but this is due rather to the restriction of the allergic food, than to the operation. The change produced in the autonomic nervous system as the result of the operation may also be a factor in the improvement.<sup>6</sup> Even the finding of a chronic pathological appendix in the

anaphylactic patients, does not necessarily mean that an operation was justified. As a result of an extensive pathological experience, I found that a normal appendix anatomically speaking, is a great rarity. In this condition it is interesting to note the experience of Williams and Slater<sup>7</sup>, who found that one-third of all women operated upon for pelvic condition, shows pathological lesions in the appendix, without ever having had clinical symptoms referable to the appendix. These patients very frequently develop all kinds of skin rashes, from obscure causes, before they leave the hospital after their appendectomy operation. A tender McBurney is a very frequent finding and means nothing in these allergic patients, no matter how prominent the gastro-intestinal symptoms and the abdominal tenderness may be. I find the absence of abdominal rigidity is a constant and reliable sign in these cases and contra-indicates operations. Theoretically, eosinophilia should be a great help, but practically I rarely find it. No class of cases are operated upon so much. No class of cases are benefited so little by these operations. I find that when appendicitis runs in families that the true condition is really one of gastro-intestinal allergy.<sup>8,9</sup> Allergy is a distinctly familial and inherited disease. Asthma, hay-fever, allergy of the skin, and gastro-intestinal tract, etc., are in reality not diseases per se. They are only manifestations of the underlying disease called allergy. These manifestations rarely occur singly, but usually in combination with the other forms. If these various forms of allergy are not present in combination at any one time, they are sure to occur later in the course of the life of the individual who suffers from allergy. Rectal bleeding may be allergic in origin.

In patients with indigestion and right-sided abdominal pain, allergy should be ruled out.

#### BIBLIOGRAPHY

- 1 Harold Barclay and Clarence A. MacWilliams. Remarks on the Diagnosis of Right Iliac Fossae Pains and the End Results in 200 Chronic Appendicitis Operations. *New York State Medical Journal*, Vol. xxi, p. 39.
- 2, 6 William Lintz. Bronchial Asthma. *Medical Journal and Record*, March 19, 1924.
- 3 G. Jacobini. Pseudo Appendicitis as Manifestation of Serum Sickness. *Semana med*, Vol. xxv, p. 327, March 21, 1918.
- 4 Wm Lintz. Intestinal Bleeding in Asthma and Other Forms of Allergy. *Boston Medical Journal*.
- 5 Mannwaring, Beattie and McBride. The Intestinal Lesion in Anaphylaxis. *A M A*, Vol. lxxx, No. 20, May, 1923.
- 7 J. T. Williams and R. Slater. Condition of Appendix in 500 Laparotomies on Patients Presenting No Symptoms of Appendicitis. *Annual Surg* No. 535, Nov. 19.
- 8 E. M. Magruder. Hereditary Disposition to Appendicitis. *Virginia Med Monthly*, Vol. xlv, p. 309, March 19.
- 9 S. D. VanMeter. Hereditary Appendicitis. *Colorado Med*, Vol. xvii, p. 241, Sept. 20.

# LEGAL

By **GEORGE W. WHITESIDE, Esq**  
Counsel, Medical Society of the State of New York

## OBJECTIONS TO RE-REGISTRATION CONSIDERED

As early as 1760 a license to practice physic and surgery in the City of New York was required of any practitioner "after due examination of his learning and skill in physick or surgery," although those who had practiced prior thereto were not required to undergo such examination

In 1792, a further licensing act was passed forbidding the practice of medicine to those who had not served an apprenticeship of two years with another physician or graduated from a college in the United States, or who had not successfully passed an examination by the constituted authorities and received a certificate accordingly. From this act likewise were exempted those who had previously practiced

In the first act referred to, the purpose of these licensing laws was set forth in a preamble to the act as follows

"Whereas many ignorant and unskilled Persons in Physik and Surgery in order to gain a Subsistence do take upon themselves to administer Physik and practice Surgery in the City of New York to the endangering of the Lives and Limbs of their Patients, and many poor and ignorant Persons inhabiting the said City who have been persuaded to become their Patients have been great Sufferers thereby "

It will be seen at once that as early as 1760 the licensing statute declared that the purpose of licensure was for the protection of the public against those who were unqualified and who sought for their selfish gain to practice medicine

In 1797 a state-wide licensing act was passed requiring practitioners to obtain from the magistrate or officer before whom proof of qualification had been given a certificate and to file it in the office of the clerk of the county of his residence

In 1801, further restrictions and qualifications were required, and registry with the county clerk continued as a prerequisite to a right to practice. Up to this time the judges of qualification were the Chancellor, a judge of the Supreme Court, a Master in Chancery or one of the judges of the Court of Common Pleas

In 1806, when the charter of the Medical Societies was passed, they were empowered by that act to examine students and give diplomas to practice physic or surgery and the charter by its terms repealed the previous licensing statutes. In this act no requirements of registration in

the county clerk's office appear. The Medical Societies continued to exercise this power of licensure for many years and by an act in 1880, all future licenses were to be issued after examination by the regents, and all physicians then licensed or who should thereafter be licensed to practice were required to register in the office of the county clerk

In 1887, a comprehensive medical practice act was passed and the standards of licensure were raised and registration in the county clerk's office was continued as a requisite to practice. The licensing power of the State Society was specifically repealed. All subsequent amendments to the Medical Practice Act contained the requirement of registration in the county clerk's office

We thus see that from 1797 to 1806 registration in the county clerk's office was required. From 1806 to 1880 that requirement was dispensed with. So that registration in the county clerk's office has been going on continuously for the last forty-five years. Practically all of the men who registered in 1880 and were then thirty-five years of age or over, are now dead. Almost all of those who were then thirty years of age are now dead, and a large majority of those who were twenty-five years of age at that time are now dead. A vast majority of those who registered before 1890 are either retired or dead, and those who registered after 1890 are practitioners who have been in practice thirty-five years. Of those who have been so registered since 1890, there has been a considerable normal death rate. It is fair, therefore, to assume that the lists in the county clerk's offices contain the names of more dead men than those who are alive today. The names of those who have been convicted of felony in whose cases there has not been definite action by the regents are likewise retained on the lists in the county clerk's office as qualified practitioners, those who have removed from the state are still upon the lists, those who have gone into other businesses or professions and abandoned the practice of medicine are still on the lists. There is no way by which one can tell from the list of practitioners in the county clerk's office, who at present are within the state or without the state, retired, active, dead or alive. There is no way by which this can be checked up except by a laborious and impractical method of personal canvass of the present licensed practitioners, and in order to make certain it would be necessary to canvass

is printed on page 232 of the February 13 issue of this Journal. This periodical seems to have a kindly feeling toward all systems of healing except that of scientific medicine, and it seldom indulges in abuse of physicians. About the worst roast of the doctors is an account of a jubilation meeting of chiropractors over a decision against a New Jersey physician who had called osteopaths and chiropractors "Quacks and Fakirs." It rather exalts the virtues of herbs and diet, and the simple life. It seems to mother old forsaken systems like barefoot walking in the dew, and the use of herb teas. It even prints several pages of diseases and the various herbs which are "good for" those conditions. It would throw the gates wide open for the practice of any kind of cult, even that of scientific medicine. It is the "clinging vine" type of literature which eventually strangles scientific medicine by its passive weight.

The periodical to which we refer repeats the grave error of appealing to the principle of in-

dividual freedom of choice of a healer, and it proposes the following amendment to the Constitution of the State of Oregon:

"No law shall be passed which deprives any citizen of the inalienable right to employ the physician of his or her choice, or to determine for himself or herself the mode, manner, method, or system which he or she shall use in case of sickness."

One of the strongest of all the appeals of cults is to this false assumption that any Medical Practice Law can prevent any person from seeking relief from any source he wishes. What the law does do is to forbid any person from holding himself out as able and prepared to treat human ills, unless he has conscientiously prepared himself by a course of study of at least four years in a disinterested scientific school. We believe that this point is not generally apprehended and understood, and that physicians should explain it to their legislators. F O

## THE PHYSICIAN AND THE PUBLIC HEALTH NURSE

A wide-spread movement is under way to increase the scope of the work of the public health nurse. Bills are introduced in the legislature authorizing the employment of public health nurses by various governmental agencies, and there is a keen competition among lay organizations, especially those of women, to promote the employment of nurses. All this is excellent and shows that people are getting ready to support measures for raising the standards of health in a community. But in all the discussion there is lacking an appreciation of the influence of the local physicians in public health matters as distinguished from their treatment of individual cases of sickness.

It is a mystery why lay organizations which promote public health persist in ignoring the practising physicians of their communities. A great criticism of public health nursing is that the nurses diagnose and treat cases of sickness. While it is true that the cases which most nurses diagnose and treat are mild and are those which a physician does not usually care to visit, yet who shall draw the line?

The borderline cases are those over which misunderstandings occur between physicians and nurses. A simple method for preventing these disputes would be that the nurse be directed by a committee of physicians to whom a list of cases visited by the nurse should be submitted. Physicians in rural places and even in the smaller cities are pretty well acquainted with the people of the

communities and can usually tell whether or not a nurse is overstepping her privileges in any particular case. At any rate, the responsibility for the visitations would lie with the Committee of the physicians' own choosing.

While most laws for public health nursing very properly recognize the health officer as a director, or at least advisor, of the nurse, the provision does not go far enough. The health officer is one of the practising physicians of a community but he does not represent the schools, or the industrial establishments, and he often has little to say regarding prenatal clinics and in fact welfare stations. The health officer's chief field is in epidemics of communicable diseases, but even here he is dependent on the practising physicians of his community.

We have often stated in our editorial columns that physicians generally are ready to co-operate with any agency, lay or official, for the promotion of public health. We have not been criticized or corrected in this statement, but on the other hand we have received evidences and assurances that physicians generally are ready to co-operate in public health nursing through their organized societies.

We believe that the proper committee to direct the professional activities of a public health nurse should consist of the health officer and the school physician, and two or three other physicians.

F O



# LEGAL

By GEORGE W. WHITESIDE, Esq.  
Counsel, Medical Society of the State of New York

## OBJECTIONS TO RE-REGISTRATION CONSIDERED

As early as 1760 a license to practice physic and surgery in the City of New York was required of any practitioner "after due examination of his learning and skill in physick or surgery," although those who had practiced prior thereto were not required to undergo such examination.

In 1792, a further licensing act was passed forbidding the practice of medicine to those who had not served an apprenticeship of two years with another physician or graduated from a college in the United States, or who had not successfully passed an examination by the constituted authorities and received a certificate accordingly. From this act likewise were exempted those who had previously practiced.

In the first act referred to, the purpose of these licensing laws was set forth in a preamble to the act as follows:

"Whereas many ignorant and unskilled Persons in Physik and Surgery in order to gain a Subsistence do take upon themselves to administer Physik and practice Surgery in the City of New York to the endangering of the Lives and Limbs of their Patients, and many poor and ignorant Persons inhabiting the said City who have been persuaded to become their Patients have been great Sufferers thereby."

It will be seen at once that as early as 1760 the licensing statute declared that the purpose of licensure was for the protection of the public against those who were unqualified and who sought for their selfish gain to practice medicine.

In 1797 a state-wide licensing act was passed requiring practitioners to obtain from the magistrate or officer before whom proof of qualification had been given a certificate and to file it in the office of the clerk of the county of his residence.

In 1801, further restrictions and qualifications were required, and registry with the county clerk continued as a prerequisite to a right to practice. Up to this time the judges of qualification were the Chancellor, a judge of the Supreme Court, a Master in Chancery or one of the judges of the Court of Common Pleas.

In 1806, when the charter of the Medical Societies was passed, they were empowered by that act to examine students and give diplomas to practice physic or surgery and the charter by its terms repealed the previous licensing statutes. In this act no requirements of registration in

the county clerk's office appear. The Medical Societies continued to exercise this power of licensure for many years and by an act in 1880, all future licenses were to be issued after examination by the regents, and all physicians then licensed or who should thereafter be licensed to practice were required to register in the office of the county clerk.

In 1887, a comprehensive medical practice act was passed and the standards of licensure were raised and registration in the county clerk's office was continued as a requisite to practice. The licensing power of the State Society was specifically repealed. All subsequent amendments to the Medical Practice Act contained the requirement of registration in the county clerk's office.

We thus see that from 1797 to 1806 registration in the county clerk's office was required. From 1806 to 1880 that requirement was dispensed with. So that registration in the county clerk's office has been going on continuously for the last forty-five years. Practically all of the men who registered in 1880 and were then thirty-five years of age or over, are now dead. Almost all of those who were then thirty years of age are now dead, and a large majority of those who were twenty-five years of age at that time are now dead. A vast majority of those who registered before 1890 are either retired or dead, and those who registered after 1890 are practitioners who have been in practice thirty-five years. Of those who have been so registered since 1890, there has been a considerable normal death rate. It is fair, therefore, to assume that the lists in the county clerk's offices contain the names of more dead men than those who are alive today. The names of those who have been convicted of felony in whose cases there has not been definite action by the regents are likewise retained on the lists in the county clerk's office as qualified practitioners, those who have removed from the state are still upon the lists, those who have gone into other businesses or professions and abandoned the practice of medicine are still on the lists. There is no way by which one can tell from the list of practitioners in the county clerk's office, who at present are within the state or without the state, retired, active, dead or alive. There is no way by which this can be checked up except by a laborious and impractical method of personal canvas of the present licensed practitioners, and in order to make certain it would be necessary to canvas

is printed on page 232 of the February 13 issue of this Journal. This periodical seems to have a kindly feeling toward all systems of healing except that of scientific medicine, and it seldom indulges in abuse of physicians. About the worst roast of the doctors is an account of a jubilation meeting of chiropractors over a decision against a New Jersey physician who had called osteopaths and chiropractors "Quacks and Fakirs." It rather exalts the virtues of herbs and diet, and the simple life. It seems to mother old forsaken systems like barefoot walking in the dew, and the use of herb teas. It even prints several pages of diseases and the various herbs which are "good for" those conditions. It would throw the gates wide open for the practice of any kind of cult, even that of scientific medicine. It is the "clinging vine" type of literature which eventually strangles scientific medicine by its passive weight.

The periodical to which we refer repeats the grave error of appealing to the principle of in-

dividual freedom of choice of a healer, and it proposes the following amendment to the Constitution of the State of Oregon:

"No law shall be passed which deprives any citizen of the inalienable right to employ the physician of his or her choice, or to determine for himself or herself the mode, manner, method, or system which he or she shall use in case of sickness."

One of the strongest of all the appeals of cults is to this false assumption that any Medical Practice Law can prevent any person from seeking relief from any source he wishes. What the law does do is to forbid any person from holding himself out as able and prepared to treat human ills, unless he has conscientiously prepared himself by a course of study of at least four years in a disinterested scientific school. We believe that this point is not generally apprehended and understood, and that physicians should explain it to their legislators. F O

## THE PHYSICIAN AND THE PUBLIC HEALTH NURSE

A wide-spread movement is under way to increase the scope of the work of the public health nurse. Bills are introduced in the legislature authorizing the employment of public health nurses by various governmental agencies, and there is a keen competition among lay organizations, especially those of women, to promote the employment of nurses. All this is excellent and show that people are getting ready to support measures for raising the standards of health in a community. But in all the discussion there is lacking an appreciation of the influence of the local physicians in public health matters as distinguished from their treatment of individual cases of sickness.

It is a mystery why lay organizations which promote public health persist in ignoring the practising physicians of their communities. A great criticism of public health nursing is that the nurses diagnose and treat cases of sickness. While it is true that the cases which most nurses diagnose and treat are mild and are those which a physician does not usually care to visit, yet who shall draw the line?

The borderline cases are those over which misunderstandings occur between physicians and nurses. A simple method for preventing these disputes would be that the nurse be directed by a committee of physicians to whom a list of cases visited by the nurse should be submitted. Physicians in rural places and even in the smaller cities are pretty well acquainted with the people of the

communities and can usually tell whether or not a nurse is overstepping her privileges in any particular case. At any rate, the responsibility for the visitations would lie with the Committee of the physicians' own choosing.

While most laws for public health nursing very properly recognize the health officer as a director, or at least advisor, of the nurse, the provision does not go far enough. The health officer is one of the practising physicians of a community but he does not represent the schools, or the industrial establishments, and he often has little to say regarding prenatal clinics and in fact welfare stations. The health officer's chief field is in epidemics of communicable diseases, but even here he is dependent on the practising physicians of his community.

We have often stated in our editorial columns that physicians generally are ready to co-operate with any agency, lay or official, for the promotion of public health. We have not been criticized or corrected in this statement, but on the other hand we have received evidences and assurances that physicians generally are ready to co-operate in public health nursing through their organized societies.

We believe that the proper committee to direct the professional activities of a public health nurse should consist of the health officer and the school physician, and two or three other physicians.

F O

prosecute, rather assumes that the District Attorneys of the state have shown in the past commendable zeal in the prosecution of offenders against the Medical Practice Act, whereas the reverse is the fact. The bill places upon the District Attorney the duty to prosecute, but provides likewise that the Attorney General may supersede him, so that the District Attorney is put upon his mettle to do his duty, and if he fails in his duty, it does not mean the failure of a case, because the Attorney General may carry on the prosecution. This gives an added weapon of offense against the illegal practitioner and expands the prosecuting machinery to make it more comprehensive in reaching violators. If this be an objection, we can conceive only of such objection being urged seriously by those who fear this added instrumentality rather than the licensed profession who should welcome this additional aid.

Further objection is made by medical men that "We have a vested interest in our state license as practitioners of medicine which should not be jeopardized by even the color of discretionary power." This objection is based upon an erroneous understanding of the legal effect of a license, it does not create a vested interest, it is subject to legislative control, regulation and even abrogation. It would seem to be folly to assume that a license is something which it is not in order to give the licensee a false sense of security.

The objection that this bill would be "an entering wedge for compulsory health insurance and other forms of state medicine" would be an excellent objection if it were susceptible of proof or if there were sufficient facts upon which to predicate a reasonable suspicion that it is true. How any bill that provides for the first time in forty-five years a proper roll call of the medical profession so as to inform everyone who is a licensed practitioner and which provides excellent machinery for the prosecution of the unlicensed practitioner and adds additional penalties to unlicensed practice, can be deemed "an entering wedge" for state medicine in any form, seems inconceivable. The two propositions have nothing in common.

The further objection that the only good that would be obtained would be to prosecute cults at the cost of great personal inconvenience, ostensibly refers to the inconvenience of annual registration. This inconvenience has been re-

duced to an absolute minimum by providing for registration through the County Societies after the first registration. A dentist came to a town in this state and started to practice. He had a very pleasant personality, joined the local social organizations, athletic clubs, lodges, churches, and made many personal friends among dentists and others, and was well liked. It appears, however, that he was not licensed in this state. No one wished to take personal responsibility of instituting action against him or being identified with any such action. Under the registration act for dentists, a line to the authorities at Albany is all that is necessary to have the authorities undertake the responsibility of investigation and stopping his practice until he should be licensed. This was an actual case. There are many similar cases throughout the state of men practicing medicine and there is no reason why any individual physician should take upon himself the burden of prosecution or any society should take the legal risk of prosecution and the legal liability that flows therefrom. Under the Karle-Dunmore bill, the authorities at Albany would have to assume all such responsibility. The individual doctor need only call their attention to the case to get action. It would seem that relief from this personal responsibility of prosecution and relief of the County Societies from possible liability in undertaking the prosecution is worth a slight personal inconvenience of the individual physician in sending in his registration the first year and having the secretary of his County Society do it for him thereafter.

The only penalty for failure to register under the act is a fee of one dollar for each thirty days of default, for wilful refusal to register one dollar a day for such refusal for the first thirty days and five dollars per day thereafter. So that the doctor who unwittingly omits to register is subject only to a small penalty such as flows from ordinary ordinance violations, such as failing to clear the snow or ice off one's sidewalk and those penalties are made the only penalties that may be imposed therefor and cannot affect the legality of a man's license and, furthermore, they may be remitted or compromised in the discretion of the regents. These penalties do not seem severe and are not comparable with many penalties for violation of city ordinances.

It would seem from an analysis of these objections that they have been met and answered.

practically all the names on the lists, which would be prohibitive in cost and in labor and subject to change each year

On the question of the necessity of registration in such form as to tell accurately year by year those who are authorized to practice, the facts above stated should answer the objections which have been made from certain quarters that the re-registration provision of the Karle-Dunmore bill is "unnecessary, unremedial, uncalled for" and that "our present laws are sufficient," and further answers the objection that "we should reject anything covered by existing laws," and finally, is quite a complete answer to the proposition of opposition "to registration in principle"

Objection that Subdivision "d" of Section 170 of the present law, which makes a ground for revocation of a doctor's license his offering or undertaking to violate Section 1142 of the Penal Law, should be restored to the Karle-Dunmore bill is worthy of consideration. Section 1142 makes it a misdemeanor, among other things, for a doctor to exhibit an article or instrument purporting to be for the prevention of conception or representing that it can be so used "or any such description as will be calculated to lead another to so use or apply such an article." If a physician is charged with this misdemeanor in a criminal proceeding, before he can be convicted, his guilt must be proved beyond a reasonable doubt. After such conviction the regents, under the Karle-Dunmore bill, could undertake a proceeding for the revocation of his license if the crime involved *moral turpitude*. If, on the contrary, the offense were unintentional, they would have no such right of revocation. In this way, a physician is protected against being framed up and his license revoked at the instance of some people whose enmity he may have aroused, whereas if he is really guilty of violating Section 1142, as that section should be construed, his license still may be the subject of attack by the regents under the Karle-Dunmore bill. The provision of the present law, the repeal of which by the Karle-Dunmore bill is objected to, makes possible the revocation of a doctor's license if he has either undertaken in any way or by any means, or has offered by any manner or means to violate the provisions of that section, whether he has been convicted therefor or not. This imposes an unconscionable penalty upon possibly innocent men and is an invitation to the unscrupulous to blackmail the profession. Under the Karle-Dunmore bill, by taking this provision out of the law, the profession is still protected against the unscrupulous doctor who may wilfully violate Section 1142 and be convicted therefor, and is protected against the blackmailer who seeks to injure the profession. It is difficult to understand how medical men can urge the removal of Section 170-d on this subject from

the present law as a ground of objection to the bill. Furthermore, the bill does make a ground of revocation the undertaking in any manner or in any way to procure or perform a criminal abortion whether or not the doctor doing so has been tried and convicted therefor. This gives ample protection against the practice of abortionists.

Further objection is cited that our present laws are sufficient. Our present laws do not seem to be sufficient to prevent people who have never received a degree of doctor or such degree that is recognized in this state, from using that title. Chiropodists use it and in a recent issue of the *Pedic Society Digest*, their counsel, Hon. John G. Dyer, cites instances of chiropodists who have been prosecuted for using the title "Doctor" and been acquitted. The publishers of the chiropodists' paper admit that the title is used by chiropodists, not because they have received such degree, *but because the public has so designated them*. In other words, any class of persons who can get the public to give them a title, under this contention, are entitled to have it and can insist upon it as a right, whether such title is a false pretense or not, if the statute does not specifically prohibit it. The Karle-Dunmore bill specifically does prohibit such use of the title "Doctor" to those who are not entitled to it. Can it be said that our present laws are sufficient when chiropodists who have no right to the use of the title "Doctor," and who have not earned it, who have no degree entitling them to it and who assume it because the public so designate them, cannot be successfully prosecuted therefor? It is said by the objectors that "we should go slowly about any change in the Medical Practice Act." If this chiropodists situation and the present chiropractic usurpation of the title of "Doctor" and the use of the title by all types of cultists who are not entitled to it, weigh for anything, we ought to speed up, rather than slow down, remedial changes in the Medical Practice Act to put a stop to this growing practice against which our present statutes seem ineffective.

The objection that the bill seeks to register the honest physician, but does not register the cults, while emanating from some physicians, expresses the views of the chiropractors. The chiropractors and other cultists would like to be registered and would probably be willing to register, not once a year, but once a week or once a month, to gain official recognition of their cult. Can this objection be urged seriously on the part of those who have consistently fought such recognition of cults? It would appear that this objection would give great courage to the cults in their present efforts to be recognized, particularly when the objection comes from medical sources.

The objection that the Attorney General may deprive the District Attorney of his right to

# SPECIAL ATTENTION

To Chairmen of County Legislative Committees and  
Members of County Medical Societies:

Have you written your letters to, or personally interviewed, your  
legislators on the following legislative bills?

## FAVORING

## AGAINST

Senate Int 115, Conc Assembly Int 215—The Narcotic Bill	Senate Int 283, Conc Assembly Int 399— County Public Health Nurses
Senate Int. 116, Conc Assembly Int 216—Re- quiring the licensing of private institutions for the treatment of drug addicts	Senate Int 473—The Drugless Practitioner Bill
Senate Int 211, Conc Assembly Int 307—State Department of Education Bill on Medical Practice	Senate Int 647, Conc Assembly Int 184—Ex- amination after injury
Senate Int 380, Conc Assembly Int 570—In- jured employee to select his physician	Senate Int 789—Senator Bouton's Chiropractic Bill
Senate Int 594, Conc. Assembly Int 301—Choice of Medical Attendants	Senate Int 943, Conc Assembly 1167—Labora- tory Supplies
Senate Int 671, Conc Assembly Int 868—Crip- pled Children	Senate Int 944—Practice of Medicine and licensing chiropractors
Assembly Int 908—Control of wood alcohol	Assembly Int 185—Assemblyman Nicoll's Chiro- practic Bill
	Assembly Int 422—Professional Secrets
	Assembly Int 649—Assemblyman Esmond's Chiropractic Bill
	Assembly Int 987—Birth Control

## INDEX OF LEGISLATIVE BILLS DISCUSSED IN THIS JOURNAL

B—Bill printed

C—Comment



## LEGISLATION



By JAMES N VANDER VEER, M.D.  
Chairman, Committee on Legislation.

Senate Int No	Assembly Int No	Law	Subject	Committee to which bill is referred	B—Bill printed	C—Comment
29	527	Penal	Prohibition Enforcement Crippled Children	S Codes Passed Both Houses to Governor	B	Feb 13 221
114	226				B	Feb 13 225
115	215	Public Health	THE NARCOTIC BILL	S Public Health	C	Mar 6 382
116	216	Insanity	Institutions for Addicts	S General Laws	B	Jan 23 80
211	307	Public Health	MEDICAL PRACTICE ACT	S Public Health	B	Mar 6 382
228	236	State Charities	Children's Institutions	S General Laws	C	Jan 23 84
263		Insanity	Insanity Examiners	S General Laws	C	Mar 6 382
283	399	County	County Nurses	S Internal Affairs	B	Jan 30 123
302	748	Education	Health Service in Schools	S Public Education	C	Mar 6 382
380	570	Workmen's Comp	Choice of Physician	S Labor and Industry	C	Mar 6 382
473		Public Health	Druggless Practitioner Bill	S Public Health	C	Feb 27 329
586	850	Education	Med Exam in Schools	S Public Education	B	Feb 6 174
594	301	Workmen's Comp	Choice of Physician	S Labor and Industry	C	Mar 6 382
647	184	Workmen's Comp	Examination After Injury	S Labor and Industry	B	Mar 6 175
671	868	Penal Law	Crippled Children	S Judiciary	C	Mar 6 383
693	950	Public Health	Foreign Medical Degrees	S Public Health	C	Mar 6 383
701		Public Health	Revocation of License	S Public Health	C	Mar 6 383
716	969	Public Health	Rural Hygiene	S Finance	B	Mar 6 383
789		Public Health	Chiropractic Bill (Bouton's)	S Public Health	C	Mar 6 383
943	1167	Public Health	Laboratory Supplies	S Public Health	C	Mar 6 383
944	127	Public Health	Chiropractic Bill (Icaron's)	S Public Health	C	Mar 6 383
	185	Public Health	Health Service in Schools	S Public Health	C	Mar 6 383
		Public Health	Chiropractic Bill (Nicoll's)	S Public Health	C	Mar 6 383
229	422	Education	Mentally Retarded Children	S Public Education	C	Mar 6 383
422		Civil Practice	Professional Secrets	A Codes	C	Mar 6 383
649		Public Health	Chiropractic	S Public Health	C	Mar 6 383
678		Public Health	Exam of Food Handlers	S Public Health	C	Mar 6 383
908		Penal Law	Wood Alcohol	S Public Health	C	Mar 6 383
925		Public Health	Reciprocity in Licenses	S Public Health	C	Mar 6 383
987		Penal	Birth Control	S Public Health	C	Mar 6 383
1321		Public Health	Vital Statistics	S Public Health	C	Mar 6 383

# CONCERNING DISTRICT LABORATORY SUPPLY BILL

## ASSEMBLY INTRODUCTORY 1167

Your Committee would oppose this amendment for the following reasons

*First* That it is in opposition to the general notion of the service the public laboratory should render

*Second* That it is an attempt to coerce the physician into submitting data concerning his patients, without stating the limitations to which such demands may go. The wording in this section of the bill might admit of considerable abuse of the privilege, were it granted,

*Third* Public health laboratories have been established by communities and financed from public monies, primarily for the purpose of protecting the public against the spread of communicable diseases. To limit their services to patients who are able to pay for such services would defeat its object,

*Fourth* No distinction is made in the character of supplies against which charges shall be made, as to whether they are supplies furnished for diagnostic purposes or therapeutic products,

*Fifth* The amendment is unnecessary, inasmuch as possibly 98 per cent of the physicians are at present submitting the required data when using the supplies for diagnostic purposes

Other reasons for objecting were held by your Committee, but since they have been practically covered in communications we have received from other members of the Society concerning the bill, we shall not repeat them. Excerpts from letters received follow

### FROM THE COUNCIL

1 "I am unalterably opposed to Assembly Bill Introductory No 1167"

2 "I feel that the bill should be opposed by the State Society, it being another distinct effort in the line of centralizing of control of the practice of medicine"

### FROM THE COUNSEL

"This bill requires institutions, physicians and other persons who use supplies distributed by the State Department of Health to furnish clinical data and reports required by the Laboratory of the State Department of Health, or to pay the market price of such supplies

"There appears to be no restriction upon the character or extent of the reports which may be required, so that the State Department of Health could apparently require the disclosure of much confidential and privileged information, as well as place upon the physician that burden of doing a great deal of clerical work for the Department. It appears to be an unjust discrimination against those who may be unable to pay the

market prices and fees for the laboratory services and supplies, in favor of those who are able so to pay, so that the ultimate effect of the bill appears to be that those who are able to pay may escape the disclosure of private and confidential information, while those unable to pay are deprived of the protection of the privilege

"The exercise of the police power of the State through the Department of Health should not place upon those unable to pay a deprivation of the right or privilege or the imposition of a burden from which those who are able to pay are excused

"The bill, therefore, appears to my judgment to be discriminatory and to place upon physicians and surgeons an unreasonable and unnecessary burden"

### FROM THE COMMITTEE ON PUBLIC HEALTH

1 "The only possible excuse for the bill would be based on a desire to prevent waste of laboratory products, in other words, inexcusable expenditure of State money

2 "Such possibility would be more than offset by the sweeping character of that portion of the bill on page 2, which gives to the Commissioner of Health unlimited authority to compel physicians to reveal the histories of their cases, which, if I understand the law, is a violation of the right of privacy of their patients. It may look innocent on the face of it, but it appears to me as fraught with hidden danger

3 "The general operation of the bill would be to strengthen the tendency towards State control of medicine, through the Department of Health. This may be a far cry, but it seems to me to be quite different from the Medical Practice Act, in that it attempts to regulate the private relations between doctors and patients, in matters which have no criminal aspect and should not be spread upon the State records. This may not apply to measles and diphtheria, but it might to the venereal diseases

"If all of the italics, including the eighth line of page 2, could be ablated, I would be in favor of the bill. As it now reads, however, it looks mischievous and should be either defeated or modified so as to limit the power of the Commissioner to demand statistics of cases, in such manner as would be within the law and not be a burden upon the doctors

"It may very well be that the present Commissioner has only the best of motives in desiring such a clause in this bill and would not abuse it, whereas another Commissioner might make all kinds of trouble. On the other hand, there can be no doubt of his right to prevent, as far as possible, wanton waste of costly laboratory prod-

# BRIEFS ON BILLS

## OPPOSITION TO COUNTY PUBLIC HEALTH NURSES' BILL

SENATE INTRODUCTORY 283, CONC ASSEMBLY INTRODUCTORY 399

The Medical Society of the State of New York, composed of over ten thousand physicians and representing in a majority degree the sentiment of all of the Medical Societies of the various Counties, begs leave to enter its objection to the above bills for the following reasons, and would request that these bills be kept in committee and not reported to the legislative bodies for consideration

*First* Under these bills direction of the public health nurse would be given over "To a committee of members of the board of supervisors, to be known as the committee on public health" No mention is made as to whether any member shall be a physician Since the public health nurse's work primarily has to do with the sick and the prevention of disease, it is the Society's opinion that her direction should be left to a committee of physicians and not to a committee of lay persons Such committee should be nominated by the physicians of the County Medical Society, who will act as the balancing power in such movements, for to them these lay boards must turn, and do turn, for medical advice—in many instances given gratis and sought gratuitously "because the doctor is the best posted on this matter"

This committee of physicians to serve efficiently should be freed from the entanglements of state governmental function and should represent solely its professional brethren

The desire on the part of half educated persons to initiate partial or complete medical treatment upon their own judgment and without proper supervision is becoming more and more apparent and instead of the physician being sought for his advice, we find that in many movements in behalf of the public health, the paid secretary of a welfare organization is the one first sought out

*Second* Among her duties are mentioned pre-natal care and maternity protection It is in-

ferred that the law intended she should give instructions in pre-natal care and maternity protection If such is the intention, it should be so stated "Discover and visitation of cases of tuberculosis, prevention and control of communicable disease, the care of the sick who may otherwise be unable to secure adequate care," are all duties for a physician and not for a nurse She may assist the physician, but can only work under his direct supervision in carrying out his immediate instructions

If this bill were enacted into law, the nurse employed by a board of supervisors to do public health nursing, might interpret her function to include diagnosis of disease from complaints and symptoms observed on her visits, without consulting a physician She might assume to take full charge of a maternity case through the pre-natal period, calling a physician only for the delivery It would leave her to decide whether adequate care other than that she herself supplied, could be gotten, and in many instances might attempt to limit her efforts to find medical care, or if she found working with a certain physician unpleasant, or if she developed a lack of confidence in a physician, she might choose not to co-operate with him, considering his efforts as inadequate

On the whole, this bill is placing entirely too much responsibility upon the nurse, considering the serious character of her work, which frequently involves life and death, a condition which the state recognizes as only to be undertaken by regularly licensed physicians

It is stated in the last paragraph that an advisory committee may be appointed, of which one member shall be a physician, but advisory committees are not directing committees and are only called to function when the directing committee feels itself lost, thus, although a physician may be appointed to this committee, he may have but a slight opportunity to assist in the direction of the nurse



make my friends use antitoxins as they should (I am the custodian of a station)"

For the bill we have the following

From a member of the Advisory Committee on Legislation

"I think the bill is a good one for the following reasons

1 "It will increase efficiency of the State Laboratory,

2 "It will prevent the present waste of much laboratory material,

3 "It is not too much to ask of the physician in return for the great service of free laboratory work,

4 "Any case that does not want a report sent to Albany should pay for the service,

5 "The physician should collect from his patient"

FROM COUNTY CHAIRMEN

1 "I am in accord with the accompanying bill The physician should report While he is not allowed to charge for the laboratory products,

he should charge for the extra time given to such reports and for administration, and then report"

2 "I am in general in favor of the bill I never have believed in the ultimate benefits of the free laboratory supplies furnished by the State Department of Health

3 "I see no objection. I think that the State Department is within its rights The doctor can escape a payment of a fee by submitting the required data I believe that there is value in the conclusions that can be drawn from these reports I hope that the bill will pass"

4 "I have no objection to make As you no doubt know, for years in every package sent out by the State Department of Health, a small slip requested data as to the results obtained Probably most of these have never been returned, and in order to keep records as to good or bad effects, the Department endeavors to try a new method If the physician wishes free products, he should report as to results, and if he does not care to report results, he can purchase the products"

---

## PROHIBITION ENFORCEMENT

Senate Int No 29, Assembly Int No 527

*Comment* Several protests have at last been received from physicians mainly along the lines that this law would duplicate the federal law and suggest that there would be more names added to the State payroll

One letter especially contains the criticism that "We have too many laws and too large a tax levy

"It is unnecessary to say to you that this country is mortally ill from a plague of laws, and any doctor who has to do with the Volstead Act doesn't want to be further handicapped by Anti-Saloon League legislation"

It would seem that physicians, as members of the Medical Society of the State of New York, should be interested in such a bill only to know that their rights as physicians in prescribing intoxicating liquors for medicinal purposes are

not curtailed The physician maintains that within professional limits and judgment, he should be allowed to prescribe anything which seems best for his case, and in that he is already governed or surrounded with laws when he transgresses this right In fact, sometimes he is prosecuted for malpractice when it is for the jury to decide as to whether he has used the best judgment as exhibited in his community

Secondly, as a State body, the Medical Society is interested to the degree of limitation "in paper work" insofar as it is practicable, since the multiplicity of rules and regulations governing the practice of medicine is now so great as to consume much of the physician's time in doing clerical work, thus depriving the public of that time in professional services

ucts and to adopt proper measures for obtaining scientific statistics for his department. But it is difficult to see how it is proper for him to exercise his rights, either as an economist or statistician, at the expense of the private rights of doctors and patients. The enactment of such a law would establish a bad precedent.

"The difficulty for me in answering your question lies in the fact that such laboratory supply stations as are called for in this bill are very much needed throughout certain districts in the State. On the other hand, the Medical Society of the State of New York should consider it a duty to support the Commissioner of Health in every legitimate effort to increase the usefulness of his department for the people of the State. The matter is very important for both him and us, in this particular, as he is in duty bound to give to the State efficient service, and it is up to us to support him in every such legitimate effort.

"As above stated, I feel that, without the italics, we could stand for this bill, but with them it would be improper to do so."

*Committee on Economics* is opposed on the following grounds:

1 The reports of the character called for are contrary to the best traditions of medicine.

2 They would deter patients from seeking medical advice.

3 Empowering the Health Commissioner to make a charge is tantamount to vesting him with the power to penalize the profession.

#### COMMITTEE ON LEGISLATION

"More paper work for the doctor, more State influence with private patients, discourages doctor from using laboratory help, too drastic."

Advisory Committee on Legislation objects:

1 That the burden imposed upon the custodian of the laboratory supplies is so great that physicians would refuse either to collect the funds or to serve as custodian.

2 The fact that reports are not received by the laboratory does not lessen the value of the materials supplied to emergency and indigent cases. Physicians may recall when antitoxin was first distributed, charge was made for syringe. In many instances the physicians chose to pay these fees from their own pocket rather than suffer the annoyance of collecting them from the patients. It is an unnecessary and unwarranted amendment.

#### FROM THE COUNTY LEGISLATIVE CHAIRMEN

1 "I have carefully read it over and taken it in from all sides. I am very much opposed to the bill as presented. It is not the price as much as the time it takes to keep the records."

2 "We are decidedly opposed to this bill."

3 "The amendment is objectionable to the medical profession and unnecessary from the standpoint of public health. Such reports as may be called for and demanded from practicing physicians, under this act, may be so voluminous and laborious to compile, that they may very likely force the doctors using State materials to procure their supplies from commercial sources, which would not be as dependable as our own State laboratory. Under the present law, no doctor using State products would refuse to submit reasonable clinical data. All the physicians, however, who have seen the proposed law, agree with me and are emphatically opposed to it."

4 "It is unnecessary, unwise, arbitrary, and tends to increase centralization of power in the State Department of Health."

5 "I am opposed absolutely to Assembly Bill Introductory No. 1167."

6 "I supposed the laboratories of the State Department of Health were to assist the physicians located outside the practical zone of the City laboratory, to get for their patients some of the advantages of the city residents. By adding more work to the already overworked physician, and penalizing him for failure, will defeat the purpose of the laboratory. I can see no reason for this legislation."

7 "I wish to state that this Society is opposed to its provision."

8 "Would say that I am not in favor of the amended provision relating to reports, fees, etc. Believe that it would not work out well, in a practical way, with the doctors or the public."

9 "Assembly Bill Print No. 1239, Introductory No. 1167, was presented, and it was the opinion of the members present that they were opposed to said bill on the grounds that it would add another burden to those already carried by the general practitioner. In case of an epidemic in a community with few physicians, the making out of compulsory reports, the extent of which we do not know, would be too much, and also the penalty of compelling the physician to pay for his laboratory supplies, when said regulations were not complied with, would not always work to the advantage of the patient. This County Medical Society is opposed to said legislation."

10 "I am against this bill. *First*, it will prevent the free use of antitoxins. If one has to write a clinical paper for every dose one gives, I should want to buy my own. The requirement of report is fair, *second*, the Department would have to establish its own stations and the cost (at present \$2000) would prevent their number being sufficient for quick service, *third*, it would punish the suffering poor for the faults of the practitioner. We country doctors have no office nurse to keep our records. I find it hard now to

### County Public Health Nurses

Senate Int No 283 (conc Assembly Int 399)

*Comment* Your Committee on Legislation has been unable to have any changes brought about by proposed amendments in the status of this bill, whereby the medical man shall be reasonably recognized and not ignored except by the remote possibility of the advisory committee which the board of supervisors is empowered to appoint

At the time of this comment the bill is now on the floor of the Senate for passage and it is hoped that the Assemblymen will see the propriety of the requests of the members of the Medical Society in so amending the bill as to make it satisfactory to the country physicians who are the ones most naturally interested in this type of proposed legislation

Your Committee on Legislation is still opposed to the bill in its present form and trusts that the County Legislative Chairmen have impressed upon their legislators the reasons for the desired amendments

### Health Service in Schools

Senate Int No 302 (conc Assembly Int 748)

*Comment* This bill is still in Public Education Committees of both houses, but the question as to what is meant by the term "health experts" has not as yet been answered to the satisfaction of your Committee on Legislation, yet no comments have been received from the members of the Society in frank opposition to the bill

### Injured Employee to Select His Physician

Senate Int No 380 (conc Assembly Int 570)

*Comment* No further comment except that the bill seems to hang fire in both committees, and a letter from one of the legislators would seem to indicate that the bill may die in committee unless the County Legislative Chairmen bring pressure to bear by argument upon the committees on Labor and Industry of both houses to push it onto the floor of the Senate and the House

### Inspection of School Children

Senate Int No 586 (conc Assembly Int 580)

*Comment* This bill still lies in the Public Education Committees of both houses

No comment at present

### Free Choice of Physician

Senate Int No 594 (conc Assembly Int 301)

*Comment* Still in Labor and Industry Committees of both houses See previous comments

The Society even through its individual members and its committees seems unable to have this bill advanced except as the individual physician may make a demand upon his own legislator to

see why the bill is not brought out of the committees

Many members of the Medical Society of the State of New York belong as well to a group of physicians active and organized who might be supposed to oppose such a measure as the free choice of physician, so that it will take extra weight on the part of your Society to extricate this bill from the committee if with any success

### Practical Tests of Injured Persons

Senate Int No 647 (conc Assembly Int 184)

*Comment* Still in Labor and Industry Committees of both houses

Your Committee on Legislation has been honored with a letter from Senator Johnson in which he has commented on a change by striking out the first "such" in the italicized reading, which would then read, "and may make physical examinations and practical tests of claimants and so forth" This, to a degree, modifies the bill and removes some of the objection, for which your Society is grateful, but the fact still remains that the commissioner will be given the power under this new amendment to make physical examinations and practical tests of claimants himself, and then sit in judgment as to his lay physical examinations in comparison with that of a physician which from the standpoint of law is an absurdity where one sits as attorney for the defendant as well as judge and jury, or *vice versa*

The principle of the bill is wrong, for now even the commissioner or deputy "may make such investigation or inquiry or conduct such hearing in such manner as to ascertain the substantial rights of the parties"

This places the commissioner in the seat of referee and should he desire advice on the matter, at present he is at liberty to utilize by subpoena the services of anyone in connection with the case, *but he is not allowed to pose as the whole court room and its occupants* under the present law

The County Legislative Chairmen should continue their opposition to this bill as it stands at present, since as to the question of medical advice your State Society feels that only those who have been properly schooled are the ones to pass upon the same There could be no objection to such a bill if by chance the commissioner was a licensed physician or even had taken a preliminary medical course to familiarize himself with injured persons and the lesions pertaining thereto

### Physically Handicapped Persons

Senate Int No 671 (conc Assembly Int 868)

*Comment* Still in Judiciary Committees of both houses

Hearing to be held on March 4th

## SUMMARY OF BILLS INTRODUCED IN LEGISLATURE IN SENATE

### Commission on Crippled Children

Senate Int 114 (conc Assembly Int 226)—  
Bill passed both houses Now in the hands of  
the Governor

### The Narcotic Bill

Senate Int No 115 (conc Assembly Int 215)

*Comment* There is no further comment to  
offer in relation to this bill

Criticism has been directed against the bill  
mainly from those who would deal in the drugs  
mentioned, but it is to be hoped that their breadth  
of vision will be such as to accept such a bill  
which attempts to limit one of the greatest  
present evils of this country, as physicians  
realize

It is to be recognized that this bill has been  
drawn after the conference of last year, called by  
Governor Smith, and that it has in it none of  
the objections which have been voiced by the  
majority of physicians in the years past

### Requiring the Licensing of Private Institutions for the Treatment of Drug Addicts

Senate Int No 116 (conc Assembly Int 216)

*Comment* This bill is still in the Committees  
and it seems that decided objection has been  
raised to its being put on the floor

The same comment as in previous issues ap-  
plies in that it would seem to be very proper  
that the Society work for the passage of the bill

### The State Department of Education Bill Amending the Medical Practice Act

Senate Int No 211 (conc Assembly Int 307)

*Comment* Attention of the members of the  
Medical Society should be directed to the fact  
that we now have two bills which in verbiage are  
very similar to this Karle-Dunmore bill

In the Assembly Mr Esmond's bill, Int No  
649, is almost identical with the Karle-Dunmore  
bill, simply omitting from the latter such sections  
obnoxious to the chiropractors and introducing  
such clauses as will give them the legal right to  
practice.

In the Senate Mr Fearon's bill, Int No 944,  
is similar to the Karle-Dunmore bill, but in gen-  
eral leaves the examination of future practition-  
ers to the present state board of medical exam-  
iners without the addition of a chiropractic  
representative, places the chiropractors in a posi-  
tion as of practicing osteopathy, *but contains a  
waiver clause of admittance for those who have  
practiced eight years*

Your Committee on Legislation now has defi-  
nite communications from the Kings County  
Medical Society in opposition to the Karle-Dun-

more bill, the arguments against it appearing in  
another part of the JOURNAL

The Queens County Medical Society has also  
transmitted its opposition to the Karle-Dunmore  
bill in a letter stating that on February 24th, the  
Society voted to oppose the bill

The hearing on this bill is called for Wednes-  
day, March 4th, and a resume of the results of  
the hearing will be published in the next  
JOURNAL

### Inspection by State Charities Boards of Children's Institutes

Senate Int No 228

*Comment* This bill will be kept before the So-  
ciety with no further comment as yet

### Qualifications of Examiners in Lunacy

Senate Int No 263—A bill introduced in the  
Senate by Senator James A Higgins of Kings  
County, would amend section 81, Insanity Law,  
relative to qualifications of examiners in lunacy  
Referred to General Laws Committee

*Comment* Physicians have awakened to the  
fact that this bill would so limit the examinations  
in lunacy as to almost negate its practicability

One communication states that "it is difficult  
enough now in emergencies to secure a second  
physician for such examination, especially in the  
smaller places You can readily see that in rural  
sections, it would require two physicians from a  
neighboring city to make such examination Fur-  
thermore, a general practitioner, as a rule, is  
quite competent to determine whether a person  
is insane within the scope of the law, while under  
the present conditions, if a patient has been ad-  
mitted to a state hospital improperly, the exam-  
ination by the physicians in the institution would  
determine any case in question

Further-  
more, I believe, a physician who has had a post-  
graduate course in nervous and mental diseases  
but who has not necessarily had two years actual  
experience in an institution for the insane, quite  
as competent to pass on mental disturbances"

The New York State Sanitary Officers' Asso-  
ciation has transmitted through its secretary, to  
the Legislative Bureau, a communication in op-  
position to the measure, pointing out that health  
officers at the present time have powers of com-  
mitment, but should this bill pass, the number  
of those who have had actually two years' ex-  
perience in a hospital for the mentally sick, would  
virtually reduce their number to none, and he  
would be seriously hampered in seeking qualified  
men under the provisions of the new law in  
emergencies that arise with which he now is  
legally entitled to deal

again is in behalf of a special society and not of the body politic as a whole

Those who have read the bill realize that the State Board of Regents are bound hand and foot, subservient to the New York State Chiropractic Society and that in general all chiropractic magazines are dwelling upon the financial and commercial aspects in the benefits to be derived from the practice of this cult to say nothing of the loopholes in the bill whereby the regents have really no authority as they have under the present medical practice act

Should the thought of this bill prevail it would not be wrong for the Medical Society of the State of New York to seek appointments for its chosen political members to sit on the board of state medical examiners, nor for the homeopathic or eclectic societies to do the same as well as for the osteopathic society. Such a power would throw the state licensure again into chaos as existed in years gone by, but happily in the advancement of education has been overcome

The bill is bad throughout, and while it contains many clauses which have been copied from previous laws and from the Karle-Dunmore bill as well, it should be vigorously opposed by all those who honestly believe in the true conservation of public health through rightful types of legislation and not in behalf of a class or group

#### Laboratory Supplies

Senate Int No 943 (conc Assembly Int 1167)  
—Bill printed in full in February 27th JOURNAL under Assembly Int. 1167, page 343

*Comment* Much opposition has developed to this bill, some coming from the health officers themselves, as well as many letters from practitioners who realize that the passage of such a bill will seriously influence the reports in an opposite manner from that which is intended by the bill. Some of the objections are as follows

(1) "Many physicians will not avail themselves as formerly of the proposal of the Health Department to furnish free laboratory supplies for indigent patients unless the physician discloses what may be demanded by the Health Department on its slips"

(2) One physician writes "It would be hard to say to what length in foolish blanks the physician would be called upon to waste his valuable time by filling in, and the taxpayer would have a little more added to his already heavy load"

(3) The physician above also writes "that it is good public health policy to distribute laboratory products freely through health officers as at present and ask no questions"

(4) Another says "That type of legislation, it seems to me, is particularly offensive which enables the state department of health or any

other department, to hold a gun at a doctor's head"

(5) It is a question whether it is good policy for the state department of health or any other state department to enter into business competition with the inhabitants of the state. In this instance the state department of health might have small charges against many physicians for oversight in filling in one or two answers and to collect the fifty cents or so which might be due for the products or "market prices and fees therefore," might expend much more than would be returned, and thus plunge the state into a far greater debt than was originally intended by public health appropriations

The theory of the state appropriation to the state department of health is that all of the people of the state contribute their moneys for the purpose of being protected in their health from the careless few ignorant and otherwise who irk under government control. Far cheaper is it to expend a thousand dollars by distributing small-pox vaccine only to be used in a limited community perhaps, but where most needed than to have only part of that thousand dollars for such distribution and the balance to be expended in collecting debts from physicians who in emergency may have stopped other pestilence from spreading

(6) "If the intent of this bill is to enforce the filling out of the existing blanks or any modifications thereof that are reasonable, then I believe that we should support it, but it does not say so in the text. The proposed amendment to the law would give to the commissioner the right to read into the law anything that he saw fit, *even to the extent of making it so burdensome that the use of the state supplies would of necessity have to be discontinued*—ED. There can be no doubt that the expense of providing supplies as is now done involves an immense expenditure of money, on which there is no financial return. This may need to be corrected, but it should not be handled in the manner in which the text of the proposed amendment would indicate that it could be.

"Furthermore, this proposed amendment by leaving so much unsaid, would permit of many abuses, besides a lot of unjust discriminations and no end of trouble. There is too much centralization of power and it smacks of state *medumne*

"We do not want the collection of personal data and other objectionable features similar to what was in existence when we were cursed with the state narcotic department

"My reaction to this bill is that the state department of health cannot afford and should not put any difficulties in the way of practicing physicians using their therapeutic supplies, right-

No further comment is offered than is noted on page 331 of your February 27th JOURNAL, but attention is again called to the fact that the old law should be amended requiring the court when appointing or designating a physician or psychologist to designate a physician duly licensed to practice in this state

#### **The Drugless Practitioner Bill**

Senate Int No 473, by Mr Gibbs

*Comment* While the Gibbs bill seems to be in behalf of public health by permitting any and all who wish so to do to practice the healing art, *because those who have practiced must have obtained some knowledge through this practice*, it is nevertheless to be condemned most severely for its low grade and should be fought most vigorously

The argument should not prevail of a *waiver clause in any amendment to the present law regarding the practice of the healing art*. Similarly no one should be allowed to practice until he has shown the worth of his basic education to be satisfactory, to the Department of Education of this state

This pan cult bill might better have been drawn to do away with examinations of any sort, with the destruction of the higher educational system of this state, with the overthrowing of our magnificent State Department of Health, and in the place of all these allow to be established without government or reasonable co-operation the savagery and witchcraft of treatment of the middle ages

During the last week, Senator Gibbs has introduced amendments to the bill. It originally provided under treatment for "the removal of abnormalities", in the amendment the words "the removal of" are stricken out

The educational requirements of those seeking examination for license are enhanced by requiring a minimum of a high school course or its equivalent

Section 285-h has been amended by the addition of a new paragraph, which provides for licensing practitioners to practice additional drugless methods after they have been licensed for one method. The paragraph follows

"That method or methods which he or she stated in the application for license. Any licensed drugless practitioner may be certified by the board to practice additional drugless methods after satisfactory proof has been offered as to ability and qualifications. The regents may waive the examination of any applicant for license hereunder who presents satisfactory proof that he has been duly licensed as a practitioner in any other state of the United States, upon such waiver and the payment of the fee of twenty-five

dollars the regents shall issue to him a license as provided in this section"

Section 285-1 has been amended by adding a new paragraph so as to provide for this person who have been practicing their method less than two years at the time the bill goes into effect.

The new material follows

"All drugless practitioners having a diploma from a legally incorporated school or college of drugless methods, who have practiced within this state when this law goes into effect, less than two years, shall pass an oral examination before the board in the theory and practice as taught in the school or college from which he or she graduated. The state board of regents shall issue a license to practice drugless methods to all those certified by the board"

#### **Admission of Foreign Practitioners**

Senate Int No 693 (conc Assembly Int 950)

*Comment* Still in Public Health Committees in both houses

No further comment

#### **Revocation of License to Practice Medicine**

Senate Int No 701—Still in Senate Public Health Committee

*Comment* Your Committee believes this bill is a fair bill and that it should pass and trusts that those who are interested in its passage will work for the same, inasmuch as the members of the Medical Society of the State of New York should stand ever ready to penalize such of its members as require it and looks upon the judiciary of the state and nation as one body from which naught but fairness and sound thinking will emanate

#### **Rural Hygiene**

Senate Int No 716 (conc Assembly Int 969)—A bill introduced in the Senate by Senator Leigh C Kirkland of Randolph, N Y, concurrent Assembly Int 969, by Assemblyman Frank H Lattin of Orleans County, would add new article to 2-b, Public Health Law, establishing provision of rural hygiene in State Department of Health and appropriating \$10,000

Referred to Finance Committee of Senate and to Ways and Means Committee of Assembly

#### **The Bouton Chiropractic Bill**

Senate Int No 789—A bill introduced in the Senate by Senator Arthur F Bouton of Roxbury, would define and regulate the practice of chiropractic

Referred to Public Health Committee

*Comment* This is another of the cult bills which the Society is called upon to fight and

cretion on the approval of the board of regents indorse a license or diploma of a physician from another state, provided the applicant has met all the preliminary and professional qualifications required for earning a license on examination in this state, has been in reputable practice for a period of ten years, and has reached a position of conceded eminence and authority in his profession. Any physician, who was actually engaged in the practice of medicine in this state prior to September first, eighteen hundred and ninety-one, and who failed to register, although eligible to do so at the time, or any physician, whose registration is not legal because of some error, misunderstanding or unintentional omission, may on the unanimous recommendation of the state board of medical examiners that he has submitted satisfactory proof of having complied with all the requirements prescribed by law at the time of his failure to register, or his incomplete registration, receive from the regents under seal a certificate of the facts which may be registered *in accordance with this act* [by any county clerk and shall make valid his registration] Before any license is issued it shall be numbered and recorded in a book kept in the regents' office, and its number shall be noted in the license, and a photograph of the licensee filed with the records. This record shall be open to public inspection, and in all legal proceedings shall have the same weight as evidence that is given to a record of conveyance of land.

§ 5 Section one hundred and seventy of such chapter is hereby amended to read as follows:

§ 170 *Registration* [Registry, revocation of license, annulment of registry. Every license to practice medicine shall, before the licensee begins practice thereunder, be registered in a book kept in the clerk's office of the county where such practice is to be carried on, with name, residence, place and date of birth, and source, number and date of his license to practice. Before registering, each licensee shall file, to be kept in a bound volume in a county clerk's office, an affidavit of the above facts, and also that he is the person named in such license, and had, before receiving the same, complied, with all requirements as to attendance, terms and amount of study and examinations required by law and the rules of the university as preliminary to the conferment thereof, that no money was paid for such license, except the regular fees paid by all applicants therefore, that no fraud, misrepresentation or mistake in any material regard was employed by any one or occurred in order that such license should be conferred. Every license, or if lost a copy thereof legally certified so as to be admissible as evidence, or a duly attested transcript of the record of its conferment, shall before registering, be exhibited to the county clerk, who, only in case it was issued or indorsed as a license un-

der seal by the regents, shall indorse or stamp on it the date and his name preceded by the words "registered as authority to practice medicine in the clerk's office of . . . county." The clerk shall thereupon give to every physician so registered a transcript of the entries in the register with a certificate, under seal that he has filed the prescribed affidavit. The licensee shall pay to the county clerk a total fee of one dollar for registration, affidavit and certificate. The regents shall have power at any and all times to inquire into the identity of any person claiming to be a licensed or registered physician and after due service of notice in writing, require him to make reasonable proof, satisfactory to them, that he is the person licensed to practice medicine under the license by virtue of which he claims the privilege of this article. When the regents find that a person claiming to be a physician, licensed under this article, is not in fact the person to whom the license was issued, they shall reduce their findings to writing and file them in the office of the clerk of the county in which said person resides or practices medicine. Said certificate shall be *prima facie* evidence that the person mentioned therein is falsely impersonating a practitioner or a former practitioner of a like or different name. The regents may revoke the license of a practitioner of medicine, or annul his registration, or do both, in any of the following cases:

(a) A practitioner of medicine who is guilty of any fraud or deceit in his practice, or who is guilty of a crime or misdemeanor, or who is guilty of any fraud or deceit by which he was admitted to practice, or

(b) Is an habitual drunkard or habitually addicted to the use of morphine, opium, cocaine, or other drugs having a similar effect, or,

(c) Who undertakes or engages in any manner or by any ways or means whatsoever, to procure or perform any criminal abortion as the same is defined by section eighty of the penal law, or,

(d) Who offers or undertakes by any manner or means to violate any of the provisions of section eleven hundred and forty-two of the penal law.

Proceedings for revocation of a license or the annulment of registration shall be begun by filing a written charge or charges against the accused. These charges may be preferred by any person or corporation, or the regents may on their own motion direct the executive officer of the board of regents to prefer said charges. Said charges shall be filed with the executive officer of the board of regents, and a copy thereof filed with the secretary of the board of medical examiners. The board of medical examiners, when charges are preferred, shall designate three of their number as a committee to hear and determine said

fully and properly There should be encouragement in the use of such supplies and the penalties for illegal use should be found elsewhere "

Several health officers have written that if they are obliged to keep more books in relation to state department of health supplies and their distribution, to record the changing market values, and to act as collection agencies and to dun their fellow practitioners, they feel the state goes too far in such a measure

### A Chiropractic Bill

No 995

Int 944

IN SENATE,

February 24, 1925

Introduced by Mr Fearon—read twice and ordered printed, and when printed to be committed to the Committee on Public Health.

### AN ACT\*

To amend the public health law, in relation to the practice of medicine.

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section one hundred and sixty-four of chapter forty-nine of the laws of nineteen hundred and nine, entitled, "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," is hereby amended to read as follows

§ 164 *Expenses* The fees derived from the operation of this article, *except as otherwise provided in section one hundred and seventy-three, subdivision five*, shall be paid into the state treasury, and the legislature shall annually appropriate therefrom for the Education Department an amount sufficient to pay all proper expenses incurred pursuant to this article

§ 2 Section one hundred and sixty-six of Chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health constituting chapter forty-five of the consolidated laws" is hereby amended by adding thereto a new subdivision seven, to read as follows

7 Where the application be for a license to practice chiropractic, the applicant shall produce evidence that he has studied chiropractic not less than four years including four satisfactory courses of not less than seven months each in four different calendar years in a school or college maintaining a standard satisfactory to the regents

§ 3 Section one hundred and sixty-seven of such chapter, as amended by chapter 496, of the laws of 1923, is hereby amended to read as follows

§ 167 *Questions* The board shall submit to

the regents, as required, lists of suitable questions for thorough examination in anatomy, physiology, hygiene, chemistry, surgery, obstetrics, gynecology, pathology including bacteriology, and diagnosis From these lists the regents shall prepare question papers for all these subjects, which at any examination shall be the same for all candidates, except that the examination may be divided as provided in section one hundred and sixty-six *Provided, however, that prior to July first, nineteen hundred and twenty-five, where the examination be for an applicant to practice Chiropractic, the foregoing question papers shall be confined to the subjects of Anatomy, Physiology, Hygiene, Diagnosis and Chemistry, and thereafter the examination shall be the same as that prescribed for practitioners of osteopathy*

§ 4 Section one hundred and sixty-nine is hereby amended to read as follows

§ 169 *Licenses* On receiving from the state board an official report that an applicant has successfully passed the examinations and is recommended for license, the regents shall issue to him a license to practice according to the qualifications of the applicant Every license shall be issued by the university under seal and shall be signed by the president and secretary of the board and by the officer of the university who approved the credential which admitted the candidate to examination, and shall state that the licensee has given satisfactory evidence of fitness as to age, character, preliminary and medical education and all other matters required by law, and that after full examination he has been found properly qualified to practice Applicants examined and licensed in accordance with the provisions of this act, who, when admitted to the licensing examination, were citizens of a foreign country, and who had declared intention of becoming citizens of the United States, shall, upon passing the examination, be issued a license valid for six years from the date of such declaration of intention and upon failure of such licensee to furnish evidence of his having actually become a citizen his license shall become invalid and automatically become revoked and his registration shall be annulled Applicants examined and licensed by other state examining boards registered by the regents as maintaining standards not lower than those provided by this article and applicants who matriculated in a New York State medical school before June fifth, eighteen hundred and ninety, and who received the degree of doctor of medicine from a registered medical school before August first, eighteen hundred and ninety-five, may without further examination, on payment of twenty-five dollars to the regents and on submitting such evidence as they may require, receive from them an indorsement of their licenses or diplomas conferring all rights and privileges of a regents' license issued after examination The commissioner of education may in his dis-

\* Matter in *italics* is new, matter in brackets [ ] is old law to be omitted.



county medical society existing in the county of his residence or to the secretary of any incorporated state medical society in which said county medical society is represented, the name and address of any person known to be practicing medicine whose name does not appear in this registry. The names of persons giving such information will not be divulged."

The names of physicians which shall in any year be added to said list after the same shall have been so printed and distributed as aforesaid, shall be reported quarterly to the secretary of any duly incorporated state medical society of which county medical societies are components.

5 Any licensed physician who having failed or neglected to register by January first of any year as required by the provisions of this section shall be required to pay upon registration, in addition to the fee of two dollars, a further fee of one dollar for each thirty days or part thereof, that he is in default, and any licensed physician who engages in practice and wilfully refuses or omits to register hereunder, shall be subject to a civil penalty of one dollar for each day that such wilful refusal or omission shall continue, provided that if the same continues for more than thirty days the penalty thereafter shall be five dollars per day so long as the said wilful refusal or omission shall continue, said penalty shall be recoverable in an action by the attorney-general of the state maintained in the name of the people of the state of New York.

6 The penalties provided in this section for failure, neglect or omission of a duly licensed physician to register under this article shall be the only penalties that may be imposed therefor, and the legality of his license shall not be affected thereby, and such penalties may for good cause shown, in the discretion of the regents, upon the recommendation of the board of medical examiners, be remitted or compromised.

7 Each licensed physician shall conspicuously display his proper registration certificate in his office at all times.

§6 Section one hundred and seventy-one of such chapter amended by chapter fifty-three of the laws of nineteen hundred and fifteen, is hereby repealed.

§7 Section one hundred and seventy-two of such chapter is hereby renumbered section one hundred and seventy-one.

§8 Section one hundred and seventy-three of such chapter as amended by chapter two hundred and eighty-two of the laws of nineteen hundred and twenty-four is hereby renumbered section one hundred and seventy-two and amended to read as follows:

[173] 172 Construction of this article [This article shall not be construed to affect commissioned medical officers serving in the United States army, navy or marine hospital service, while so commissioned, or any one while actu-

ally serving on the resident medical staff of any legally incorporated hospital, or any one while actually serving as an interne in a state hospital or other state institution in which medical service is provided, or any legally registered dentist exclusively engaged in practicing dentistry, or any person or manufacturer who mechanically fits or sells lenses, artificial eyes, limbs, or other apparatus or appliances, or is engaged in the mechanical examination of eyes, for the purpose of constructing or adjusting spectacles, eyeglasses and lenses, or any lawfully qualified physician in other states or countries meeting legally registered physicians in this state in consultation, or any physician residing on a border of a neighboring state and duly licensed under the laws thereof to practice medicine therein, whose practice extends into this state, and who does not open an office or appoint a place to meet patients or receive calls within this state, or any physician duly registered in one county called to attend isolated cases in another county, but not residing or habitually practicing therein, or the furnishing of medical assistance in case of emergency, or the domestic administration of family remedies, or the practice of chiropody, or the practice of the religious tenets of any church. This article shall be construed to repeal all acts or parts of acts authorizing conferment of any degree in medicine *causa honoris* or *ad eundem* or otherwise than on students duly graduated after satisfactory completion of a preliminary medical course not less than that required by this article as a condition of license.]

I This article shall not be construed so as to prevent the following: (1) The practice of medicine in this state in obedience with the requirements of the laws of the United States, of any commissioned medical officer serving in the United States army, navy, or public health service while engaged in the performance of the actual duties prescribed for him under the United States statutes; or (2) the practice of medicine in a duly incorporated hospital operating pursuant to the state charities law, of a duly appointed member of the resident medical staff or of an interne, or (3) the practice of medicine by any physician duly licensed to practice medicine in a bordering state, who resides on a border of such neighboring state, whose practice extends into this state and who does not open an office or appoint a place to meet patients or receive calls within this state, or (4) any lawfully qualified physician in other states or countries meeting legally registered physicians in this state in consultation, or (5) the furnishing of medical assistance in case of emergency, or (6) the domestic administration of family remedies, or (7) the practice of chiropody, dentistry, or veterinary medicine, provided those practicing are legally authorized and licensed under the laws of this state so to do, or (8) the practice of the religious tenets of any

charges. A time and place for the hearing of said charges shall be fixed by said committee as soon as convenient, and a copy of the charges, together with a notice of the time and place when they will be heard and determined, shall be served upon the accused or his counsel, at least ten days before the date actually fixed for said hearing. Where personal service or service upon counsel can not be effected, and such fact is certified on oath by any person duly authorized to make legal service, the regents shall cause to be published for at least seven times, for at least twenty days prior to the hearing, in two daily papers in the county in which the physician was last known to practice, a notice to the effect that at a definite time and place a hearing will be had for the purpose of hearing charges against the physician upon an application to revoke his license. At said hearing the accused shall have the right to cross-examine the witnesses against him and to produce witnesses in his defense, and to appear personally or by counsel. The said committee shall make a written report of its findings and recommendations, to be signed by all its members, and the same shall be forthwith transmitted to the executive officer of the board of regents. If the said committee shall unanimously find that said charges, or any of them are sustained, and shall unanimously recommend that the license of the accused be revoked or his registration be annulled, the regents may thereupon in their discretion, revoke said license or annul said registration, or do both. If the regents shall annul such registration, they shall forthwith transmit to the clerk of the county or counties in which said accused is registered as a physician, a certificate under their seal certifying that such registration has been annulled, and said clerk shall, upon receipt of said certificate, file the name and forthwith mark said registration "annulled." Any person who shall practice medicine after his registration has been marked "annulled" shall be deemed to have practiced medicine without registration. Where the license of any person has been revoked, or his registration has been annulled as herein provided, the regents may, after the expiration of one year, entertain an application for a new license in a like manner as original applications for licenses are entertained, and upon such new application they may in their discretion, exempt the applicant from the necessity of undergoing any examination.]

1 Every person now lawfully engaged in the practice of medicine within the state and every person hereafter duly authorized to practice medicine, shall, on or before January first of each year, apply to the secretary of the board of medical examiners for a certificate of registration with the regents of the university upon a blank form which shall be furnished by said secretary and shall pay at such time to said secretary a fee of two dollars, provided that any physician who has

registered for five consecutive years hereunder shall register annually without the payment of fee and be so registered during the time he shall thereafter continuously practice medicine in this state

2 A physician in making his first registration hereunder shall write or cause to be written upon the application blank so furnished by said secretary, his full name, post-office and residence address, the date and number of his license and such other facts for the identification of the applicant as a licensed practitioner of medicine as the regents may deem necessary and shall duly execute and verify the same before an officer empowered to take acknowledgments of deeds and deliver the same to said secretary by mail or in person. Subsequent registrations after the first registration need not be upon a sworn application by the applicant unless in a particular case the regents, for reasons satisfactory to them, may require that the application be under oath, such subsequent registration shall be made with as little inconvenience to duly licensed practitioners of medicine as possible and to that end the secretary of the board may employ and use in obtaining such subsequent registrations, the assistance of the secretary of duly incorporated medical societies who shall be empowered as a representative of the secretary of the board to receive and transmit such application blanks from physicians after the physicians' first registration, together with the license fees payable upon such applications

3 The secretary of the board, on or before October first of each year, after the first registration, shall mail or cause to be mailed to every physician registered in his office, a blank form of application for registration addressed to the last known post-office address of such physician or may cause such blank form of application to be sent to such physicians through the secretary of any duly incorporated medical society. The form of application shall be such as to contain proper spaces for the insertion by the applicant of the information required under paragraph 2 of this section

4 The secretary of the board shall issue to any duly licensed physician in this state, upon his application therefor in accordance with the provisions hereof, a certificate of registration under the seal of the university for the year ensuing and ending December thirty-first

Upon the first of March in each year, or within ten days thereafter, the secretary of the board shall publish and cause to be mailed to each physician registered hereunder in this state, a printed list of the duly registered physicians in this state and each such published list shall contain at the beginning thereof these words

"Each registered physician receiving this list is requested to report to the secretary of the board and to the secretary of any duly incorporated

tion under this article, or under sections eleven hundred and forty-seven of the penal law, and any amendments thereto, is made on the complaint of any incorporated medical society of the state, or any county medical society entitled to representation in a state society, any fines collected shall be paid to the society making the complaint, and any excess of the amount of fines so paid over the expense incurred by the said society in enforcing the medical laws of this state, shall be paid at the end of the year to the county treasurer ]

1 Any person who shall,

(a) Sell or fraudulently obtain or furnish any medical or osteopathic diploma, license, record or registration, or aid or abet in the same, or

(b) Practice medicine under cover of any diploma, license, record or registration illegally or fraudulently obtained or signed or issued unlawfully or under fraudulent representation or mistake of fact in a material regard, or

(c) Advertise to practice medicine under a name other than his own or under a false or assumed name, and

2 Any person, who not being then lawfully licensed and authorized to practice medicine within this state and so registered according to law, shall

(a) Practice or advertise to practise medicine, or

(b) Use in connection with his name any designation tending to imply or designate him as a practitioner of medicine, or

(c) Use the title "doctor" or any abbreviation thereof in connection with his name or with any trade name in the conduct of any occupation or profession involving or pertaining to the public health, unless duly authorized by law to use the same, and

3 Any person, who during the time his license to practice medicine, shall be suspended or revoked shall practice medicine shall be guilty of a misdemeanor and shall also be subjected to the recovery of civil penalties

Such misdemeanor shall be punishable by imprisonment for not more than one year or by a fine of not more than five hundred dollars or by both such fine and imprisonment for each separate violation

4 All courts of special sessions within their respective territorial jurisdictions are hereby empowered to hear, try, and determine such crimes without indictment and to impose in full the punishments of fines and imprisonments herein prescribed

Such misdemeanors shall be prosecuted upon the private information of any person by the district attorney of the county wherein the same are committed and at any time the attorney-general

may, without further authority or direction, supersede the district attorney in the prosecution of such misdemeanors

5 In addition to the criminal punishments of imprisonment and fine as above provided, a civil penalty is hereby prescribed and imposed which shall be one hundred dollars for each such violation, to be recovered by the attorney-general in an action against the party or parties guilty of such violation, which action shall be maintained in the name of the people of the state of New York. Such civil penalties shall be cumulative, a separate penalty being recoverable for each separate violation, and each separate day's violation shall constitute a separate violation for which recovery may be had as above provided. The attorney-general, with the consent of the state commissioner of education may compromise claims for such penalties and accept less than the amount claimed or due before or after an action has been begun. No compromise may be made, however, after decision has been made or a verdict rendered, except pursuant to section thirty-four of the state finance law. Notwithstanding the provisions of any other general, local or special law, all fees, fines, penalties and other moneys derived from the operation of this article shall be paid to the regents of the university and shall be available, together with the appropriations made from time to time by the legislature, for the payment of all proper expenses of the regents, for the administration and enforcement of this act only, including the salary of any deputy attorney-general assigned for the purpose of enforcing the provisions of this article. The unexpended balance of all such fees, fines, penalties and other moneys derived from the operation of this article remaining on June thirtieth of each year shall be paid into the state treasury.

After this act shall take effect, the regents shall report to the state comptroller on the fifth day of every month the amounts received by them under this article and remaining in their hands, with all expenditures made by them for the preceding month.

6 Judgments for civil penalties recovered under this article may be enforced by execution against the person as provided in the civil practice act. A person taken into custody under such an execution shall not be admitted to the liberties of the jails and shall be confined, Sundays and legal holidays included, for not less than one day and at the rate of one day for each dollar of the amount of the judgment recovered for civil penalties and costs and remaining unpaid. No person shall be imprisoned more than once or for more than six months on the same judgment. The provisions of this article relative to imprisonment for such debts shall be exclusive and the provisions of the debtor and creditor law and of section seventy-two of the civil rights law shall

church, or (9) the fitting or selling of lenses, artificial eyes, limbs or other apparatus or appliances by any person or manufacturer of the same or the engaging in the mechanical examination of eyes for the purpose of constructing or adjusting spectacles, eyeglasses and lenses

II This article shall be construed to repeal all acts or parts of acts authorizing conferment of any degree in medicine *causa honoris* or *ad eundem* or otherwise than on students duly graduated after satisfactory completion of a preliminary medical course not less than that required by this article as a condition of license

It is further provided that any person who shall be actively engaged in the practice of osteopathy in the state of New York on the thirteenth day of May, nineteen hundred and seven, and who shall present to the board of regents satisfactory evidence that he is a graduate in good standing of a regularly conducted school or college of osteopathy within the United States which at the time of his or her graduation required a course of study of two years or longer, including the subjects of anatomy, physiology, pathology, hygiene, chemistry, obstetrics, diagnosis and the theory and practice of osteopathy, with actual attendance of not less than twenty months, which facts shall be shown by his or her diploma and affidavit, shall upon application and payment of ten dollars be granted, without examination, a license to practice osteopathy, provided application for such license be made within six months after the thirteenth day of May, nineteen hundred and seven. A license to practice osteopathy shall not permit the holder thereof to administer drugs or perform surgery with the use of instruments. Licenses to practice osteopathy shall be registered in accordance with the provisions of this article, and the word osteopath be included in such registration, and such license shall entitle the holder thereof to the use of the degree D O, or doctor of osteopathy

It is further provided that any person who shall have been continuously and actively engaged in the practice of chiropractic in the state of New York for a period of eight years on the first day of July, nineteen hundred and twenty-five, and who shall present to the regents satisfactory evidence that he or she is a graduate in good standing of a legally chartered school or college of chiropractic within the United States which at the time of his or her graduation required a course of study including the subjects of anatomy, physiology, pathology, hygiene, analytical chemistry, obstetrics and the theory and practice of chiropractic, which facts shall be shown by his or her diploma and affidavit, shall upon application and payment of a fee of ten dollars be granted, without examination, a license to practice chiropractic, provided application for such license be made within six months after the first day of July, nineteen hundred and twenty-five

It is further provided that the continuous practice of chiropractic for a period of eight years shall not apply to such practitioners of chiropractic who served the United States in the world war during this eight year period and who shall present evidence of such service and an honorable discharge. All other persons who are now engaged in the practice of chiropractic prior to the taking effect of this act shall take an examination to be provided for by the regents in the foregoing subjects, after, certifying by diploma and affidavit to the regents that he or she has graduated from a secondary school and from a chiropractic school or college in the United States with credentials satisfactory to the regents and from a course of satisfactory study of not less than eighteen months

A license to practice chiropractic shall not permit the holder thereof to administer drugs or to practice surgery or obstetrics. Licenses to practice chiropractic shall be registered in accordance with the provisions of this article and the word *chiropractor* shall be included in such registration and such license shall entitle the holder thereof to the use of the word *chiropractor* or *licensed chiropractor* and no others may use such word or words under the penalties of this article

§ 9 Section one hundred and seventy-four of such chapter is hereby renumbered section one hundred and seventy-three and amended to read as follows

§[174 Penalties and their collection] §173 *Penalties* [Any person who, not being then lawfully authorized to practice medicine within this state and so registered according to law, shall practice within this state without lawful registration or in violation of any provisions of this article, and any person who shall buy, sell or fraudulently obtain any medical diploma, license, record or registration, or who shall aid or abet such buying, selling or fraudulently obtaining, or who shall practice medicine under cover of any medical diploma, license, record or registration illegally, obtained, or signed or issued unlawfully or under fraudulent representations or mistake of fact in a material regard, or who, after conviction of a felony, shall attempt to practice medicine, or shall so practice, and any person who shall in connection with his name use any designation tending to imply or designate him as a practitioner of medicine within the meaning of this article without having registered in accordance therewith, or any person who shall practice medicine or advertise to practice medicine under a name other than his own, or any person not a registered physician who shall advertise to practice medicine, shall be guilty of a misdemeanor. Any person who shall practice medicine under a false or assumed name, or who shall falsely personate another practitioner or former practitioner of a like or different name, shall be guilty of a felony. When any prosecu-

such fact is certified on oath by any person duly authorized to make legal service, the secretary of the board of medical examiners shall cause to be published for at least four times, at least thirty days prior to the hearing, a notice of hearing, in a newspaper published in the county in which the physician was last known to practice, and a copy of such notice shall also be mailed to the accused at his last known address. All such notices of charges shall contain a plain and concise statement of the material facts, without unnecessary repetition, but not the evidence by which the charges are to be proven, with a notification that a stenographic record of such proceedings will be kept and that the accused will have opportunity to appear either personally or by counsel at the hearing, with the right to produce witnesses and evidence upon his own behalf, to cross-examine such witnesses, to examine such evidence as may be produced against him and to have subpoenas issued by the board. The said committee shall make a written report of its findings and recommendations, to be signed by all its members, and the same shall be forthwith transmitted to the board of regents with the entire record and evidence. If the said committee shall unanimously find that said charges, or any of them are sustained, and shall unanimously recommended that the license of the accused be revoked or the practitioner suspended from practice, and his registration annulled, or that he be otherwise reprimanded or disciplined, the regents may thereupon in their absolute discretion, revoke or suspend said license and annul said registration or otherwise reprimand or discipline as in their absolute discretion they may deem best for the public interest, provided that no greater penalty than that recommended by said committee be imposed. Where the license of any person has been revoked, or his registration has been annulled as herein provided, the regents may, after the expiration of one year entertain an application for a restoration of license and registration, in like manner as original applications for licenses are entertained, and upon such new application they may in their discretion exempt the applicant from the necessity of undergoing any examination. The regents may in their discretion restore to good standing any physician who has been suspended from practice.

1. Any licensed practitioner found guilty under the provisions of this section on charges or whose license is otherwise revoked or suspended or registration annulled or who has been refused registration, or who is otherwise reprimanded or disciplined by the board of regents under this article, shall have an order of certiorari for the purpose of reviewing such determination returnable before the appellate division of the judicial department where the board of regents made the determination complained of, but no such deter-

mination of the board of regents shall be stayed or enjoined except upon application to such appellate division, after notice to the state commissioner of education, and upon a showing that the determination of the board of regents was clearly wrong, that the constitutional rights of the applicant have been violated or that the board of regents made its determination without jurisdiction. The board of medical examiners or the board of regents may issue subpoenas and administer oaths pursuant to section sixty-one of the public officers law in connection with any hearing or investigation under this article and it shall be the duty of such boards to issue subpoenas at the request of and upon behalf of the defense.

§ 11 This act shall take effect July first, nineteen hundred and twenty-five.

*Comment.* This bill is by far the sanest bill which has thus far been introduced relative to the practice of any cult, but it too has a waiver clause not yet satisfactory though approaching more nearly to the thought of admittance of special practitioners in the healing art for license to practice the same.

Waiving the question for the sake of argument as to the all-curative properties of the chiropractic theory (which broad statement is denied by scientific men) this bill provides that examination shall be held by the State Board of Medical Examiners, first, that prior to July 1, 1925, where the examination be for an applicant to practice chiropractic the question papers shall be confined to the subjects of anatomy, physiology, hygiene, diagnosis and chemistry, then after that date the examination shall be the same as that prescribed for practitioners of osteopathy.

The first part of the bill is the same as the Karle-Dunmore bill.

The waiver clause, however, limits the practitioners who would come in thereby to those who have practiced for eight years and who shall present to the regents satisfactory evidence that he or she is a graduate in good standing of a legally chartered school or college of chiropractic within the United States, etc., and teaching certain subjects whereupon the payment of a fee of ten dollars and without examination a license may be issued up to and including the thirty-first day of December, 1925. The next provision is that all other persons now engaged in the practice of chiropractic must take an examination in the subjects as above described after certifying satisfactory to the regents that she or he has graduated from a secondary school and from a chiropractic school or college with credentials satisfactory to the regents.

The last sentence forbids the administering of drugs, the practice of surgery or obstetrics, requires registration according to the Karle-Dunmore bill, and the license thereunder entitles the

have no application and prosecutions for a crime under this article shall not bar prosecutions for civil penalties

7 The display of a sign or an advertisement bearing a person's name as a practitioner of medicine in any manner or by implication or containing any other matter forbidden by law shall be presumptive evidence in any prosecution or hearing that the person whose name is so borne is responsible for the display of such sign or advertisement and of a holding out and of the practice of medicine by such person for each separate day such sign or advertisement is anywhere displayed by anyone, but such presumptions are rebuttable by the defense. It shall be necessary to prove in any prosecution or hearing under this article only a single act prohibited by law or a single holding out or an attempt, without proving a general course of conduct, in order to constitute a violation

8 In any action for damages for personal injuries or death against a person not licensed hereunder for any act or acts constituting the practice of medicine as herein defined, where such injuries or death were contributed to by such act or acts, the fact that such person practiced medicine as herein defined without being duly licensed shall be deemed *prima facie* evidence of negligence

9 All violations of this act when reported to the regents and duly substantiated by affidavits or other satisfactory evidence, shall be investigated and if the report is found to be true and the complaint substantiated, the regents shall report such violation to the attorney general or district attorney and request prompt prosecution. The regents may appoint such inspectors as are necessary, to be paid from the funds received under this act at such salaries as the regents may determine and it shall be the duty of such inspectors under the direction of the regents, to investigate promptly and thoroughly such violations and to procure, where possible, legal evidence of the same for prosecution of the offenders

§ 10 Article eight of such chapter is hereby amended by adding thereto a new section to be known as section one hundred and seventy-four to read as follows

§ 174 *Revocation of certificates and annulment of registrations*

1 Whenever any practitioner of medicine shall be convicted of a felony, there may be presented to the regents a certified or exemplified copy of the judgment of such conviction and thereupon the registration of the person so convicted shall be annulled and his license revoked

Upon reversal of the conviction of such practitioner the regents shall upon receipt of a certified copy of the judgment or order of reversal vacate their order of revocation and annulment

of registration but nothing herein contained shall divest the regents of power to proceed against such practitioner under the next subdivision

2 The regents may revoke or suspend the license of a practitioner of medicine and annul his registration or reprimand or discipline as in their discretion they may deem best for the public interest in any of the following cases

Upon finding after due hearing

a That a physician is guilty of fraud or deceit in the practice of medicine or in his admission to the practice of medicine or in his procuring registration, or

b That a physician has been convicted in a court of competent jurisdiction, either within or without this state, of a crime involving moral turpitude, or

c That a physician is a habitual drunkard, or addicted to the use of morphine, cocaine or other drugs having a similar effect, or has become insane, or

d That a physician is guilty of untrue, fraudulent, misleading or deceptive advertising, or advertising that he can cure diseases which are recognized by the medical profession as incurable, or advertising that he can cure or treat disease by a secret method, procedure, treatment or medicine, or that he can treat, operate or prescribe for any human condition by a method, means or procedure which he refuses to divulge upon demand to the regents, or

e Who undertakes or engages in any manner or by any ways or means whatsoever to procure or perform any criminal abortion as same is defined by the penal law

3 Proceedings for revocation of a license, suspension of a practitioner from practice or the annulment of registration under subdivision two of this section shall be begun by filing a written charge or charges against the accused. These charges may be preferred by any person, corporation or public officer, or by the executive officer of the board of regents. Any charges shall be filed with the commissioner of education and a copy thereof filed with the secretary of the board of medical examiners. The president of the board of medical examiners, when charges are preferred, shall designate three of its members as a committee to hear and determine said charges and such committee shall contain at least one member who represents the same school of practice as the physician against whom the charges are preferred. A time and place for the hearing of said charges shall be fixed by said committee as soon as convenient, and a copy of the charges, together with a notice of the time and place when they will be heard and determined, shall be served upon the accused or his counsel at least ten days before the date actually fixed for said hearing. Where personal service or service upon counsel cannot be effected, and

*each county legislative chairman and individual in discussing medical and chiropractic legislation that the six bills pertaining to the practice of the healing art may not be confused, as is evidently the intent on the part of some, when in discussions the essential facts of differences in the bills are omitted perhaps to befog the mind of the discussors, and of the legislators when ultimate voting comes up*

### **The Periodic Health Examination of Food Handlers**

Int 678

IN ASSEMBLY,

February 3, 1925

Introduced by Mr Samberg—read once and referred to the Committee on Public Health

#### **AN ACT**

To amend the public health law, in relation to sanitation in ractories, stores and shops engaged in the business of selling food.

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Article seventeen-a of chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter five hundred and fifty-two of the laws of nineteen hundred and thirteen," is hereby amended by inserting therein a new section, to follow section three hundred and forty-three-c, to be section three hundred and forty-three-d, to read as follows

§ 343-d Factories, stores and shops for sale of food, food to be examined Every person employed in preparing, packing or otherwise handling articles of food in every factory, store, shop or other place in this state, at the time of entering such employment, and at least every six months periodically thereafter, shall be examined by a physician duly licensed to practice medicine in this state. It shall be the duty of a physician making such examination to furnish a certificate stating whether or not the person examined by him is suffering from a communicable disease Any person suffering from such a disease shall not engage or be employed in the work mentioned in this section Any person, firm or corporation who employs a person who has not been examined as prescribed in this section or whose certificate of examination discloses that he is suffering from such a communicable disease, and any such person who engages in the work mentioned in this section without undergoing the examination required by this section or while suffering from such a communicable disease, shall be guilty of a misdemeanor

§ 2 This act shall take effect immediately

*Comment* Through error this bill was omitted and is now printed for the information of the profession

While theoretically the bill is excellent for the protection of the public health there are only a few of the communicable diseases which might be discovered at each six months' examination

#### **Health Service in Schools**

Assembly Int No 748 (conc Senate Int 302)

—See concurrent Senate Int 302, for digest and comment

#### **Medical Examination in Schools**

Assembly Int No 850 (conc Senate Int. 586)

—See concurrent Senate 586 for digest and bill printed.

#### **Physically Handicapped Persons**

Assembly Int. No 868 (conc Senate 671)—

See concurrent Senate 671 for digest and printed bill

#### **Regulating Sale of Wood or Methanol Alcohol**

Assembly Int No 908—A bill introduced in the Assembly by Assemblyman Frank H Lattin of Orleans County, would add new sections 416, 447, 447-a Penal Law, forbidding sale of wood or methyl alcohol except as methanol, and making it a felony to sell goods or drink or medicinal or toiled preparations for internal use in which there is methanol.

Referred to Codes Committee

*Comment* It is to be hoped that this bill will find a concurrent number in the Senate and see the light of day

#### **Relative to Those Who Have Received Licenses in Other States**

Assembly Int No 925—A bill introduced in the Assembly by Assemblyman Edward J Coughlin of Brooklyn, N Y, would amend section 169, Public Health Law, relative to licenses to practice medicine who have received the license in another state

Referred to Public Health Committee

No further comment as yet

#### **Rural Hygiene**

Assembly Int No 969 (conc Senate Int. 716)

—See concurrent Senate Int 716 for digest

#### **Dissection of Dead Bodies**

Assembly Int No 986 (conc Senate Int 681)

—See concurrent Senate Int. 681 for digest

#### **The Birth Control Bill**

Assembly Int No 987—A bill introduced in the Assembly by Assemblyman John Boyle, Jr, of Suffolk County, would amend section 1145,

holder to the use of the word "chiropractic" or "licensed chiropractor"

It will be seen that more and more those who would hurdle the present law must come up to reasonable requirements in preliminary education, to reasonable requirements in health and education along the basic lines of science, to be graduates of real schools or colleges if there be such who are honestly teaching the basic laws of science and yet who believe in the all-curative thought of this cult, following this thought fanatically as in the history of other cults

It is a safe prediction for one to make that eventually those who have studied the basic principles of medicine and have been licensed as medical practitioners and who have honestly believed, though perhaps deluded in mind, special cult practice followed by some, whatever it may be, will declare themselves and come out with a demand that all of their specialist brother and sister practitioners shall take the same road which they traveled, but perhaps with minor exceptions, and arrive at their journey's end in an honest, legal and definite manner such as to win approbation not alone of the lay people, but of all scientific groups

#### **Health Service in Schools**

Assembly Int No 127—Referred to Public Education Committee

*Comment* This bill is slowly moving though no concurrent bill has appeared in the Senate and as a consequence must be watched with keen sight and be opposed vigorously by County Legislative Chairmen as has been suggested before

#### **Practical Tests of Injured Persons**

Assembly Int No 184 (conc Senate Int 647)  
—See concurrent Senate Int 647 for digest and comment

#### **The Nicoll Chiropractic Bill**

Assembly Int No 185—A bill introduced in the Assembly by Assemblyman William Nicoll of Schenectady County, would define and regulate the practice of chiropractic

Referred to Public Health Committee

*Comment* See other chiropractic bills for comment

#### **The Narcotic Bill**

Assembly Int No 215 (conc Senate Int 115)  
—See concurrent Senate Int 115 for digest and comment

#### **Requiring the Licensing of Private Institutions for the Treatment of Drug Addicts**

Assembly Int No 216 (conc Senate Int 116)  
—See concurrent Senate Int 116 for digest and comment

#### **Supervising Education of Children With Retarded Mental Development**

Assembly Int No 229—A bill introduced in the Assembly by Assemblyman A Spencer Feld of New York County, would add new section 579a Education Law, providing for county supervisors to supervise education of children with retarded development

Referred to Public Education Committee

No further comment

#### **Empowering State Charities Board to Inspect Children's Institutions**

Assembly Int No 236 (conc Senate Int 228)  
—See concurrent Senate Int 228 for printed bill and comment

#### **Free Choice of Physician**

Assembly Int No 301 (conc. Senate Int. 594)  
—See Senate concurrent No 594 for printed bill and comment

#### **The State Department of Education Bill Amending the Medical Practice Act**

Assembly Int No 307 (conc Senate Int 211)  
—See concurrent Senate Int 211 for digest and comment

#### **County Public Health Nurses**

Assembly Int No 399 (conc Senate Int. 283)  
—See concurrent Senate Int 283 for digest and comment

#### **Disclosure of Confidential Communications**

Assembly Int No 422—A bill introduced in the Assembly by Assemblyman Samuel Rosenman of New York County would amend section 352, Civil Practice Act, by providing physicians and nurses may disclose professional information as witnesses in action to annul marriage on ground of fraud

Referred to Codes Committee

*Comment* It is again asked if the County Chairmen have written to the Assembly Codes Committee as requested in opposition to the bill

#### **Free Choice of Physician**

Assembly Int No 570 (conc Senate Int 380)  
—See concurrent Senate Int 380, for digest and comment

#### **The Chiropractic Bill**

Assembly Int No 649—A bill introduced in the Assembly by Assemblyman Burton D Esmond of Saratoga County would amend sections 164, 169, 170, 173, adding new article 8-b, Public Health Law, relative to the practice of medicine and to chiropractic

Referred to Public Health Committee

*Comment* Again your Committee on Legislation would call attention to the fact that *extreme caution and precise care must be used by*



§ 4 Section three hundred and eighty-five of such chapter, as added by chapter six hundred and nineteen of the laws of nineteen hundred and thirteen, is hereby amended to read as follows

§ 385 Registration of physicians, midwives, and undertakers Every physician, midwife and undertaker shall, on or before the day on which this article takes effect, register his or her name, address and occupation with the registrar of the district in which he or she resides, and shall so register in any district in which he or she may hereafter establish a residence *or maintain an office*, and shall thereupon be supplied by the registrar with a copy of this article, together with such rules and regulations as may be prepared by the public health council relative to its enforcement Within thirty days after the close of each calendar year each registrar shall make a return to the State Commissioner of Health of all physicians, midwives, [or] *and* undertakers who have been registered in his district during the whole or any part of the preceding calendar year, provided, that no fee or other compensation shall be charged by registrars to physicians, midwives or undertakers for registering their names under this section or making returns thereof to the State Commissioner of Health

§ 5 Section three hundred and eighty-seven of such chapter, as added by chapter six hundred and nineteen of the laws of nineteen hundred and thirteen and amended by chapter four hundred and fifteen of the laws of nineteen hundred and twenty-two, is hereby amended to read as follows

§ 387 Records to be kept by State Commissioner of Health The State Commissioner of Health shall prepare, print, and supply to all registrars all blanks and forms used in registering, recording and preserving the returns, or in otherwise carrying out the purposes of this article, and shall prepare and issue such detailed instructions, not inconsistent with the regulations established by the public health council, as may be required to procure the uniform observance of its provisions and the maintenance of a perfect system of registration, and no other blanks shall be used than those supplied by the State Commissioner of Health He shall carefully examine the certificates received monthly from the registrars, and if any such are incomplete or unsatisfactory he shall require such further information to be supplied as may be necessary to make the record complete and satisfactory All physicians, midwives, undertakers, or informants, and all other persons having knowledge of the facts, are hereby required to supply, upon a form provided by the State Commissioner of Health or upon the original certificate, such information as they may possess regarding any birth or death upon demand of the State Commissioner of Health, in person, by mail, or through the registrar, provided, that no certificate of birth or death, after its acceptance for registration by the registrar,

and no other record made in pursuance of this article, shall be altered or changed in any respect otherwise than by amendments properly dated, signed and witnessed The State Commissioner of Health shall arrange, and permanently preserve the certificates in a systematic manner, and shall prepare and maintain a comprehensive and continuous typewritten or printed index of all births and deaths registered, said index to be arranged alphabetically, in case of deaths, by the names of decedents, and in the case of births, by the names of fathers or mothers if born out of wedlock. He shall inform all registrars what diseases are to be considered infectious, contagious, or communicable and dangerous to the public health, as decided by the public health council [in order that] *and* when deaths occur from such diseases *the registrar shall forthwith report to the local health officer, on a form provided for the purpose, the name, age, and address of the deceased, together with the disease, and the name of the physician who has certified the cause of death, so that proper precautions may be taken to prevent their spread*

§ 6 Section three hundred and eighty-nine of such chapter, as added by chapter six hundred and nineteen of the laws of nineteen hundred and thirteen, and last amended by chapter one hundred and sixty-eight of the laws of nineteen hundred and twenty-four, is hereby amended to read as follows

§ 389 District records to be kept by registrar Each registrar shall supply blank forms of certificates to such persons as require them Each registrar shall carefully examine each certificate of birth or death when presented for record in order to ascertain whether or not it has been made out in accordance with the provisions of this act and the instructions of the State Commissioner of Health, and if any certificate of death is incomplete or unsatisfactory, it shall be his duty to call attention to the defects in the return, and he may withhold the burial or removal permit until such defects are corrected All certificates, either of birth or death, shall be written legibly, in durable black ink, and no certificate shall be held to be complete and correct that does not supply all of the items of information called for therein, or satisfactorily account for their omission If the certificate of death is properly executed and complete, he shall then issue a burial or removal permit to the undertaker, provided, that in case the death occurred from some disease which is held by the public health council to be infectious, contagious, or communicable and dangerous to the public health, no permit for the removal or other disposition of the body shall be issued by the registrar, except to an undertaker licensed under section two hundred and ninety-five of the public health law, under such conditions as may be prescribed by the state public health council If a certificate of birth is incomplete, the local regis-

Penal Law, by permitting use of instruments for contraceptive treatment of married persons

Referred to Codes Committee

*Comment* It is asked that the County Legislative Chairmen register their disapproval to this measure

A hearing has been called for March 17th

#### Laboratory Supplies

Assembly Int No 1167 (conc Senate Int 943)  
—A bill introduced in the Assembly by Assemblyman Frank H Lattin of Orleans County, would amend section 5, Public Health Law, by providing institutions and persons using laboratory supplies shall furnish clinical data and report or pay market prices and fees therefore

Referred to Public Health Committee

*Further Comment* See concurrent Senate Int. 943 for comment

#### Vital Statistics

Int 1321

February 27, 1925

#### AN ACT\*

Introduced in the Assembly by Mr Lattin

To amend the public health law, in relation to vital statistics

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section three hundred and seventy-two of chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," as added by chapter six hundred and nineteen of the laws of nineteen hundred and thirteen, and last amended by chapter two hundred and thirteen of the laws of nineteen hundred and nineteen, is hereby amended to read as follows

§ 372 Registration districts The State shall be divided into registration districts as follows Each city, each incorporated village, and each town, [and each state hospital, charitable or penal institution] shall constitute a primary registration district, provided that the State Commissioner of Health may combine two or more primary registration districts or divide one registration district into two or more primary districts to facilitate registration [,] and he may establish any state hospital, charitable, or penal institution as a primary district When a district is divided into two or more primary registration districts, the appointment of a registrar for each shall be made by the same appointed authority which had jurisdiction over the original district, excepting in the instance of a state hospital, charitable, or penal institution, the registrar for which shall be the superintendent or person in charge as provided in section three hundred and seventy-three

of this chapter When two or more primary districts are combined, the registrar for such combined district shall be appointed at a joint session of the authorities which heretofore made the appointment of registrars of the original districts

Remuneration and expenses of registrars of of districts which have been divided into two or more primary registration districts shall be paid by the municipality comprising the original district, except that the registrar of a state hospital, charitable, or penal institution shall receive no additional remuneration for acting as registrar

Remuneration and expenses of registrars of combined districts shall be paid by the municipalities comprising such districts in proportion as each would be required to compensate a separate registrar for its own district, except that when such combined districts coincide with a consolidated health district the remuneration and expenses of the registrar shall be paid by the consolidated health board of such district as provided by section twenty of chapter three of the public health law

§ 2 Section three hundred and seventy-six of such chapter, as added by chapter six hundred and nineteen of the laws of nineteen hundred and thirteen, is hereby amended to read as follows

§ 376 Registration of stillborn children A stillborn child shall be registered as a birth and also as a death, and separate certificates of both the birth and the death shall be filed with the registrar of vital statistics in the usual form and manner, the certificate of birth to contain in place of the name of the child, the word "still-born", provided, that a certificate of birth and a certificate of death shall not be required for a child that has not advanced to the fifth month of uterogestation *The State Commissioner of Health may furnish a combined birth and death certificate for the recording of stillbirths and may require it to be used instead of the separate birth and death certificates* The medical certificate of the cause of death shall be signed by the attending physician, if any, and shall state the cause of death as "stillborn," with the cause of the stillbirth, if known, whether a premature birth, and, if born prematurely, the period of uterogestation, in months, if known, and a burial or removal permit of the prescribed form shall be required Midwives shall not sign certificates of death for stillborn children, but such cases, and stillbirths occurring without attendance of either physician or midwife shall be treated as death without medical attendance, as hereinafter provided in this article

§ 3 Subdivision twenty-one of section three hundred and eighty-three of such chapter, as added by chapter six hundred and nineteen of the laws of nineteen hundred and thirteen, is hereby amended to read as follows

21 Number of children of this mother [living] born alive, stillborn, and total now living

\* Matter in italics is new matter in brackets [ ] is old law to be omitted

may, upon request, supply to any applicant a certified copy of the record of any birth or death registered under the provisions of this act, for the making and certification of which he shall be entitled to a fee of one dollar, to be paid by the applicant, provided that the United States census bureau may obtain, without expense to the state, transcripts of certified copies of births and deaths without payment of fee here prescribed, for use solely as statistical data. Any copy of the record of a birth or death, when properly certified by the state commissioner of health or person authorized to act for him shall be prima facie evidence in all courts and places of the facts therein stated. For any search of the files and records when no certified copy is made, the state commissioner of health shall be entitled to a fee of fifty cents for each hour or fractional part of an hour of time of search, said fee to be paid by the applicant.

If at any time after the birth, or within one year of the death of any person within the state, a certified copy of the official record of said birth or death with the information required to be registered by this act, be necessary for legal, judicial, or other proper purposes and, after search by the state commissioner of health or his representative, it should appear that no such certificate of birth or death was made and filed as provided by this act, then the [person asking for such certified copy may file a sworn statement, to be accompanied by the affidavits of two competent witnesses, as to the fact of birth or death, with as many particulars of the standard certificate supplied as possible, and the state commissioner of health shall file it and issue a certified copy thereof to said applicant without fee and without charge for time of search, and the] state commissioner of health shall immediately require the physician, or midwife, who, being in attendance upon a birth since the date of the taking effect of this act, failed or neglected to

file a certificate thereof or the undertaker, or other person who having charge of the interment or removal of the body of the deceased person since the date of the taking effect of this act, failed or neglect to file the certificate of death, if he or she be living to obtain and file at once with the local registrar such certificate in as complete form as the lapse of time will permit, together with a fee of five dollars, which shall be transmitted to the state commissioner of health and accounted for as a fee for certified copies. With said certificate shall be filed [the] such sworn statements [and] or affidavits [hereinafter mentioned] as may be required by the state commissioner of health. The delinquent physician, midwife, undertaker, or other person may also, in the discretion of the state commissioner of health be prosecuted as required by this article, and shall be prosecuted without bar from the statute of limitations, if he or she shall neglect or fail to file promptly the certificate required by this section [as a substitute for the certificate not filed as required by this article,] and to pay the filing fee provided for in this section.

*If the physician, midwife, or undertaker responsible for the report, is deceased or cannot be located, then the person making application for the certified copy of the record may file such certificate of birth or death together with such sworn statements and affidavits as the state commissioner of health may require, and the state commissioner of health shall file it and issue a certified copy thereof to said applicant without fee and without charge for time of search.*

The state commissioner of health shall keep a true and correct account of all fees by him received under this section, and turn the same over to the state treasurer.

§ 9 This act shall take effect immediately.

No comment, printed for the information of the profession.

## HEARINGS

Wednesday, March 4th

Senate Int 211 (conc. Assembly Int 307)—  
Medical Practice Act (Karle-Dunmore)  
Senate Int 473—Drugless Therapy (Gibbs)  
Assembly Int No 649—Chiropractic Bill (Esmond)  
Assembly Int No 185—Chiropractic Bill (Nicoll)  
Senate Int 789—Chiropractic Bill (Bouton)  
Senate Int 944—Chiropractic Bill (Fearon)  
Senate Int 671 (Assembly No 868)—Physically handicapped persons (Cole-Boyle)

Wednesday, March 11th

Senate Int 308 (conc Assembly Int No 386)  
Workmen's comp Silirosis (Truman and Miller, CP)  
Senate Int 380 (conc Assembly Int No 570)

—Workmen's comp medical attendance (Farrell and Dunne)

Senate Int 594 (conc. Assembly Int No 301)

—Workmen's comp medical attendance (Love and Lattin)

Senate Int 647 (conc Assembly Int No 184)

—Workmen's comp physical exams (Johnson and Miller, F A.)

Assembly Int No 152—Workmen's comp medical service (Weinfeld)

Assembly Int No 203—Workmen's comp skin infection (Reich)

Assembly Int No 204—Workmen's comp silica dust (Reilly)

Assembly Int No 233—Workmen's comp time, file claim (Kammerer)

Assembly Int No 987—Penal Law, contraceptive treatment (Boyle)

trar shall immediately notify the informant, and require him to supply the missing items of information if they can be obtained. He shall number consecutively the certificates of birth and death, in two separate series, beginning with number one for the first birth and the first death in each calendar year, and sign his name as registrar in attest of the date of filing in his office. He shall also make a complete and [accurate] *accurate* copy of each birth and each death certificate registered by him in a record book supplied by the State Commissioner of Health, to be preserved permanently in his office as the local record, in such manner as directed by the State Commissioner of Health. Within ten days after receiving the certificate of any legitimate birth he shall furnish to the parents or guardian of the child a certificate of registration, to be made out on a form which shall be furnished by the State Commissioner of Health, [except that the issuance of such certificate of registration may be postponed until the child's given name is also registered,] and such certificate of registration shall be accepted by public authorities in this state for the purposes indicated in section three hundred and eighty-eight of this chapter in the same manner as certified copies of birth certificates, he shall also make a notation on his copy of the original birth certificate indicating the date of issuance of such certificate of registration. He shall, on the fifth day of each month transmit to the State Commissioner of Health all original certificates registered by him for the preceding month [ ] *and also any delayed certificates registered by him during the month.* If no births or no deaths occurred in any month, he shall on the fifth day of the following month, report that fact to the State Commissioner of Health on a card provided for such purpose.

*A local registrar may charge a fee of twenty-five cents for a search or fifty cents for a verified transcript of any record of a birth or death recorded in his district, provided, however, that no fee shall be charged for certifications or transcripts to be used for school entrance, employment certificates, or for purposes of government compensation.*

Each registrar shall transmit weekly to the district health officer, if such registrar's primary district is included as part of a general health district established under section twenty-b of article three of this act, on a form or forms to be designed and furnished by the state commissioner of health, a report of the number of births, stillbirths, deaths under one year of age, and total deaths from all causes, and the number of deaths from each disease declared reportable in the state sanitary code, which have been registered in such primary registration district. Such weekly report shall be transmitted to the district health officer on each Saturday morning for the births, stillbirths, and deaths which have been registered during the seven preceding days,

and if no births or deaths have been registered he shall report to this effect. Each registrar shall be paid by the board of health of the general health district twenty cents for each complete weekly report promptly transmitted, for each district which such registrar serves, and such compensation shall be paid annually upon certification by the district health officer to the board of health.

§ 7 Section three hundred and ninety of such chapter as added by chapter six hundred and nineteen of the laws of nineteen hundred and thirteen and last amended by chapter two hundred and thirteen of the laws of nineteen hundred and nineteen, is hereby amended to read as follows:

§ 390 Fees of registrar for the prompt and correct return and filing of birth and death certificates, except as hereinbefore otherwise provided each registrar and each physician and each midwife shall be paid the sum of twenty-five cents for each birth certificate properly and completely made out and registered and each death certificate properly and completely made out in accordance with the international list of causes of death and returned and filed with the registrar and correctly recorded and promptly returned by him to the state commissioner of health, as required by this article. And in case no births or no deaths were registered during any month, the local registrar shall report to that effect. Each local registrar shall be paid the sum of two dollars for a *complete* monthly report to be transmitted on the fifth day of the following month to the state commissioner of health on such form as may be provided or required by the commissioner. All amounts payable to the local registrar under the provisions of this article shall be paid by the municipality comprising the registration district, upon certification by the state commissioner of health and all amounts payable to physicians and midwives shall be certified to by the local registrar annually and paid to said physicians and midwives by said municipality. The state commissioner of health shall annually certify to the municipality the number of births and deaths properly registered, *and of complete monthly reports promptly transmitted*, with the name of the local registrar and the amount due him at the rate fixed herein. In addition thereto the local registrar shall be paid a fee of twenty-five cents for each burial, removal or transit permit issued by him.

§ 8 Section three hundred and ninety-one of such chapter, as added by chapter six hundred and nineteen of the laws of nineteen hundred and thirteen and amended by chapter three hundred and ninety-eight of the laws of nineteen hundred and twenty-one, is hereby amended to read as follows:

§ 391 Certified copies of records, state commissioner of health to furnish. The state commissioner of health or person authorized by him

## THE GORGAS MEMORIAL

The Gorgas Memorial Institute of Tropical and Preventive Medicine, which is making an appeal for a \$5,000,000 Endowment of the public

this winter has on its New York Governing Committee the following well-known members of the medical profession

### NEW YORK STATE GOVERNING COMMITTEE

GOVERNOR ALFRED E. SMITH, *Honorary Chairman*

#### ALBANY

Harold D. Cochrane  
J. Ivimey Dowling  
Arthur B. Van Loon  
Albert Vander Veer  
Edgar Vander Veer

#### AUBURN

Frederick A. Lewis

#### BINGHAMTON

Arthur S. Chittenden

#### BROOKLYN

Herbert C. Allen  
Bruno W. Bierbauer  
William W. Blackman  
Martin L. Bodkin  
W. F. Campbell  
George E. Deely  
A. A. de Yoanna  
Charles Eastman  
M. J. Fein  
G. Garthwaite Fisher  
Edwin H. Fiske  
Emil Goetsch  
Charles A. Gordon  
Onslow A. Gordon, Jr.  
Magnus Tate Hopper  
O. P. Humpstone  
Frank D. Jennings  
John D. Jennings  
Earl H. Mayne  
John O. Polak  
Jacques Rushmore  
Leo S. Schwartz  
James S. Waterman

#### BUFFALO

John L. Butsch  
Charles Cary  
Chester C. Cott  
James E. King  
Earl P. Lothrop  
Irving W. Potter  
Charles G. Stockton  
Grover W. Wende  
Thew Wright

#### GLOVERSVILLE

Burlin G. McKillip

#### JAMAICA

George K. Meynen

#### JAMESTOWN

Charles E. Goodell

#### MIDDLETON

Charles L. Redfield

#### MT. KISCO

George Tucker Harrison

#### NEW YORK CITY

Fred H. Albee  
Harry Aranow  
Arthur S. Armstrong

Julius Auerbach  
Charles G. Bandler  
S. W. Bandler  
Anthony Bassler  
Abraham J. Beller  
Dougal Bissell  
Robert E. Brennan  
George E. Brewer  
Walter M. Brickner  
Harlow Brooks  
Aaron Brown  
Samuel A. Brown  
Leo Buerger  
W. E. Caldwell  
G. N. B. Camac  
R. J. Carlisle  
Louis Casamajor  
C. H. Chetwood  
John W. Churchman  
A. Schuyler Clark  
Henry Coggeshall  
Lewis G. Cole  
William B. Coley  
Royal S. Copeland  
Wm. L. Culbert  
Edward R. Cunniffe  
Thos. H. Curtin  
Asa Barnes Davis  
F. M. Dearborn  
N. L. Deming  
W. H. Dieffenbach  
William E. Doid  
Arthur B. Ducl  
W. Meddaugh Dunning  
Francis C. Edgerton  
Charles A. Elsberg  
John F. Erdmann  
Ernest Fahnestock  
Lilian K. P. Farrar  
E. Ross Faulkner  
Israel L. Feinberg  
Hermann Fischer  
E. Rodney Fiske  
F. J. C. Fitzgerald  
Austin Flint  
Nellis B. Foster  
Alexander Fraser  
H. W. Frauenthal  
Isidore Friesner  
William V. P. Garretson  
Samuel H. Geist  
H. Rawle Geyelin  
J. Henry Guntzer  
Graeme M. Hammond  
W. H. Haslan  
Louis Hauswirth  
Harold M. Hays  
William P. Healy  
Alfred M. Hellman  
James P. Hennessy  
Alfred F. Hess  
Russell A. Hibbs  
W. F. Honan  
Abraham Hyman  
H. M. Imboden  
Frank N. Irwin

Simon M. Jacobs  
C. F. Jellinghaus  
John L. Kantor  
Foster Kennedy  
Edward L. Kejes  
Edward A. King  
Thomas J. Kerwin  
Samuel Kleinberg  
F. H. Knight  
L. Winfield Kohn  
Samuel J. Kopetzky  
Louis J. Ladin  
Alexander Lambert  
Samuel W. Lambert  
Walter Eyre Lambert  
Richard Lewsohn  
Emanuel Libman  
Howard Lilienthal  
Ralph W. Lobenstein  
Oswald S. Lowesley  
William C. Lusk  
G. M. MacKee  
W. J. MacNeal  
Duncan Macpherson  
Walton Martin  
W. R. May  
J. L. Maybaum  
J. F. McCarthy  
John McCoy  
W. C. McFarland  
John F. McGrath  
Charles A. McKendree  
James F. McKernon  
C. A. McWilliams  
Harold D. Mecker  
Willy Meyer  
Samuel Milbank  
Seth M. Milliken  
T. H. Morgan  
Robert T. Morris  
R. L. H. Murphy  
Charles Norris  
Frank R. Oastler  
B. S. Oppenheimer  
John Randolph Page  
Charles H. Peck  
James Pedersen  
V. C. Pedersen  
Hasell S. Phelps  
Charles Phillips  
Wendell C. Phillips  
Edward W. Pinkham  
John B. Rae  
Edwin G. Ramsdell  
Martin Rehling  
E. J. Rhodebeck  
Edward S. Rimer  
Dudley Roberts  
B. L. Robins  
M. R. Robinson  
A. J. Rongy  
Henry Roth  
M. A. Rothschild  
Isidor C. Rubin  
George H. Ryder  
Bernard Sachs

R. H. Sayre  
Gustav Seeligmann  
George H. Semken  
Newton M. Shaffer  
J. F. Sheehan  
H. M. Silver  
William L. Sneed  
Francis W. Sovak  
W. Allen Starr  
DeWitt Stetten  
George David Stewart  
Raymond P. Sullivan  
Rufus E. Stetson  
Mills Sturtevant  
Samuel Swift  
Charles F. Tenney  
B. T. Tilton  
Norman E. Titus  
Fenton B. Turck  
Cornelius J. Tyson  
Henry H. Tyson  
F. T. van Beuren, Jr.  
N. B. Van Eitten  
John C. Vaughan  
John B. Walker  
Charlton Wallace  
Ralph F. Ward  
Wilbur Ward  
George W. Warren  
M. A. Werner  
James N. West  
John M. Wheeler  
J. S. Wheelwright  
A. O. Whipple  
B. H. Whitbeck  
C. M. Williams  
J. F. Williams  
Lucius A. Wing  
A. L. Wolbarst  
Francis C. Wood  
George Woolsey  
John H. Wyckoff  
E. G. Zabriske

#### OLEAN

J. Ross Allen

#### OSISING

C. C. Sweet

#### POUGHKEEPSIE

W. A. Krieger  
James E. Sadler

#### RICHMOND HILL

L. Howard Moss

#### ROCHESTER

Corden T. Graham  
John M. Lee  
J. L. Mangano

#### SYRACUSE

T. L. Deavor

#### TROY

H. C. Gordinier  
F. M. Sulzman

An outstanding feature of this Memorial is that it is to be directed by medical men rather than laymen, the Governing Committee memberships being composed 75 per cent of scientific medical men and 25 per cent of laity

There are two distinct phases of the Gorgas Memorial

#### 1 Research in tropical diseases

The Panama Government in recognition of the splendid work of William Crawford Gorgas in eliminating yellow fever and controlling malaria, thus making possible the Panama Canal, has donated the site and guaranteed a building (estimated at \$750,000) for tropical research. This Institute will be established in the city of

Panama on the Western coast of the Isthmus and the property will adjoin that of the Santa Tomas Hospital, a \$2,000,000 government hospital, which will be available for men and materials

A portion of the income derived from the Endowment Fund will be utilized in carrying on a national health educational campaign which has for its object the development of a close co-operation between the public and the scientific medical profession

A general knowledge of scientific medicine's achievements will secure the recognition of the scientific doctor as the real medical authority in contradistinction to the irregular cultist whose harmful influence is felt in every community



# State Department of Health



## SYPHILIS NOW ACKNOWLEDGED AS ONE OF THE CHIEF CAUSES OF DEATH

Syphilis is the second principal cause of the cardio-vascular diseases, which are now by far the leading causes of death in the United States. Lamb estimated cardiac involvement to be present in 50-75 per cent of all syphilitics.

For generations there has been a reluctance to mention syphilis publicly or openly to give it as the direct cause of various lesions, estimated to constitute as high as one-third of all pathology, or to sign a death certificate giving syphilis as the cause of death. Public health activities to control venereal infections, inaugurated of neces-

sity during the World War, have been instrumental in bringing this "Great Imitator" and the most interesting of diseases, into the open as an infectious, and not necessarily a moral, condition.

Reid, in the *American Journal of Syphilis* for October, 1924, emphasizes that once infection has taken place efforts should be directed to prevent serious cardiac and aortic injuries, and that the disease calls for the careful attention of the whole profession and not merely that of specialists.

## TWO BROTHERS DIE FROM DIPHTHERIA ON THE SAME DAY

The Department has recently received a report on the deaths from diphtheria on the same day of two brothers in one of the cities in the north-western part of the State. According to this history, one of the patients, seven years of age, had symptoms four days before death and three days before a physician was called. In this case the primary site of the disease was in the nose, the larynx being subsequently involved. The physician who saw the patient on the third day of the disease did not make a diagnosis of diphtheria. Another physician was called on the fourth day,

and gave 10,000 units of antitoxin. The report indicates that the parents refused to have antitoxin given the other child, two years of age. The mode of death in both cases, as stated in the report, was respiratory obstruction.

The tragedy in this family adds another to a long list of instances where parents have neglected to call physicians sufficiently early, and the not inconsiderable list of cases in which a more careful examination by the attending physician might have resulted in an earlier diagnosis, with possible saving of life.

## PHYSICIAN FAILS TO TAKE CULTURE OR GIVE ANTITOXIN CHILD DIES

In a second class city in central New York a physician was called to see a case of sore throat on February 3. A greenish gray membrane was present in the throat. According to information received by the Department this physician continued to treat the case during the rest of the week, and although later admitting a knowledge of the desperate condition of the child, did not take a culture or give antitoxin "as the health officer would say it was diphtheria and put a sign on the house." No antitoxin was given "as it weakens the heart and they die when you give

it." The family was told to remain in the house and to allow no visitors. Five days after the child was first seen this doctor advised that a nose and throat specialist be called. The latter immediately made a clinical diagnosis of diphtheria, gave 60,000 units of antitoxin and took a culture which later was reported positive, but the administration of antitoxin had been delayed too long. Despite the efforts of the specialist the child died twelve hours later. Two other children in the family are reported as ill and in both cases positive cultures have been obtained.

## EFFECTIVENESS OF HEALTH TALKS

It is often difficult for people not directly interested in promoting health activities to appreciate the eagerness of the public for accurate and scientific information on health questions. The desire on the part of the masses for authoritative data on the prevention of venereal diseases is shown by the large number of requests for literature that follow each lecture. It is probably due

to the fact that the subject of gonorrhea and syphilis has been taboo for so many years. The public now recognizes these as communicable diseases and understands that their treatment and prevention require controlling measures similar to those that have proved efficacious in the reduction of other contagious diseases.

hand we are not sure of a positive diagnosis with an abnormal "sugar curve" Nephritis, arteriosclerosis, lues, carcinoma, hyperthyroidism, advancing years and other conditions apparently bring about pictures resembling those characteristic of diabetes. The greatest caution is therefore necessary in interpreting them

#### SUMMARY

1 Overindulgence in food and a sedentary mode of life favor the development of "latent diabetes"

2 Hereditary cases of diabetes have been recorded, the children of diabetic parents should be watched carefully

3 The earlier treatment is begun the better is the chance of keeping the disease in check and not having it become severe so as to threaten life in itself or by its complications

4 The best means of early diagnosis is urine analysis, frequently repeated, blood sugar determinations as a diagnostic aid must be interpreted very cautiously

### KINGS COUNTY AGAINST THE MEDICAL PRACTICE ACT OF 1925

Along somewhere in the early part of December, 1924, the newly elected President of the Medical Society of the County of Kings, Dr John E. Jennings, said to the writer "With reference to legislative changes in the Medical Practice Act, especially the re-registration feature, I don't think Kings ought to be satisfied with simply the decision of any one meeting no matter how well or poorly attended. In my opinion we ought to get out a questionnaire to all the physicians in Brooklyn, so I would like you to pick a committee of four others and draw it up"

Promptly I appointed a committee consisting of two strong advocates of annual registration (one a former President of the State Society) and two bitter opponents of registration, annual or any other kind. The proponents of registration opposed a questionnaire claiming "A referendum would be most unfortunate, as a relatively small percentage of the voters will be familiar with the bill." Finally we all agreed to fall back on the January 20th meeting making an extra effort to get a large crowd out.

The night of the meeting was the worst storm of the winter. The attendance was 155. Dr Downing and Dr Rypins of the State Education Department had the floor for over two hours pleading the cause of the Karle-Dunmore 1925 Medical Practice act with its registration features. This was followed by open and very free discussion from the floor led by Dr John O'Reilly, Dr Richard Kevin and Dr Charles Gordon, in the course of which Dr Downing admitted that last year in the closing days of the legislative session the chiropractors had succeeded in amending in the Assembly the Lattin portion of the Carroll-Lattin bill excluding them from the provisions of the act and this had been consented to by the Attorney-General and the State Department of Education. Promptly the Society voted its opposition to the Karle-Dunmore Bill and referred it to the legislative committee. If this committee voted unanimously one way or another, that is for or against the bill, the Society was to stand behind it, whereas if the committee

was split, there was to be a majority and minority report and the whole registration problem would be submitted by mail to the 1,600 members in the Society.

Ten days later the committee met and went carefully over the new matter in the bill, line for line with Judge John Dyer, counsel for the County Society. After long deliberation and free discussion the committee cast one vote in unanimous opposition to the bill.

On February 17th the findings of the committee were reported to the Society at the regular monthly meeting and the report was unanimously adopted by the Society with instructions to send a copy of the same to every County Legislative Chairman, and every County Society in the State, seeking comment and advice.

Thus far I have given a brief outline of how Kings County tries to swing the "Mother Society" by giving over its platform continually and continuously to the advocates of changing the Medical Practice Act and incorporating the—to us—unpleasant features of annual registration, etc but always with the same result. Does the reader know that out of the last nine meetings of our Society covering a period of fourteen months four meetings in their entirety have been given over to one legislative feature only—the Medical Practice act (1924 then 1925)?

In January, 1924, Dr Vander Veer and Dr Rypins appeared before us with a bill which the Society rejected and for which Counsellor Whiteside of the State Society complimented us saying the bill was vicious.

In February, 1924, Dr Wightman and Counsellor Whiteside appeared before us with the Carroll-Lattin bill which we rejected. Later on we asked the Chairman of the Senate Health Committee to take the bill out of committee, and we did this for the sake of unanimity with the State Society. Then we heard about the atrocious amendment excluding chiropractors and we got busy with our own Assemblymen, and we are glad to say every Assemblymen in Kings and Queens Counties (33) voted to re-commut



# NEWS NOTES



## DIABETES MELLITUS IN PERIODIC HEALTH EXAMINATIONS

By HERMAN O MOSENTHAL, M.D.,

NEW YORK CITY

Abstract of the fourteenth lecture in the Symposium on Health Examinations conducted by the Medical Society of the County of New York, given January 27, 1925

During the past forty years the incidence of diabetes mellitus has increased enormously, in the registration area of the United States the death rate per 100,000 of population from diabetes has risen from 28 to 161, while the death rate from all causes diminished during this period. Diabetes in the United States now stands twelfth in numerical order as a cause of death.

The significance of this rise in the diabetic mortality rate is not generally appreciated. The usual explanation given is that our methods of diagnosis and the thoroughness of physical examination have changed for the better to such a degree that our diagnoses have become more accurate. This may be true of the early and mild cases, but surely does not apply to the severely ill and moribund. A simple routine urine analysis reveals the situation now as it did forty years ago. The cause for increased diabetic mortality must be sought in other directions.

Experiences during the world war gave us a very distinct indication that a low caloric diet reduced the incidence of diabetes to a considerable extent, not only that, but the lives of diabetics were prolonged under these circumstances. In France, England and the United States there has been a direct ratio between diabetes on the one hand and the number of calories consumed per capita on the other. In other words, as the dietary habits of a country have become more luxurious, the occupations more sedentary, the nation more prosperous, diabetes has become more prevalent. This in all probability is due to the fact that if a diminished ability to utilize carbohydrates—a "prediabetic condition"—exists in an individual, it is brought to the fore by overeating and underexercising, it is not likely that such habits induce diabetes in anyone not predisposed to it. However, the data we have are a very striking demonstration of the number of potential diabetics among us, they also show that living sensibly and moderately puts less strain upon our carbohydrate digesting functions than over-indulgence in food and an absolutely sedentary life.

*Heredity*—In some families diabetes is a distinctly "hereditary disease." Van Noorden and others have published very interesting examples of this kind. It may be that this idea has been

somewhat exaggerated since it is not to be wondered at, considering the prevalence of diabetes, that about 20 per cent of these sufferers should have an instance of diabetes existing among their forebears. However we may regard this matter, it is a wise precaution to have frequent urine analyses in children of diabetic parents and thus enable us to detect the disease at the earliest possible moment and treat it to the greatest advantage.

*Nervous Strain* will often aggravate an existing diabetes. It is doubtful whether nervous strain or shock in itself can initiate diabetes, the lessened incidence of the disease during the war would bear out this statement.

*The Importance of Early Diagnosis*—In most diabetics the over-strain of sugar-utilizing functions, as evidenced clinically by glycosuria, is followed by a further impairment of carbohydrate digestion. Hence an early diagnosis and prompt treatment may prevent the condition from becoming severe and keep it within the category of mild ailments rather than a life-threatening scourge.

*The Means of Early Diagnosis*—Urine analyses today are easily obtained and if frequently repeated constitute the surest guide to the early detection of diabetes. Such monthly urine examinations, preferably of the afternoon or evening specimens, should be carried out in all suspected cases. No routine physical examination should be considered complete without a urinary test. In my experience the analysis of urine by the patient or prospective patient is to be avoided, such amateur chemists, as well as their immediate families, often become professional neurotics.

A single blood sugar determination taken two hours after breakfast or later in the day may furnish confirmatory evidence of the urinary findings.

The final appeal in diagnosis of diabetes has been and still is the sugar tolerance tests. About 100 grams of glucose are given to the fasting patient. If during two hours the blood sugar returns to the fasting level and at no time during this period rises above 150 mgm. per 100 c.c. we are not dealing with a diabetic. On the other



hand we are not sure of a positive diagnosis with an abnormal "sugar curve" Nephritis, arteriosclerosis, lues, carcinoma, hyperthyroidism, advancing years and other conditions apparently bring about pictures resembling those characteristic of diabetes. The greatest caution is therefore necessary in interpreting them

#### SUMMARY

1 Overindulgence in food and a sedentary mode of life favor the development of "latent diabetes"

2 Hereditary cases of diabetes have been recorded, the children of diabetic parents should be watched carefully

3 The earlier treatment is begun the better is the chance of keeping the disease in check and not having it become severe so as to threaten life in itself or by its complications

4 The best means of early diagnosis is urine analysis, frequently repeated, blood sugar determinations as a diagnostic aid must be interpreted very cautiously

### KINGS COUNTY AGAINST THE MEDICAL PRACTICE ACT OF 1925

Along somewhere in the early part of December, 1924, the newly elected President of the Medical Society of the County of Kings, Dr John E. Jennings, said to the writer "With reference to legislative changes in the Medical Practice Act, especially the re-registration feature, I don't think Kings ought to be satisfied with simply the decision of any one meeting no matter how well or poorly attended. In my opinion we ought to get out a questionnaire to all the physicians in Brooklyn, so I would like you to pick a committee of four others and draw it up"

Promptly I appointed a committee consisting of two strong advocates of annual registration (one a former President of the State Society) and two bitter opponents of registration, annual or any other kind. The proponents of registration opposed a questionnaire claiming "A referendum would be most unfortunate, as a relatively small percentage of the voters will be familiar with the bill". Finally we all agreed to fall back on the January 20th meeting making an extra effort to get a large crowd out

The night of the meeting was the worst storm of the winter. The attendance was 155. Dr Downing and Dr Rypins of the State Education Department had the floor for over two hours pleading the cause of the Karle-Dunmore 1925 Medical Practice act with its registration features. This was followed by open and very free discussion from the floor led by Dr John O'Reilly, Dr Richard Kevin and Dr Charles Gordon, in the course of which Dr Downing admitted that last year in the closing days of the legislative session the chiropractors had succeeded in amending in the Assembly the Lattin portion of the Carroll-Lattin bill excluding them from the provisions of the act and this had been consented to by the Attorney-General and the State Department of Education. Promptly the Society voted its opposition to the Karle-Dunmore Bill and referred it to the legislative committee. If this committee voted unanimously one way or another, that is for or against the bill, the Society was to stand behind it, whereas if the committee

was split, there was to be a majority and minority report and the whole registration problem would be submitted by mail to the 1,600 members in the Society

Ten days later the committee met and went carefully over the new matter in the bill, line for line, with Judge John Dyer, counsel for the County Society. After long deliberation and free discussion the committee cast one vote in unanimous opposition to the bill.

On February 17th the findings of the committee were reported to the Society at the regular monthly meeting and the report was unanimously adopted by the Society with instructions to send a copy of the same to every County Legislative Chairman, and every County Society in the State, seeking comment and advice.

Thus far I have given a brief outline of how Kings County tries to swing the "Mother Society" by giving over its platform continually and continuously to the advocates of changing the Medical Practice Act and incorporating the—to us—unpleasant features of annual registration, etc., but always with the same result. Does the reader know that out of the last nine meetings of our Society covering a period of fourteen months four meetings in their entirety have been given over to one legislative feature only—the Medical Practice act (1924 then 1925)?

In January, 1924, Dr Vander Veer and Dr Rypins appeared before us with a bill which the Society rejected and for which Counsellor Whiteside of the State Society complimented us saying the bill was vicious.

In February, 1924, Dr. Wightman and Counsellor Whiteside appeared before us with the Carroll-Lattin bill which we rejected. Later on we asked the Chairman of the Senate Health Committee to take the bill out of committee and we did this for the sake of unanimity with the State Society. Then we heard about the atrocious amendment excluding chiropractors and we got busy with our own Assemblymen, and we are glad to say every Assemblymen in Kings and Queens Counties (33) voted to re-committ

the bill thereby killing it. We then received a tirade of intolerant abuse from all over the State, but we still think we were right.

Now we come to the Karle-Dunmore bill. The findings of the legislative committee which were unanimously adopted by the Society are printed on page 349 in last week's issue of this Journal, but perhaps some of the points in opposition to the bill need further explanation.

One of the reasons we are told why we should be registered is that nine other professions in this State are registered while doctors and lawyers are not. On investigation we find four professions, dentistry, optometry, podiatry and nursing registered, and in each case licenses are subject to revocation or suspension at the discretion of the Regents for failure of the name to appear on the register. We have always claimed that once we are registered, in a short while the law will be amended as some of the other four were to make the security of a license subordinate to registration. We have a vested right in our State license and no degree of discretionary power under re-registration should be allowed to jeopardize it. Not only that but any one can see that compulsory health insurance would be made easy with compulsory registration a law. Furthermore the honest doctor will be registered and must make an affidavit and pay a fee, but the cults—no.

Still again this registration is supposed to be the one and only way of getting at the cults, yet as I pointed out before, the Lattin bill of last year was amended to exclude chiropractors from its provisions. Who is there to assure me that *this* bill will not be amended at the last moment? Kings County was the child that burned its fingers and we are not going to touch the hot stove again. It is the personal belief of the writer that the chiropractors, very much enheartened by getting in their amendment last year, have purposely introduced the Esmond bill which is the Karle-Dunmore bill with Sections added to it, which is the chiropractic bill, in the confident expectation that at the last minute it will be jammed through giving the State Department of Education its registration of physicians provided the chiropractors are licensed. Certainly they are willing to register annually, pay fees, make affidavits, restore Section 170-d having to do with contraceptive measures in their part of the bill, etc., etc., so long as they are licensed, but what will the price of registration be for us?

Another reason why we should be for this bill is because of the fines imposed which would drive out of the State the illegal practitioners, the cultists, etc. We have legal advice that the fines and penalties imposed are so very severe, cruel, and inhuman it is a question if they would be sustained. It was my privilege to appear before Governor Miller at a hearing on a bill

enforcing the Medical Practice act some three or four years ago, and the penalties were so severe he just threw it out. Again Dr Stanton of Schenectady pointed out some time ago in a little pamphlet he issued, that attempts to enforce laws of this type simply makes martyrs of any prosecuted cult and the reaction of the public to martyrs is only too well known. Then again what will happen to such fines as are collected under this new law? They will be used along with the \$2 fee collected from each of us to administer the new law paying the cost of the head of the new department with the salaries of two or three inspectors for the entire State and whatever office force is necessary, also for a special attorney general. At the end of five years we do not pay any further fee but as the State will have been cleaned up and no more fines can be collected it is the impression of many in Kings County that our fee by amending the law will be increased. In one State, I think it is Virginia, the fee is now \$25. Finally if any money is left over at the end of the year, it is turned over to the State Treasurer. Thus we protect the public health and pay for the privilege of so doing. Not even all of our small \$2 is likely to be used for our benefit as whatever portion of it may be turned over to the State Treasurer is used for some other purpose. The County Society under this bill is "OUT FOR GOOD." Under the present law if a county society prosecutes and is successful, it shares in the profits of the fines imposed. Within the last twelve months in Kings County there has been collected in fines \$500 from illegal practitioners of medicine and \$1,300 from chiropractors. Unfortunately we have not got the protecting reserve fund of five or six thousand dollars needed to be the actual plaintiff and so share in the fines. Our District Attorney is the plaintiff and prosecutor on information furnished by the "Illegal Practitioners Committee."

Section 170c has been taken out of the new bill, but later it is put in again. This section related to abortions. Section 170d has been taken out and put back. This has to do with the use of contraceptive measures. Just as we had supposed, there has been introduced already a birth-control bill permitting the use of contraceptive measures in married persons which will go hand in hand with the removal of Section 170d. Why is it taken out? Our counsel tells us that leaving the section out removes one of the grounds for revocation of license. Why? Why not leave it in if there was no real reason for taking it out?

At the present time lists of practicing physicians are available at the County Clerks offices, from the State Medical Society, from the Board of Regents, and several other sources. In fact Dr Downing tells us that the Department of Education recently checked up a list of 10,000

doctors from the Internal Revenue Department. Nevertheless this new bill will supply each physician with a printed list yearly of the licensed men in his State, and he is then requested to report to qualified authorities the names and addresses of any person known to be practicing medicine whose name does not appear in this registry. In other words, there is to be no initiative by the new board created by this bill. All action is to come from practitioners first, so that after protecting the public health and paying for the privilege we are now to do the detective work or the whole thing may not function!

In conclusion it is the general opinion in Kings

County that this bill gives the public health nothing, not even protection. In Connecticut where they have had registration for years, we were treated to a diploma-mill scandal. It gives the medical profession nothing, and all that it might do is covered by existing law, which is not enforced except in Kings County. Try as hard as we have to look at this bill from every angle, we still believe it is unnecessary, unremedial, and uncalled for.

(Signed) JOSEPH A. DRISCOLL, M.D.  
*Chairman Legislative Committee  
Medical Society, County of Kings*

---

## BRONX COUNTY MEDICAL SOCIETY

A special meeting of the Bronx County Medical Society, held at Hollywood Gardens, 896 Prospect Avenue, on February 4, 1925, was called to order at 9 P. M., the President, Dr. Jacobs, in the chair.

Dr. Allen K. Krause, associate Professor of Medicine, Johns Hopkins University, and Lecturer Trudeau School of Tuberculosis, spoke on "The Historical Relation of Tuberculosis to General Medicine."

It was moved and carried that a vote of thanks be extended to Dr. Krause.

I. J. LANDSMAN, *Secretary*

A regular meeting of the Bronx County Medical Society, held at Hollywood Gardens February 18, 1925. The meeting was called to order at 9 P. M., the President, Dr. Jacobs, in the chair.

Drs. David Berman, Joseph Bronstein, Samuel M. Clurman, Harry J. Lesnick, Benjamin Segal, Jacob H. Landes, Harry Weaver were elected to membership.

Under new business, Dr. Van Etten moved that the Bronx County Medical Society invite the American Medical Association to hold its 1926 meeting in the City of New York. Motion was seconded and carried.

## SCIENTIFIC SESSION

"Relation of County Societies to the State" Society, Joseph S. Lawrence, M.D., Executive Officer Medical Society of the State of New York.

At the conclusion of Dr. Lawrence's discussion of the relationship of the County Societies to the State Society and summary of the bills affecting the medical profession now before the State Legislature, Dr. Gitlow moved that a set of resolutions be drawn up favoring the proposed Medical Practice Act and that these resolutions be forwarded to the *State Journal*, to Governor Smith and to the Legislature signifying our approval of the act. This motion was seconded by Dr. Cunniffe, was put to vote and carried.

"Human Constitution in Relation to Disease," George Draper, M.D., New York City.

Discussion Drs. Herrman, Lukin, Weiskopf and Zuckerman. Dr. Draper closed the discussion.

Dr. Van Etten moved that a vote of thanks be extended to Dr. Draper for his most interesting paper. Seconded and carried, the President, Dr. Jacobs, extended the thanks of the Society to Dr. Draper.

The meeting adjourned at 11 P. M.

I. J. LANDSMAN, *Secretary*

---

## MEDICAL SOCIETY OF THE COUNTY OF GREENE

The meeting was called to order at 8:45 P. M., at the Saulpaugh Hotel. The President in the chair.

Members present: Drs. Honeyford, Willard, Goodrich, Waller, Daley, A. O. Person, R. E. Person, Van Dusen, Van Slyke, and Rapp. Dr. Huntington Williams, District State Health Officer, was guest of the meeting.

The minutes of the last meeting were read for information only.

Dr. Waller, Chairman of the Committee on Legislation, reported on his activities in relation to bills introduced in the State Legislature, particularly in regard to the chiropractic bill introduced by Senator Bouton. Dr. Waller reported that he had already written Senator Bouton.

Dr. Van Dusen introduced the following resolution:

"Resolved, that we the members of the Medical Society of the County of Greene, are unalterably opposed to the chiropractic bill introduced by

the bill thereby killing it. We then received a tirade of intolerant abuse from all over the State, but we still think we were right.

Now we come to the Karle-Dunmore bill. The findings of the legislative committee which were unanimously adopted by the Society are printed on page 349 in last week's issue of this Journal, but perhaps some of the points in opposition to the bill need further explanation.

One of the reasons we are told why we should be registered is that nine other professions in this State are registered while doctors and lawyers are not. On investigation we find four professions, dentistry, optometry, podiatry and nursing registered, and in each case licenses are subject to revocation or suspension at the discretion of the Regents for failure of the name to appear on the register. We have always claimed that once we are registered, in a short while the law will be amended as some of the other four were to make the security of a license subordinate to registration. We have a vested right in our State license and no degree of discretionary power under re-registration should be allowed to jeopardize it. Not only that but any one can see that compulsory health insurance would be made easy with compulsory registration a law. Furthermore the honest doctor will be registered and must make an affidavit and pay a fee, but the cults—no.

Still again this registration is supposed to be the one and only way of getting at the cults, yet as I pointed out before, the Lattin bill of last year was amended to exclude chiropractors from its provisions. Who is there to assure me that *this* bill will not be amended at the last moment? Kings County was the child that burned its fingers and we are not going to touch the hot stove again. It is the personal belief of the writer that the chiropractors, very much enheartened by getting in their amendment last year, have purposely introduced the Esmond bill which is the Karle-Dunmore bill with Sections added to it, which is the chiropractic bill, in the confident expectation that at the last minute it will be jammed through giving the State Department of Education its registration of physicians provided the chiropractors are licensed. Certainly they are willing to register annually, pay fees, make affidavits, restore Section 170-d having to do with contraceptive measures in their part of the bill, etc., etc., so long as they are licensed, but what will the price of registration be for us?

Another reason why we should be for this bill is because of the fines imposed which would drive out of the State the illegal practitioners, the cultists, etc. We have legal advice that the fines and penalties imposed are so very severe, cruel, and inhuman it is a question if they would be sustained. It was my privilege to appear before Governor Miller at a hearing on a bill

enforcing the Medical Practice act some three or four years ago, and the penalties were so severe he just threw it out. Again Dr Stanton of Schenectady pointed out some time ago in a little pamphlet he issued, that attempts to enforce laws of this type simply makes martyrs of any prosecuted cult and the reaction of the public to martyrs is only too well known. Then again what will happen to such fines as are collected under this new law? They will be used along with the \$2 fee collected from each of us to administer the new law paying the cost of the head of the new department with the salaries of two or three inspectors for the entire State and whatever office force is necessary, also for a special attorney general. At the end of five years we do not pay any further fee but as the State will have been cleaned up and no more fines can be collected it is the impression of many in Kings County that our fee by amending the law will be increased. In one State, I think it is Virginia, the fee is now \$25. Finally if any money is left over at the end of the year, it is turned over to the State Treasurer. Thus we protect the public health and pay for the privilege of so doing. Not even all of our small \$2 is likely to be used for our benefit as whatever portion of it may be turned over to the State Treasurer is used for some other purpose. The County Society under this bill is "OUT FOR GOOD." Under the present law if a county society prosecutes and is successful, it shares in the profits of the fines imposed. Within the last twelve months in Kings County there has been collected in fines \$500 from illegal practitioners of medicine and \$1,300 from chiropractors. Unfortunately we have not got the protecting reserve fund of five or six thousand dollars needed to be the actual plaintiff and so share in the fines. Our District Attorney is the plaintiff and prosecutor on information furnished by the "Illegal Practitioners Committee."

Section 170c has been taken out of the new bill, but later it is put in again. This section related to abortions. Section 170d has been taken out and put back. This has to do with the use of contraceptive measures. Just as we had supposed, there has been introduced already a birth-control bill permitting the use of contraceptive measures in married persons which will go hand in hand with the removal of Section 170d. Why is it taken out? Our counsel tells us that leaving the section out removes one of the grounds for revocation of license. Why? Why not leave it in if there was no real reason for taking it out?

At the present time lists of practicing physicians are available at the County Clerks offices, from the State Medical Society, from the Board of Regents, and several other sources. In fact Dr Downing tells us that the Department of Education recently checked up a list of 10,000

doctors from the Internal Revenue Department. Nevertheless this new bill will supply each physician with a printed list yearly of the licensed men in his State, and he is then requested to report to qualified authorities the names and addresses of any person known to be practicing medicine whose name does not appear in this registry. In other words there is to be no initiative by the new board created by this bill. All action is to come from practitioners first so that after protecting the public health and paying for the privilege we are now to do the detective work or the whole thing may not function!

In conclusion it is the general opinion in Kings-

County that this bill gives the public health nothing, not even protection. In Connecticut where they have had registration for years, we were treated to a diploma-null scandal. It gives the medical profession nothing, and all that it might do is covered by existing law which is not enforced except in Kings County. Try as hard as we have to look at this bill from every angle, we still believe it is unnecessary, unremedial, and uncalled for.

(Signed) JOSEPH A. DRISCOLL, M.D.  
*Chairman, Legislative Committee  
Medical Society, County of Kings.*

## BRONX COUNTY MEDICAL SOCIETY.

A special meeting of the Bronx County Medical Society, held at Hollywood Gardens, 896 Prospect Avenue, on February 4, 1925, was called to order at 9 P. M., the President, Dr. Jacobs in the chair.

Dr. Allen K. Krause, associate Professor of Medicine, Johns Hopkins University and Lecturer Trudeau School of Tuberculosis spoke on "The Historical Relation of Tuberculosis to General Medicine."

It was moved and carried that a vote of thanks be extended to Dr. Krause.

I. J. LANDSMAN, Secretary.

A regular meeting of the Bronx County Medical Society, held at Hollywood Gardens February 18, 1925. The meeting was called to order at 9 P. M., the President Dr. Jacobs in the chair.

Drs. David Berman, Joseph Bronstein, Samuel M. Clurman, Harry J. Lesnick, Benjamin Segal, Jacob H. Landes, Harry Weaver were elected to membership.

Under new business Dr. Van Etten moved that the Bronx County Medical Society invite the American Medical Association to hold its 1926 meeting in the City of New York. Motion was seconded and carried.

## SCIENTIFIC SESSION

Relation of County Societies to the State Society. Joseph S. Lawrence, M.D., Executive Officer Medical Society of the State of New York.

At the conclusion of Dr. Lawrence's discussion of the relationship of the County Societies to the State Society and summary of the bills affecting the medical profession now before the State Legislature, Dr. Gitlow moved that a set of resolutions be drawn up favoring the proposed Medical Practice Act and that these resolutions be forwarded to the *State Journal*, to Governor Smith and to the Legislature signifying our approval of the act. This motion was seconded by Dr. Cunniffe, was put to vote and carried.

Human Constitution in Relation to Disease. George Draper, M.D., New York City.

Discussion. Drs. Herman Lukan, Wenskopf and Zuckerman. Dr. Draper closed the discussion.

Dr. Van Etten moved that a vote of thanks be extended to Dr. Draper for his most interesting paper. Seconded and carried, the President Dr. Jacobs, extended the thanks of the Society to Dr. Draper.

The meeting adjourned at 11 P. M.

I. J. LANDSMAN, Secretary.

## MEDICAL SOCIETY OF THE COUNTY OF GREENE.

The meeting was called to order at 8:45 P. M. at the Saulpaugh Hotel. The President in the chair.

Members present: Drs. Honeyford, Willard, Goodrich, Waller, Daley, A. O. Person, R. E. Person, Van Dusen, Van Slyke, and Rapp. Dr. Huntington Williams, District State Health Officer, was guest of the meeting.

The minutes of the last meeting were read for information only.

Dr. Waller, Chairman of the Committee on Legislation, reported on his activities in relation to bills introduced in the State Legislature, particularly in regard to the chiropractic bill introduced by Senator Bouton. Dr. Waller reported that he had already written Senator Bouton.

Dr. Van Dusen introduced the following resolution:

'Resolved that we the members of the Medical Society of the County of Greene, are unalterably opposed to the chiropractic bill introduced by

Senator Bouton, also to any bill to license any one to practice medicine in the State of New York unless he or they have complied with the same educational requirements we have had to, and that a copy of this resolution be sent to Senator Bouton and to Dr Joseph Lawrence for his use at the hearing in Albany"

On motion duly made and seconded the above resolution was adopted as read

Dr Van Dusen made a motion that a copy of the above resolution be sent to the Ulster County Medical Society and to Assemblyman Bentley It was seconded by Dr Rapp and carried

Dr Van Dusen also moved that the president appoint a committee to wait upon the Chairman of the Republican County Committee in regard to this matter, it was seconded by Dr A O Person and carried The President appointed Drs Van Dusen, Rapp and R E Person as such committee

Under the head of unfinished business the Committee appointed to interview the Board of Supervisors relative to the employment of two nurses for the county made their report.

Dr Waller made a motion that the President appoint a committee to draft resolutions on the death of Drs Griffin, Conklin and Jennings, and that they be spread on the minutes and copy sent to the widows It was seconded by Dr Goodrich and carried

The President appointed Drs Rapp, Willard and R E Person as such committee

Dr Williams addressed the Society on the administration of toxin-antitoxin to school children A general discussion followed, most of the members apparently being in favor of it

Dr Waller moved that the meeting be adjourned to the second Tuesday in May and that it be held at Catskill It was seconded by Dr Willard and carried

---

### TOMPKINS COUNTY MEDICAL SOCIETY

The regular meeting of the Tompkins County Medical Society was held in the Chamber of Commerce parlors, Tuesday evening, February 17th, President John W Judd in the chair

A goodly number of members were in attendance, also a number from the Graduate Nurse's Association and from the City Hospital, invitations having been extended to them for this meeting

The minutes of the January meeting were read and approved as read

Following the business session Dr Frank Howard Richardson of Brooklyn presented a paper on "Practical Breast Feeding" Dr Richardson also has had a large experience in the feeding of infants, believes that they should be breast fed if possible, and thinks that a great many more cases can be so fed than is now done

He stated that the mortality in favor of breast feeding over bottle feeding is in the ratio of 1 to 5 The doctor gave in great detail the latest

methods of accomplishing breast feeding in difficult cases and how to promote and maintain the supply of breast milk, and gave demonstrations on three patients presented

The paper and talk was of intense interest and many questions were asked bringing out additional points and discussion

Dr Bertis R Wakeman of Hornell was present and gave an account of his work which he stated had been gaining adherents ever since it was started among doctors, nurses and mothers

Dr J A Conway of Hornell also spoke in favor of the work

Dr L T Genung moved a vote of thanks to the speakers and offered the following resolution, both of which were adopted

*Resolved*, The Tompkins County Medical Society endorses breast feeding as presented by Dr Richardson and hereby requests our State District Health Officer, Dr Conway, to have a nurse sent to us to teach the method

---

### COUNTY MEDICAL SOCIETY BULLETINS

We are pleased to welcome the appearance of two additional Bulletins of County Medical Societies

The Medical Society of the County of Albany began the publication of a four-page "Bulletin" in January, 1925, and we have received the first two numbers Each contains a notice of the coming monthly meeting, and prints comments on medical matters in which the Society is taking an active part It is emphasizing the work of

the Committee on Periodic Health Examinations, and carries a few personal items

The two issues are a credit to the medical profession of Albany and doubtless will have to be enlarged to keep pace with the activities of the Society

The Medical Society of the County of Queens issued Volume 1, number 1 of its "Bulletin," on February 20, 1925 The Bulletin contains eight pages, one of which carries advertisements It

contains a list of the officers and committees of the Society, and a program of the February meeting. It carries an account of the January meeting and a summary of the papers which were read. It also prints extracts from the Principles of Medical Ethics and comments on local medi-

cal affairs, and lightens its pages with a few lines of humor.

The list of County Societies issuing publications regularly is, New York (weekly), Erie, Bronx, Kings, Queens, Albany and Suffolk.

F O

### MEDICAL SOCIETY OF THE COUNTY OF ONEIDA

The annual meeting of the Medical Society of the County of Oneida was held on January 13th, 1925, in the Hotel Utica. The following officers for 1925 were elected: President, Dr. D. E. Pugh, Vice-President, Dr. J. L. Kelly, Rome, Secretary, Dr. William Hale, Jr., Treasurer, Dr. Hyzer W. Jones, Librarian, Dr. T. Wood Clarke, Censors, Dr. G. M. Fisher, Dr. W. B. Roemer, Dr. G. M. Lewis, Vernon, Dr. H. F. Hubbard, Rome, Dr. R. D. Helmer, Delegates to State Society, Dr. G. M. Fisher, Dr. Robert L. Bartlett, alternates, Dr. D. H. Roberts, Dr. E. R. Evans.

Resolutions on the death of Dr. Roy B. Dudley were adopted.

Dr. Owen E. Jones, Rochester, President of the Medical Society of the State of New York, made an able and thoughtful address on the subject of progress in the medical profession. He showed how it is more and more the practice to have periodical examinations thoroughly made of a person to keep them in health, conserve their strength and prolong their days.

Dr. Joseph S. Lawrence, executive officer of the State Society, spoke along similar lines. He

emphasized the necessity of co-operation, and the importance of periodic examinations of patients. There are 9,000 physicians in this state who are giving yearly \$500,000 in free service to the sick poor. He advised the Society to have clinics on certain subjects, and invite specialists to conduct them. All the meetings of the Society should be instructive.

A resolution to increase the annual dues of the Society from \$2.00 to \$10.00 was discussed at length and was finally rejected by a vote of 17 ayes to 36 noes.

A resolution to meet six times a year instead of four times was adopted by unanimous vote. Future meetings will be held in January, March, May, July, September and November.

The Society discussed the need of a sanatorium for the care of incipient tuberculosis. The Society voted to approve the project and appointed the following committee to promote the plan:

Dr. Florence I. Staunton, Utica, Dr. D. M. Allison, Camden, Dr. Roy J. Marshall, Rome, Dr. Stephen L. Taylor, Kenwood.

### THE ASSOCIATED PHYSICIANS OF LONG ISLAND

The twenty-seventh annual meeting of the Associated Physicians of Long Island was held on Wednesday afternoon and evening, January 28th, at the Maitland Club, Brooklyn. The President, Dr. Herbert Dana Schenck, of Brooklyn, presided, and over one hundred members were present. The meeting was opened at 4:30 o'clock with a business session. Twelve new members were admitted. The Secretary reported that the present enrollment was 985 members.

The Treasurer reported that all expenses of the Association had been met and that a balance of over seven hundred dollars remained. It was voted to make the annual dues five dollars in order to insure adequate funds to conduct the *Long Island Medical Journal* in an efficient manner.

The following officers were elected: President, Dr. A. D. Jaques, Lynbrook, Vice-Presidents, Drs. W. A. Sherwood, Brooklyn, L. Howard

Moss, Richmond Hill, Burdge P. MacLean, Huntington, and W. J. Malcolm, Jericho, Secretary, Dr. J. C. Hancock, Brooklyn, Treasurer, Dr. H. C. Courten, Richmond Hill.

The scientific session was opened at five o'clock at which four papers were presented. Dr. John Joseph Nutt, Professor of Orthopedic Surgery at the University and Bellevue Hospital Medical College, New York, gave a practical talk on lower backache from an etiological and therapeutic standpoint. He dwelt especially on the milder lesions of the sacro-iliac joint, and used a medical student to demonstrate the method of examining the joints and the treatment by strapping the pelvis with a circle of adhesive plaster applied just below the crest of the ileum. The talk was extremely practical and useful, for the condition which he described is common and the proper method of treatment is satisfactory.

Senator Bouton, also to any bill to license any one to practice medicine in the State of New York unless he or they have complied with the same educational requirements we have had to, and that a copy of this resolution be sent to Senator Bouton and to Dr Joseph Lawrence for his use at the hearing in Albany"

On motion duly made and seconded the above resolution was adopted as read

Dr Van Dusen made a motion that a copy of the above resolution be sent to the Ulster County Medical Society and to Assemblyman Bentley It was seconded by Dr Rapp and carried

Dr Van Dusen also moved that the president appoint a committee to wait upon the Chairman of the Republican County Committee in regard to this matter, it was seconded by Dr A O Person and carried The President appointed Drs Van Dusen, Rapp and R E Person as such committee

Under the head of unfinished business the Committee appointed to interview the Board of Supervisors relative to the employment of two nurses for the county made their report.

Dr Waller made a motion that the President appoint a committee to draft resolutions on the death of Drs Griffin, Conklin and Jennings, and that they be spread on the minutes and copy sent to the widows It was seconded by Dr Goodrich and carried

The President appointed Drs Rapp, Willard and R E Person as such committee

Dr Williams addressed the Society on the administration of toxin-antitoxin to school children A general discussion followed, most of the members apparently being in favor of it.

Dr Waller moved that the meeting be adjourned to the second Tuesday in May and that it be held at Catskill It was seconded by Dr Willard and carried

---

### TOMPKINS COUNTY MEDICAL SOCIETY

The regular meeting of the Tompkins County Medical Society was held in the Chamber of Commerce parlors, Tuesday evening, February 17th, President John W Judd in the chair

A goodly number of members were in attendance, also a number from the Graduate Nurse's Association and from the City Hospital, invitations having been extended to them for this meeting

The minutes of the January meeting were read and approved as read

Following the business session Dr Frank Howard Richardson of Brooklyn presented a paper on "Practical Breast Feeding" Dr Richardson also has had a large experience in the feeding of infants, believes that they should be breast fed if possible, and thinks that a great many more cases can be so fed than is now done

He stated that the mortality in favor of breast feeding over bottle feeding is in the ratio of 1 to 5 The doctor gave in great detail the latest

methods of accomplishing breast feeding in difficult cases and how to promote and maintain the supply of breast milk, and gave demonstrations on three patients presented

The paper and talk was of intense interest and many questions were asked bringing out additional points and discussion

Dr Bertis R Wakeman of Hornell was present and gave an account of his work which he stated had been gaining adherents ever since it was started among doctors, nurses and mothers.

Dr J A Conway of Hornell also spoke in favor of the work

Dr L T Genung moved a vote of thanks to the speakers and offered the following resolution, both of which were adopted

*Resolved*, The Tompkins County Medical Society endorses breast feeding as presented by Dr Richardson and hereby requests our State District Health Officer, Dr Conway, to have a nurse sent to us to teach the method

---

### COUNTY MEDICAL SOCIETY BULLETINS

We are pleased to welcome the appearance of two additional Bulletins of County Medical Societies

The Medical Society of the County of Albany began the publication of a four-page "Bulletin" in January, 1925, and we have received the first two numbers Each contains a notice of the coming monthly meeting, and prints comments on medical matters in which the Society is taking an active part It is emphasizing the work of

the Committee on Periodic Health Examinations, and carries a few personal items

The two issues are a credit to the medical profession of Albany and doubtless will have to be enlarged to keep pace with the activities of the Society

The Medical Society of the County of Queens issued Volume 1, number 1 of its "Bulletin," on February 20, 1925 The Bulletin contains eight pages, one of which carries advertisements It





# THE DAILY PRESS



Very few items on the oyster situation now appear in the daily press, but now and then a newspaper follows up the situation with comments on the constructive remedies which have been undertaken in order to insure the healthfulness of the oysters. The *Ithaca Journal News*, February 18th, contains an editorial which will tend to restore public confidence in shellfish. The editorial says

"Coincident with the publication of this report (of the U S Public Health Service) the oyster growers and dealers announce the organization of a vigilance committee to prevent if possible another winter of oyster-bred typhoid with resultant losses which, the oyster men state, have set them back \$30,000,000 during the recent scare.

"This is the kind of news that makes good reading and inspires the public with confidence and intelligence of big business. The first reaction of the oyster boycott on the oyster men was one of natural resentment and denials. Far better the statement issued by William Fellowes Morgan, Jr, president of the Middle Atlantic Oyster Fisheries, saying, 'We have no criticism to make of that action (Health Department restrictions on the sale of oysters). We don't want to make five cents at the expense of public health'."

"While the oyster growers and retailers will not admit that their product was responsible for the typhoid outbreak, they are formulating a code of ethics. This code will stop production of oysters in areas where water pollution is likely, patrol boats which will be floating bacteriological laboratories will be put in service, while dealers are to be educated in the proper method of handling oysters.

"Oysters offer a highly nutritious form of food, especially rich in iodides that keep healthy the important thyroid gland. Their production should be unhindered by public scares. And in this, the cities that empty sewage into coastal waters are more to blame than the oyster men. Perhaps their vigilance committee to be organized with 'real power and responsibility' will look into this situation."

The February 26th issue of the *Brooklyn Eagle* has a column article on the oyster situation from the point of view of the growers of "Blue Points" on the south side of Long Island. It says

"The fog of depression in the oyster industry is lifting here in the home of the world-famous Blue Point. Public confidence in the edible fitness of the oyster is evidenced by the orders coming in and the carload shipments going out

"The Middle Atlantic Fisheries Association, through its vigilance committee, plans to co-operate with the commission appointed at Washington to set up certain standards and regulations to govern all oyster producers in the country. The result would be the establishment of rules and operating conditions that would be above reproach, placing the handling of the shellfish almost on a par with milk production in cleanliness.

"Under the new dispensation the sanitary conditions of the packing and shucking houses, as applying both to the oysters and to the employees handling them, would be of the best. No oyster would be touched by the hand after its final sterilization and packing for shipment. There would be abundant cleansing facilities in the plants and no containers to be refilled that were not of a shape and size easily rinsed out.

## CODE OF ETHICS GOVERN

"The members of the commission appointed in Washington to draw up the new regulations are Surgeon W H Frost and Dr Lewis Radcliffe for the Federal Government, W H Raye and W H Kilian for the Shellfish Dealers and Growers' Association of North America, and Drs H B Costill (New Jersey), J M Fulton (Maryland), Oscar Dowling (Louisiana) and A T McCormick (Kentucky), representing the health departments of their respective States.

"This body will meet in the near future to map out plans to set up standards of handling oysters on the general basis of the eight points agreed to by the conference. The understanding is that the Public Health Service will back up the rules adopted under laws already on the books empowering it to enforce such a 'code of ethics'."

"P O Mercer, head of the big Blue Points Company, has collected these interesting statistics on the scope of the industry: (1) It is located in 19 States, (2) it employs 67,000 persons, (3) the production amounts to 75,000 tons of food ready for the table in normal times, (4) the underwater area involved is more than 1,000,000 acres that would be unadaptable to any other use.

"Oystermen here, while insisting that the local product cultivated and sold by them has not been exposed to any contagious disease, believe firmly that by the time another season rolls around the confidence of the distant consumer will have been fully restored, and that the new order of things will insure an unqualified clean bill of health from the health officials themselves.

"Furthermore, by another year, it is hoped that a process of so clearly identifying the source

Dr Dudley Roberts, of New York, described the serious symptoms produced by the spasm of the union of the esophagus and the stomach and the brilliant results of the simple dilation of the dilating the cardio-spasm under direct fluoroscopic vision

Dr Harold E P Pardee, of New York, read a paper on precordial pain and its relief by removal of the cervical sympathetic ganglia Dr Pardee said that the condition which he described might be called angina pectoris, but the term included a number of different conditions He gave the histories of a number of cases on whom the operation had been done and the object of the operation is to relieve pain, and the results varied from satisfactory to no relief

Dr John E Jennings, of Brooklyn, showed a specimen consisting of about six inches of nerve and ganglia which he had removed from a patient that afternoon

Dr Charles H Peck, of New York, described the surgical aspect of gastric and duodenal ulcer

At seven o'clock the scientific meeting adjourned and the members at once assembled for a dinner in the dining-room In the after-dinner speaking Dr John E Jennings, President of

the Medical Society of the County of Kings, described the educational work of the Society, the Rev John L Davis, of New York, gave an amusing and inspirational address on the Dimensions of Life—its length and breadth, and Judge George W Martin, of Brooklyn, gave some of the merciful principles which actuated him in sentencing prisoners

The Associated Physicians of Long Island is entirely independent of all other medical societies It holds three meetings annually and publishes its own monthly paper, the *Long Island Medical Journal*, which is at the service of the four County Medical Societies on Long Island, and is a great factor in promoting their activities The *Journal* also has a list of over three hundred exchanges in thirty-three foreign countries and is often quoted in the medical journals of those countries because it represents the medical thought of the great City of Brooklyn

The Associated Physicians of Long Island is practically the Second District Branch of the Medical Society of the State of New York Joint meetings of the two organizations have been held in the past, and others are planned for the future  
F O

## DINNER TO CELEBRATE FIFTIETH ANNIVERSARY

A dinner will be tendered to Dr Eliza M Mosher of Brooklyn, on Wednesday evening, March 25, at 7 30 at the new Hotel Roosevelt, Madison Avenue and 45th Street

The dinner is to celebrate the 50th Anniversary of Dr Mosher's entrance into the field of medicine About fifty organizations will be represented Among them are the American Women's Hospitals, Brooklyn Women's Club, Brooklyn Chamber of Commerce, Woman's Club of New York, Women's Medical of the State of New York, Women's Press Club, University of Michigan Alumni of New York, and the University of Michigan

Dr Mosher, who is a graduate in medicine of the University of Michigan, has been connected with Michigan University, as Dean of Women, Professor of Hygiene and Home Economics in the Department of Literature, Science and The Arts, as well as Director of Physical Training for Women She has held the position of Resident Physician and Professor of Physiology in Vassar College, and was a Lecturer at Wellesley and Adelphi Colleges

Recently the Brooklyn Chamber of Commerce appointed Dr Mosher Chairman of a "Cleaner Brooklyn Committee"

Among the speakers at the dinner will be Dr Lewis Stephen Pilcher, presiding, Dr W Seaman Bainbridge, Toastmaster, U S Senator Royal S Copeland, who is a graduate of the University of Michigan, Dr Jos E Raycroft of Princeton University, Dr W Francis Campbell of Brooklyn, Dr John E Jennings, President of the Kings County Medical Society, Dr H Noble MacCracken, President of Vassar College, Mr Arthur Somers, Dr Esther Lovejoy, Miss Jessie Bancroft, and Dr Eliza M Mosher

There will be music and college songs by various groups

Mrs Edward H Cross of 140 W 55th Street, New York City, is the Chairman of the Committee, and the Banquet tickets may be obtained from her The Banquet is limited to 500 tickets and it will be necessary to make early reservations to obtain the most desirable locations



# THE DAILY PRESS



Very few items on the oyster situation now appear in the daily press, but now and then a newspaper follows up the situation with comments on the constructive remedies which have been undertaken in order to insure the healthfulness of the oysters. The *Ithaca Journal News*, February 18th, contains an editorial which will tend to restore public confidence in shellfish. The editorial says:

"Coincident with the publication of this report (of the U S Public Health Service) the oyster growers and dealers announce the organization of a vigilance committee to prevent if possible another winter of oyster-bred typhoid with resultant losses which, the oyster men state, have set them back \$30,000,000 during the recent scare.

"This is the kind of news that makes good reading and inspires the public with confidence and intelligence of big business. The first reaction of the oyster boycott on the oyster men was one of natural resentment and demals. Far better the statement issued by William Fellowes Morgan, Jr, president of the Middle Atlantic Oyster Fisheries, saying, 'We have no criticism to make of that action (Health Department restrictions on the sale of oysters). We don't want to make five cents at the expense of public health.'"

"While the oyster growers and retailers will not admit that their product was responsible for the typhoid outbreak, they are formulating a code of ethics. This code will stop production of oysters in areas where water pollution is likely, patrol boats which will be floating bacteriological laboratories will be put in service, while dealers are to be educated in the proper method of handling oysters.

"Oysters offer a highly nutritious form of food, especially rich in iodides that keep healthy the important thyroid gland. Their production should be unhindered by public scares. And in this, the cities that empty sewage into coastal waters are more to blame than the oyster men. Perhaps their vigilance committee to be organized with 'real power and responsibility' will look into this situation."

The February 26th issue of the *Brooklyn Eagle* has a column article on the oyster situation from the point of view of the growers of "Blue Points" on the south side of Long Island. It says:

"The fog of depression in the oyster industry is lifting here in the home of the world-famous Blue Point. Public confidence in the edible fitness of the oyster is evidenced by the orders coming in and the carload shipments going out.

The Middle Atlantic Fisheries Association, through its vigilance committee, plans to co-operate with the commission appointed at Washington to set up certain standards and regulations to govern all oyster producers in the country. The result would be the establishment of rules and operating conditions that would be above reproach, placing the handling of the shellfish almost on a par with milk production in cleanliness.

"Under the new dispensation the sanitary conditions of the packing and shucking houses, as applying both to the oysters and to the employees handling them, would be of the best. No oyster would be touched by the hand after its final sterilization and packing for shipment. There would be abundant cleansing facilities in the plants and no containers to be refilled that were not of a shape and size easily rinsed out.

## CODE OF ETHICS GOVERN

"The members of the commission appointed in Washington to draw up the new regulations are Surgeon W H Frost and Dr Lewis Radcliffe for the Federal Government, W H Raye and W H Kilham for the Shellfish Dealers and Growers' Association of North America, and Drs H B Costill (New Jersey), J M Fulton (Maryland), Oscar Dowling (Louisiana) and A T McCormick (Kentucky), representing the health departments of their respective States.

'This body will meet in the near future to map out plans to set up standards of handling oysters on the general basis of the eight points agreed to by the conference. The understanding is that the Public Health Service will back up the rules adopted under laws already on the books empowering it to enforce such a 'code of ethics'.

"P O Mercer, head of the big Blue Points Company, has collected these interesting statistics on the scope of the industry: (1) It is located in 19 States, (2) it employs 67,000 persons, (3) the production amounts to 75,000 tons of food ready for the table in normal times, (4) the underwater area involved is more than 1,000,000 acres that would be unadaptable to any other use.

"Oystermen here, while insisting that the local product cultivated and sold by them has not been exposed to any contagious disease, believe firmly that by the time another season rolls around the confidence of the distant consumer will have been fully restored, and that the new order of things will insure an unqualified clean bill of health from the health officials themselves.

"Furthermore, by another year, it is hoped that a process of so clearly identifying the source

of shipments will be in force that the practice of substitution among dealers will be wiped out. This has been one of the chief bones of contention among the tongmen in defense of the Great South Bay article. They assert that misleading labels have been used falsely to the discredit of the local product."

---

Troy is now in the midst of a campaign for pure milk. The *Troy Record*, February 17th, contains an editorial comment on a hearing on the milk question before the Common Council, and says

"That public sentiment in this city runs high in regard to the proposed Model Milk Ordinance was definitely proved last night by the tremendous gathering of citizens that attempted first to gain access to the Common Council Chambers in the City Hall and, failing in that, packed the High School auditorium to hear both sides of the argument presented.

"There were two kinds of arguments presented at the hearing last night. The first was the kind that always is heard in such a popular assemblage. Good natured humor and not a little prejudicial oratory was indulged in, and, as is always the case, this expression of sentiment fetched a laugh. Mingled with this was honest conviction that the Milk Ordinance is unnecessary as a health protection. Opposed to these arguments were the hard-and-cold facts offered by men eminent in the medical profession of both the city and the state, proving conclusively that impure milk is one of the contributory causes of Troy's unenviable high infant mortality and conducive to other diseases, and that, being a contributory cause, it should be of a quality that can be safely consumed both by infants and adults. The Council has the facts of the Rensselaer County Medical Society's recent health survey of the county and city, the arguments of other advocates of the ordinances and the endorsements of the ordinance by a large number of civic organizations vitally interested in the health of the city and in a measure designed reasonably to offer a measure of protection in one particular that Troy of all the cities in the state needs most.

"The real question now is whether Troy can longer afford to be without such an ordinance. The situation, long known both in Troy and outside of Troy, demands action. The spirit of progress in Troy to keep in step with other progressive cities, the predominating sentiment in favor of the ordinance expressed at the hearing, and the public health, particularly proper protec-

tion for the infants of this city, unite as a mighty urge to favorable action on the measure by the Honorable members of the Council."

The people of Troy and the physicians of Rensselaer county are evidently taking a deep interest in matters of public health, for in our issue of February 6th, page 245, we quoted a clipping from the *Troy Times* regarding the chlorination of the city water. When a public health movement is started along one line, it is likely to be extended to other health activities.

---

The *Albany Evening News*, February 9th, carries the announcement of a unique physicians' exchange, and says

"A physicians' central telephone exchange has been organized in Albany, to bring into closer contact Albany physicians and their patients.

"The exchange, one of the first to be organized in this section of the United States, will be located at 86 Jay Street, with executive offices at 82 State Street, R. S. Hill, director, announced today. Service will start March 1, according to arrangements now under way.

"The exchange will fill a long want in Albany," Mr. Hill said today, discussing plans of the organization.

"Many times have we heard of illness or accident where a physician could not be reached in time. The central exchange system corrects all these difficulties. When the system is placed in operation March 1, at every minute of the day we will know where every physician or his alternate can be reached. We will know where every nurse can be located and summoned at a minute's notice.

"There will be a trained telephone operator on three eight-hour shifts every day. When a physician leaves his home, his office or club, he will call the exchange and leave a memorandum where he is going. He will keep the exchange informed of his routine.

"This information will be constantly before the operator. Multiple telephone listings now being arranged will give the physician's home, office and exchange number. A card index also will list his alternates and nurses.

"A patient will be able to locate the physician and a nurse in much less time than heretofore.

"In the event of a catastrophe or serious accident in Albany or nearby it would be possible through the exchange to summon every physician and nurse within a few moments.

"All data relative to medical supplies, etc., also will be listed at the exchange to facilitate action in time of emergencies."

## BOOK REVIEWS

**MODERN METHODS IN THE DIAGNOSIS AND TREATMENT OF RENAL DISEASE.** By HUGH MACLEAN, M.D., D.Sc. Second Edition, revised and enlarged. Octavo 110 pages, four colored plates. Phila. and New York, Lea & Febiger, 1924. Cloth, \$2.50.

But few changes appear in the second edition of MacLean's little book on nephritis. The subject is covered in about one hundred pages. It is presented in simple terms. While some of the statements are at least debatable, the reader is impressed, on the whole, with the accurate observation and sound thinking of the author. It should appeal not only to the general practitioner, for whom it was written, but to anyone interested in nephritis. T. H.

**BASAL METABOLISM IN HEALTH AND DISEASE.** By EUGENE F. DUBOIS, M.D. Octavo of 372 pages, illustrated with 79 engravings. Phila. and New York, Lea & Febiger, 1924. Cloth, \$4.75.

An authoritative and comprehensive book on the subject of the basal metabolism and its clinical application has for a long time been greatly needed. The current literature has been exceedingly voluminous, but, nevertheless, no single work of reference has been available. Dr. DuBois has given us a text-book which contains all of the essential facts relating to the clinical study of the basal metabolism. Every phase of this important subject is adequately handled. The writer has attempted to bring basal metabolism out of the realm of pure physiology into the domain of clinical medicine, and he has succeeded.

HENRY M. FEINBLATT

**A STUDY OF MASTURBATION AND ITS REPUTED SEQUELAE.** By JOHN F. W. MEAGHER, M.D., F.A.C.P., Neurologist St. Mary's Hospital, Brooklyn. William Wood and Co., New York, 1924. Price, \$1.50.

With great thoroughness as well as terseness Dr. Meagher has crowded a review of the literature and a practical discussion of this important subject into an extremely small compass. The attitude of the laity as well as of teachers and clergymen, is not always that of the physician and a medical treatise of this kind does much to clarify many factors which are too often veiled in secrecy or enveloped in tradition.

The conclusions reached by the author are interesting, namely that masturbation is not abnormal in children but is distinctly so in adults in whom it shows a psychosexual maldevelopment that sympathy and encouragement are great aids to the patient while censure and punishment are usually harmful. That the problem is more often a psychopathological than a medical and surgical one.

WM. HENRY DONNELLY

**THE CURE OF OBESITY.** By Doctor JEAN FRUMUSAN. Translated from the French by ELAINE A. WOOD. William Wood & Co., New York, 1924. \$2.50.

This is not a scientific volume. It deals at length with the author's own opinions as to the causes of obesity, and he boasts that these opinions are not substantiated by laboratory findings. It seems a little absurd to assert that restriction of diet is not the proper means of approach in treating obesity and then, in a record of treated cases, to outline a diet which even a mild diabetic would think too severe. Nevertheless, the book is interesting and instructive and important in the respect that it repeatedly condemns superalimentation. In a rough way all of the treatments for obesity are described and the author's own system is outlined. Such 'cures' are

not practicable for individuals in this country on account of the lack of electrical equipment. On the whole it may be summed up by saying that it is an interesting little volume not too scientific and not too rational.

L. C. J.

**PEDIATRICS FOR NURSES.** By JOHN C. BALDWIN, M.D., Lecturer in Pediatrics Johns Hopkins Hospital School for Nurses. D. Appleton and Co., New York, 1924.

This textbook is the outgrowth of a series of lectures on Pediatrics given by the author for the past six years at the Johns Hopkins School for Nurses.

Preference is given to the English system of weights and measures as opposed to the metric, since few mothers in this country are familiar with the latter and furthermore practically all scales outside of laboratories are graduated in pounds and ounces.

The same is true of infant feeding as milk is bought in pints and quarts and nursing bottles are graduated in ounces.

Many procedures are employed in the treatment of children which are never used in adults and also many other therapeutic measures are used differently in the child, so that a book on Pediatric Nursing has a definite field of usefulness.

Quite properly the author begins with the Normal Infant and his care, then he takes up the Premature Infant and goes on to a general consideration of Infant Feeding.

Maternal Nursing, Artificial Feeding, and Diet for Older Children are next considered after which the text passes on to Diagnostic Methods and Therapeutics, Diseases Incident to Birth and finally the care of the child in the various diseases.

The care of children forms such an important part of general nursing, and most text books for nurses contain so little matter on the care of children that such a work as this must fill a great need.

WM. HENRY DONNELLY

**GOITER, NON-SURGICAL TYPES AND TREATMENT.** By ISRAEL BRAM, M.D. Instructor, Clinical Medicine, Jefferson Medical College, Phila., Pa. The Macmillan Co., New York, 1924.

The author's wide experience and success in the non-surgical treatment of goiter is the basis of this thorough and complete monograph. Every phase of the subject, anatomy, physiology, pathology, etiology, diagnosis, and classification, symptomatology, and the various signs and signals of insipidity, are definitely described. Goiter is undoubtedly on the increase. Conditions labeled "shell shock," "effort syndrome," "neurocirculatory asthenia," and the like, are, in many instances, early or a typical form of Graves' disease, and often the diagnosis of neurasthenia, hysteria, nervous indigestion, nervous breakdown, phthisis, cardiac neurosis, etc., etc., turn out to be early, formative or borderline cases. The chapters on treatment, hygiene, diet, local measures, and medical treatment are exceedingly precise and instructive, while the chapter on psychotherapy in the management of exophthalmic goiter furnishes practical suggestions in the handling of these difficult cases.

One hundred and fifty reproductions of photographs of goiter cases, most of them "before and after," scattered throughout the four hundred and fifty odd pages of text, help the reader recognize the various types, and enables him to note the improvement, often to complete recovery, careful long-continued treatment produces. A good book for study and reference.

ROBERT ORMISTON BROCKWAY

of shipments will be in force that the practice of substitution among dealers will be wiped out. This has been one of the chief bones of contention among the tongmen in defense of the Great South Bay article. They assert that misleading labels have been used falsely to the discredit of the local product."

Troy is now in the midst of a campaign for pure milk. The *Troy Record*, February 17th, contains an editorial comment on a hearing on the milk question before the Common Council, and says

"That public sentiment in this city runs high in regard to the proposed Model Milk Ordinance was definitely proved last night by the tremendous gathering of citizens that attempted first to gain access to the Common Council Chambers in the City Hall and, failing in that, packed the High School auditorium to hear both sides of the argument presented

"There were two kinds of arguments presented at the hearing last night. The first was the kind that always is heard in such a popular assemblage. Good natured humor and not a little prejudicial oratory was indulged in, and, as is always the case, this expression of sentiment fetched a laugh. Mingled with this was honest conviction that the Milk Ordinance is unnecessary as a health protection. Opposed to these arguments were the hard-and-cold facts offered by men eminent in the medical profession of both the city and the state, proving conclusively that impure milk is one of the contributory causes of Troy's unenviable high infant mortality and conducive to other diseases, and that, being a contributory cause, it should be of a quality that can be safely consumed both by infants and adults. The Council has the facts of the Rensselaer County Medical Society's recent health survey of the county and city, the arguments of other advocates of the ordinances and the endorsements of the ordinance by a large number of civic organizations vitally interested in the health of the city and in a measure designed reasonably to offer a measure of protection in one particular that Troy of all the cities in the state needs most.

"The real question now is whether Troy can longer afford to be without such an ordinance. The situation, long known both in Troy and outside of Troy, demands action. The spirit of progress in Troy to keep in step with other progressive cities, the predominating sentiment in favor of the ordinance expressed at the hearing, and the public health, particularly proper protec-

tion for the infants of this city, unite as a mighty urge to favorable action on the measure by the Honorable members of the Council."

The people of Troy and the physicians of Rensselaer county are evidently taking a deep interest in matters of public health, for in our issue of February 6th, page 245, we quoted a clipping from the *Troy Times* regarding the chlorination of the city water. When a public health movement is started along one line, it is likely to be extended to other health activities

The *Albany Evening News*, February 9th, carries the announcement of a unique physicians' exchange, and says

"A physicians' central telephone exchange has been organized in Albany, to bring into closer contact Albany physicians and their patients

"The exchange, one of the first to be organized in this section of the United States, will be located at 86 Jay Street, with executive offices at 82 State Street, R. S. Hill, director, announced today. Service will start March 1, according to arrangements now under way

"The exchange will fill a long want in Albany," Mr. Hill said today, discussing plans of the organization

"Many times have we heard of illness or accident where a physician could not be reached in time. The central exchange system corrects all these difficulties. When the system is placed in operation March 1, at every minute of the day we will know where every physician or his alternate can be reached. We will know where every nurse can be located and summoned at a minute's notice

"There will be a trained telephone operator on three eight-hour shifts every day. When a physician leaves his home, his office or club, he will call the exchange and leave a memorandum where he is going. He will keep the exchange informed of his routine

"This information will be constantly before the operator. Multiple telephone listings now being arranged will give the physician's home, office and exchange number. A card index also will list his alternates and nurses

"A patient will be able to locate the physician and a nurse in much less time than heretofore

"In the event of a catastrophe or serious accident in Albany or nearby it would be possible through the exchange to summon every physician and nurse within a few moments

"All data relative to medical supplies, etc., also will be listed at the exchange to facilitate action in time of emergencies."

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 9

NEW YORK, N Y

MARCH 13, 1925

## A CASE OF KALA-AZAR IN AN INFANT \*

By MARTHA WOLLSTEIN, M D,

NEW YORK CITY

INFANTILE kala-azar is sufficiently rare, and from the standpoint of international hygiene, sufficiently important, to make the report of a case occurring in an infant in New York City of interest. In 1918, Talbot and Lyon<sup>1</sup> reported a case observed in Boston, a Greek girl, four years old, who recovered after splenectomy, followed by intravenous administration of antimony tartrate. In 1923, Faber and Schuessler<sup>2</sup> detailed the case of an Italian girl, twenty-seven months old, seen in San Francisco, who also recovered after the use of antimony intravenously. The case which is the subject of this paper, the third one of visceral kala-azara infection in children reported in this country, occurred in an Italian boy who died of a complicating noma. The Leishman-Donovan bodies were found in the bone marrow during life and in the liver, spleen and kidneys at autopsy.

The patient was a white boy, twenty-one months old, who had been born in Palermo, Sicily. He was the only child of an Italian physician. The family history was negative and the child had been perfectly well, except for an attack of measles at the age of thirteen months. He was still breast fed at twenty-one months, with the addition of yolk of egg, orange juice and vegetables in small amounts. Ten days before sailing for America, in October, 1923, when the child was eighteen months old, he developed a slight fever, intermittent in type. The temperature was higher at night and in the early morning. This was all that was noticed until five days before he came to the Babies Hospital on January 7, 1924, when a small dark blue spot appeared on the left cheek. This area increased in size until at the time of admission it had become an indurated mass 2 cm in diameter. The skin over it was shiny and discolored. The mucous surface was ulcerated over an area  $1\frac{1}{2}$  by 2 cm. The child was growing thinner and los-

ing appetite. The father said that he was quite certain the child was suffering from Leishmaniasis, having seen the disease in Di Cristina's clinic. He wished to have the diagnosis confirmed by means of a marrow biopsy.

Physical examination showed a well developed and fairly well nourished, but extremely pale boy. The axillary, inguinal, cervical and epitrochlear glands were palpable. The child was not rachitic. There was a foul odor from the mouth. The abdomen was not distended, but the spleen was palpable 5 cm below the costal margin. The liver was not enlarged. There were no abnormal signs in the lungs or heart. Blood examination showed a haemoglobin of 35 per cent, red blood cells 1,400,000, white cells 3,650, polymorphonuclear cells 47 per cent, lymphocytes 25 per cent, transitional and mononuclears 25 per cent, and basophiles 3 per cent. One nucleated red cell was seen to the hundred leucocytes counted. The urine contained a trace of albumin, but nothing else abnormal. Spreads from the ulcer in the mouth showed many fusiform bacilli, a few spirals and many cocci.

Neo-salvarsan was swabbed on the ulceration and was also given intravenously. The child's pallor and anemia remained the same and the ulceration in the mouth seemed to increase. Blood culture gave a negative result.

Two days after admission, Dr Bolling punctured the upper end of the shaft of the left tibia and withdrew some red marrow which was spread on slides. These were stained with Leishman's stain and with Giemsa's stain. Many Leishman-Donovan bodies were found. Some were extracellular, in groups of three to five, some occurred singly, and others were contained in large endothelial cells in groups of five to twelve (Fig 1). One polynuclear leucocyte was seen to contain a single parasite.

The diagnosis having been established, treatment with antimony tartrate was begun. Four cc of a 1 per cent solution were given intravenously. In spite of repeated doses of antimony

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester April 23 1924

† From the Babies Hospital of the City of New York

A TEXTBOOK OF PHYSIOLOGY By H E ROAF, M.D., D.Sc., M.R.C.S., L.R.C.P. Illustrated Longmans, Green & Co., New York, 1924 Price, \$8 50 net.

This book is admirably well written and concise to the point of terseness. It presents many commendable features which should make it of value, not only to the student, but to the general practitioner. It goes a point farther than most books on the subject by giving in detail all experimental data necessary to furnish a proof for the conclusions reached. It stresses particularly the chemistry of the blood and respiration and draws attention to their interpretation in the light of the modern conception of diseased states. In spite of this it is not too highly technical, and should form easy reading matter for the physician, who because of the large demand on his time has been unable to keep up with the more modern trends in physiology.

Of unusual interest is the meritorious effort upon the part of the author to integrate those phenomena which, when studied as separate subjects, are apt to lose their full meaning, and be rather indifferently understood. In this manner the interrelationship between digestion and excretion are clearly brought forward. Likewise the various factors concerned in metabolism are correlated and clearly defined, so that instead of remaining an abstract definition in the mind of the reader, he regards metabolism in the light of the various phenomena which compose it. He thus thinks of the intake of food and the supply of oxygen, though arriving through different channels, as furnishing integral parts to the important processes of cellular activity.

The task of reviewing this volume was a pleasureable one and the reading of it is highly recommended to both student and practitioner.

A. Moss

SAFEGUARDING CHILDREN'S NERVES, A Handbook of Mental Hygiene. By JAMES J WALSH, M.D., Ph.D., Sc.D., and JOHN A. FOOTE, M.D. Foreword by Honorable HERBERT HOOVER. J. B. Lippincott Co., Phila. and London, 1924 Price, \$2.00

The varied and extensive experience of these eminent authors with the medical problems of childhood has enabled them to produce an unusually sensible book on the mental and nervous health of the child. The importance of heredity, rest, fatigue, fears, habits, recreation and the complexes of child psychology is well emphasized, and the entire work is replete with sound, practical advice on the various problems of behavior in childhood, and the management of the backward and the defective child.

Physicians, nurses, teachers, social workers, etc., are urged to read it. Parents, fathers as well as mothers, should be compelled to do so!

ROBERT ORMISTON BROCKWAY

FUNDAMENTALS OF HUMAN PHYSIOLOGY By R. G. PEARCE, B.A., M.D., and J. J. R. MACLEOD, M.B., D.Sc., F.R.S. Assisted in 3rd edition by Dr NORMAN B. TAYLOR. Third Edition The C V Mosby Co., St. Louis, 1924 Price, \$3 50

It is surprising how complete this little book really is when one considers its size. It has something to say of every phase in physiology, though of necessity much abbreviated. Because of this it loses in clearness that which it gains in brevity. It should form an excellent book for a rapid review of the subjects, and should be invaluable for students preparing for examinations, as well as for practitioners who wish to refresh their memories but have not sufficient time to delve into the more exhaustive volumes. As the title states it deals with the "Fundamentals" of human physiology, and these are most interestingly described and on the whole rather readily grasped. The book should have a useful field amongst those desiring a concise, well-written review.

A Moss

A TEXTBOOK OF MATERIA MEDICA FOR NURSES By A. L. MUIRHEAD, M.D., and EDITH P. BRODIE, A.B., R.N. Second Edition C. V. Mosby Co., St. Louis, 1924. Price, \$2.00

Books of this kind, written for the student nurse, are usually too technical to be practical and the student thereby fails to get a fair working knowledge of the subject. This little volume presents the subject in a comprehensible manner, the authors keeping in mind those essentials necessary for the undergraduate which are readily understood and within her grasp. The book is divided into twenty-four short chapters and as each chapter is well suited for an hour's lecture it makes it an ideal book for teaching.

FREDERICK SCHROEDER

LECTURES ON PATHOLOGY (Delivered in the United States, 1924) By LUDWIG ASCHOFF, M.D., Professor Pathologic Anatomy, University Freiburg. Thirty five illustrations. Paul B. Hoeber, Inc., New York, 1924 Price, \$5.00

This small volume embodies a series of selected lectures delivered by the author during his recent tour of this country. The lectures cover a variety of subjects in the domain of tissue change and pathologic physiology. Much original thought founded on observation by himself and his co-workers, and profound knowledge and understanding of the literature is expressed in a clear, concise, masterful way. Correlation of numerous facts published by various investigators have been lined up so that unity has been established where chaos has existed, and reasonable conclusions have been reached. Explanations of pathologic phenomena are built on a basis of logical sequence, and many fine points previously mentioned in an off hand way, have been emphasized, and their importance has been shown.

It is true that in his concept of inflammation, one follows him with some difficulty. His idea is so radical, and he destroys old beliefs and teachings so ruthlessly, that one is left somewhat bewildered. The viewpoint is a new one and gives rise to new thought. It seems as though old things have been expressed in a new language. Anatomic alterations are spoken of in terms of clinical change. His lecture on the reticuloendothelial system is a gem. It sparkles with life, reflecting rays of light from a subject which has been shrouded in darkness. It radiates his views very modestly, simply and convincingly. A very complex and understandable conception of this subject is obtained from its reading.

All in all, it is a refreshing and interesting volume, well worth reading and possessing. It reflects the activities of an unusually brilliant and fertile mind, and is characterized by the personality of its remarkable and noted author.

MAX LEDERER

DEVELOPMENTAL ANATOMY A Text-Book and Laboratory Manual of Embryology By LESLIE BRAINERD AREY, Prof. of Anatomy, Northwestern University Medical School, Chicago. Octavo 433 pages 419 illustrations. Phila. and London, W. B. Saunders Co., 1924. Cloth, \$5 50

The "Developmental Anatomy" by Arey is a text book that can be used both by medical students in their course of Embryology and also by practitioners as a reference book. The developmental history is limited principally to mammalian types. The book is divided into three sections. In the first part, the early stages of development are described. The second part treats of organogenesis according to germ layers, the third division consists of a laboratory manual.

This text excels in the splendid illustrations. The descriptions are clear, well outlined and easily understood. Those who are interested in the developmental anatomy of mammalian forms will find this volume well worth reading.

O. C. P.



gested The *lungs* were congested but showed no consolidation Spreads made from the spleen and from the liver showed numerous Leishman-Donovan bodies

The anatomical diagnosis was Noma, fatty and congested liver, hyperplasia and congestion of the abdominal lymph nodes, hyperplasia of the spleen, visceral Leishmaniasis

#### MICROSCOPIC EXAMINATION

*Spleen*—The capsule and the connective tissue septa were of normal thickness The Malpighian bodies varied somewhat in size but were normal in number Each showed a normal central vessel, the lymphoid cells were not densely packed The pulp spaces were filled with red blood cells, and many of their lining endothelial cells were large and contained Leishman-Donovan bodies, from one to ten in number The pulp was encroached upon by the dilated blood spaces and the pulp cells were not increased in number There were many dark brown pigment granules lying free or within phagocytes (See Fig 3)



FIG. 3

Section of spleen showing Leishman-Donovan bodies within endothelial cells lining pulp sinus.  
X 1,000

*Liver*—The capsule was not thickened The inter- and intralobular vessels were congested In many lobules the cells around a central vein had undergone pressure atrophy as a result of the congestion of the vessels Many other cells contained droplets of fat, and very few of the liver cells remained normal The connective tissue was not increased in amount Many of the endothelial cells of the liver capillaries were swollen and contained Leishman-Donovan bodies from one to six in number A few polymorphonuclear leucocytes were seen in the liver capillaries carrying one or two parasites (See Fig 4)



FIG. 4

Blood capillary of liver in which a pealed endothelial cell (a) contains a group of Leishman-Donovan bodies, (b) liver cells, fatty

*Kidneys* — The kidneys showed a moderate amount of degeneration and peeling of the epithelial cells of the convoluted tubules The glomeruli were quite normal All the blood vessels were filled with red blood cells The lesion was one of congestion and moderate epithelial degeneration of the cortical tubules In endothelial cells lining the small blood vessels, Leishman-Donovan bodies were present, both in the cortex and in the medulla of the kidney Fig 5 shows the parasites in a cell lining a capillary within a glomerulus



FIG. 5

Section of kidney showing glomerulus, (a) Leishman-Donovan bodies within an endothelial cell, (b) capillary blocked with cocci.

*Colon*—The colon showed loss of superficial epithelium, but the deeper portion of the mucosa with its glands was intact. The submucosa was

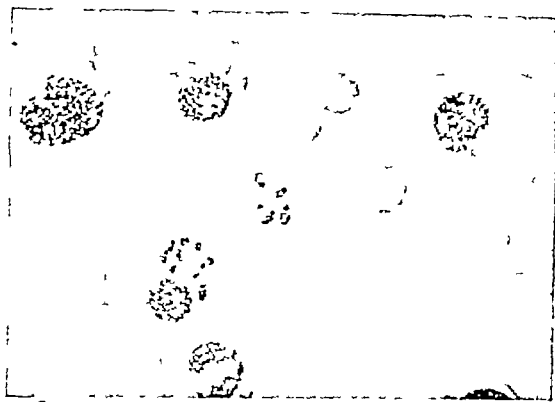


FIG 1

Marrow obtained by puncture during life, intracellular (a) and extracellular (b) Leishman-Donovan bodies

and two transfusions with blood from the father, the child grew steadily more toxic, the leucopenia persisted, the noma increased in size and finally perforated the cheek on the day before death. This occurred two weeks after admission to the hospital, and three and three-quarters months after the first symptoms had been noted.

The temperature chart (Fig 2) shows the irregularity of the fever, which ranged between  $102^{\circ}$  and  $104^{\circ}$  for the greater part of his stay in the hospital.

Autopsy through an abdominal incision was permitted. The anatomical findings were as follows:

The body was that of a fairly well nourished male white child. There was a perforating noma of the left cheek, incised transfusion wounds in

the anterior cubital fossae and a puncture wound over the upper end of the left tibia. No skin eruption was present. The peritoneum was normal. The spleen weighed 164 gm and measured 15 cm in length, 8 cm in width and 4 cm in thickness. The capsule was smooth, dark blue in color. The whole organ was very soft and on section the pulp was dark red and almost friable. The Maphighian bodies were not increased in size. The liver weighed 580 gm and extended 5 cm below the costal margin. Its capsule was smooth. The substance was firm, mottled yellow and red, moderately congested and slightly fatty, and without connective tissue increase. The gall bladder and ducts were normal. The stomach was normal in size, its mucosa was congested and there was a slight amount of mucus present, no food. The congestion was attributed to repeated lavage. The intestines were normal throughout. The mesenteric lymph nodes were enlarged, several measured 0.75 cm in length and were pink in color. The small lymph nodes in the mesentery close to the colon wall were all hemorrhagic in color, brilliant red, and measured 3 mm in length and 1 or 2 mm in width. All the retro-peritoneal lymph nodes showed the same hemorrhagic, swollen condition. The inguinal nodes on both sides were pale and normal in size. The testicles were normal in color and consistency. The kidneys weighed 48 gm. They were red, the markings were slightly blurred and the capsule was free. The ureters and bladder were normal. There was a large amount of urine in the distended bladder. The suprarenal glands weighed 8 gm. Their medulla was distinctly con-

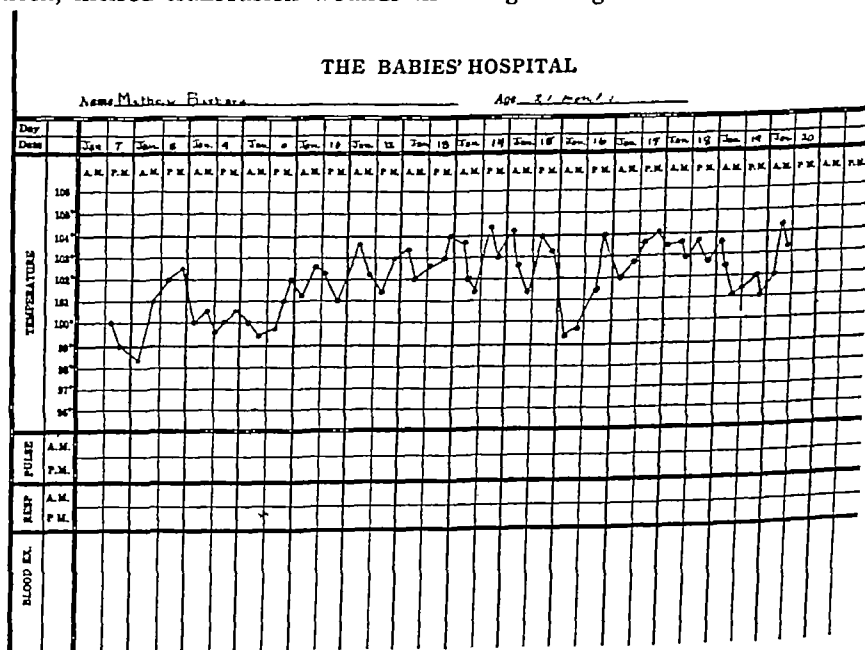


FIG 2 Temperature Chart

blood Recently Young and Van Sant<sup>16</sup> have described a method by which positive cultures of Leishman-Donovan bodies were obtained in about 90 per cent of untreated cases studied in Pekin

The method of transmission is still a mystery, and while fleas, bed bugs and mosquitoes have been accused of carrying the parasites, scientific proof is lacking that any of these insects is really involved<sup>18</sup>

The method of action of the parasite, once it enters the human host, is apparently clear from the microscopic studies That is, the organisms penetrate endothelial cells, especially those lining the blood vessels These cells burst when they become too distended with parasites, which are then set free into the blood stream Leucocytes, especially polymorphonuclears, take up the free parasites and carry them to all viscera, apparently depositing them anew in endothelial cells Red cells would seem to be unmolested by the organisms As Shortt has pointed out, Leishmaniasis is essentially a disease of endothelial tissue By destroying the cells in which it multiplies, the organism gradually causes cell destruction and a toxemia which leads to anemia, asthenia and death

Ray<sup>13</sup> described a reaction which shows a turbidity and flocculation of the blood on the addition of distilled water The test was positive in our case, when controlled by the serum from four other children in the hospital free from kala-azar

#### TREATMENT

In 1913, Gaspar Vianna<sup>14</sup> first used tartar emetic in treating cases of South American cutaneous Leishmaniasis Two years later, Di Cristina and Carona<sup>15</sup> treated children with visceral Leishmaniasis by means of intravenous injections of antimony tartrate and obtained excellent results, the drug acting as a specific In our case, the treatment was begun only after the noma had progressed and added to the toxemia The fact that the postmortem spreads made from the liver and spleen showed many less Leishman-Donovan bodies than did the marrow spreads made before treatment was begun, suggests that the antimony had acted on these organisms, and that the secondary infection from noma was the real cause of death Young and Van Sant have pointed out that after 12 mg of antimony per kilo of body weight had been administered, they were unable to find cultivable Leishman-Donovan bodies in the peripheral blood of patients studied in Pekin

#### SUMMARY

A case of visceral Leishmaniasis or kala-azar in an infant born in Palermo is reported It is the third American case recorded in a child, and the first one to come to necropsy These three children came to the United States from the endemically infected regions about the Mediterranean coast (Greece and Italy) and lived in Boston, San Francisco and New York, respectively

Noma of the cheek appeared three weeks before death

During life, Leishman-Donovan bodies were found in the bone marrow After death Leishman-Donovan bodies were found in spreads from the spleen and liver and in sections from the liver, spleen and kidneys

#### REFERENCES

- 1 Talbot, F B., and Lyon, A. B *Am J Dis Child*, 1918, Vol XVI, p 154
- 2 Faber, H. K., and Schuessler, H., Jr *J Am Med Assn*, 1923, Vol. LXXX, p 93
- 3 Christophers, S R Scientific Memoirs by Officers of the Medical and Sanitary Departments of the Government of India, 1904, n s, Nos. 8, 11 and 15
- 4 Shortt, H. E *India J Med Research*, 1923, Vol XI, p 186
- 5 Di Cristina, G., and Cannata Cited by Laveran.
- 6 Shortt, H. E. *India J Med Research*, 1923, Vol XI, p 319
- 7 Jemma, R., and Di Cristina, G *Centralbl Bakt, Orig*, 1911, Vol. LIX, p 109
- 8 Laveran, A *Leishmanoses*, Paris, 1917
- 9 Leishman, W B *Brit Med J*, 1903, Vol I, p 1252
- 10 Donovan, C. *Brit Med J*, 1903, Vol II, p 79
- 11 Laveran and Cathoire *Bull Acad Med*, 1904, Vol LI, p 247
- 12 Di Giorgio, G *Gaz Internaz Med Clin Igiene* 1915, Vol XXI, p 4824
- 13 Ray C *Ind Med Gaz* 1921, Vol LVI, p 9
- 14 Vianna, G *Arch bras Med*, 1913, Vol II, p 426
- 15 Di Cristina, G., and Carona, G *Pediatrics*, 1915, Vol. XXXII, p 81
- 16 Young, C W., and Van Sant, H M *J Exp Med*, 1923, Vol. XXXVIII, p 233
- 17 Napier, L. E., and Muir, E. *Kala Azar*, 1923, London, Bombay, Madras and Calcutta
- 18 Hegner, R. W., and Tahaferro, W H *Human Protozoology*, New York, 1924

edematous and the muscle and serous coats normal

*Suprarenal* — The suprarenal gland showed intense congestion of the vessels of the medulla, and this congestion extended into the cortex

Leishman-Donovan bodies were found in the bone marrow, liver, spleen and kidneys, but not in the colon nor suprarenal glands

The pathological changes were similar to those which have been described by other observers

In the three adult autopsies described by Christophers<sup>3</sup>, the liver was not enlarged. Microscopically the dilated intralobular capillaries had large cells, the nature of which Christophers found it difficult to determine. Shortt<sup>4</sup>, describing the organs of rhesus monkeys successfully inoculated with kala-azar by means of liver and spleen emulsions from a fatal case in an adult, found the bodies in endothelial cells of capillaries and in Kupffer cells, not in the liver cells themselves. In the human spleen, Christophers found the parasites more numerous than in the liver, and always intracellular. In the monkey, Shortt found hyperplasia of endothelial cells of the spleen capillaries and the blood sinuses, with many parasites. Christophers found the organisms in red bone marrow, but less numerous than in the spleen and liver. They were contained in macrophages, occasionally in polymorphonuclear leucocytes and myelocytes, but never in red blood cells. In the experimental disease, Shortt found the parasites within a certain number of leucocytes in spreads made from the spleen, but the endothelial cells are the chief carriers of the Leishman-Donovan bodies. Christophers found organisms in the spreads from the ulcers present in the large intestine. Di Christina<sup>5</sup> described the mesenteric and retroperitoneal nodes as "cyanotic," just as were those in our case.

Shortt found that the experimental disease in monkeys is essentially the same as in human beings, a disease of endothelial tissue and especially of vascular endothelium.

The fact that Shortt<sup>6</sup> was successful in cultivating Leishman-Donovan bodies from the urine of an adult case and that the kidney sections from our case showed the organism, is of great importance from the standpoint of hygiene and epidemiology.

We found no parasites in sections of the colon, which was not ulcerated. Jemma and Di Christina<sup>7</sup> found ulcerative colitis at necropsy in children who died of kala-azar. Parasites have been demonstrated in the lymph nodes draining ulcers of the colon<sup>7</sup> and of the skin<sup>3</sup>. Although the Leishman-Donovan bodies have been described

as being present in the feces, Laveran points out that the bacteria in the intestinal tract would soon disintegrate the parasites and that their presence in the intestinal tract could not do permanent harm from an epidemiological standpoint.

Leishmaniasis is of two varieties, cutaneous or tropical boil, and visceral or kala-azar (black fever)<sup>17</sup>. The disease has been known for a long time in its endemic areas in India, China and along the Mediterranean Coast. Authentic cases, however, date only from the discovery of the organism by Leishman<sup>8</sup> and Donovan<sup>10</sup>, in 1903. The organism is a protozoon, class mastigophora, genus *Leishmania*. It develops a flagellum only in culture media outside of the body. Within the vertebrate host it develops within cells of the endothelial type and in the leucocytes, dividing by binary fission.

The first case to be described in a child was that which Laveran and Cathoire<sup>11</sup>, published in 1904, in an infant seven months old, a native of Tunis. Since then many cases have been studied and published from both the northern and southern coasts of the Mediterranean. In Sicily, Leishmaniasis is endemic in the region of Messina and Palermo. Di Giorgio<sup>12</sup> saw forty-one cases at the clinic for sick children in Palermo during a single year. The disease has been observed in children in Naples and even in Rome<sup>1</sup>. It is interesting in connection with the present case that he was born in Palermo, one of the endemically infected areas of the Mediterranean coast.

The incubation stage of kala-azar is not definitely known because of the insidiousness of the onset, but it probably ranges between six weeks to three months<sup>7</sup>. The only symptom in the early stage is a mild irregular fever which may be intermittent or remittent. Splenomegaly, anemia and emaciation develop gradually after a period of months. The blood shows a leucopenia, with diminution in the polynuclear cells, low hemoglobin and diminished red cells. Noma is a complication of the late stage and usually proves fatal. It has been noted in 8 per cent of cases occurring in Italy and in 16 per cent occurring in Tunis<sup>8</sup>. The duration of the disease is an extended one. Six months is short and one and a half to two years is not exceptional. In our case the duration was from about the 1st of October until the 20th of January, a period of three months and three weeks, or 112 days. This would seem to be unusually short, providing the date of origin was rightly given.

The organisms have been found in practically every organ of the body and in the peripheral

clusions already reached by the authors mentioned. The parietal peritoneum, over its anterior surface and over the lateral surfaces explored, responds to pressure or scratching stimulation with a sharp, stitch-like pain that is localized by the patient within half an inch of the points of contact. As we reached the hitherto unexplored region of the under surface of the diaphragm we found the pain was referred either to the subcostal region or the neck, depending upon whether the outer margin or the central part of the diaphragm was stimulated. Exactly the same phenomena of referred pain were observed as from stimulating the upper or plueral surface of the diaphragm.

#### CLINICAL OBSERVATIONS

The pain of an ordinary parietal pleurisy is familiar to everyone. It is only necessary to point out that this pain is never referred to a distant part, but is quite sharply localized.

Diaphragmatic pleurisy is far more common, especially in association with pneumonia of the lower lobes, than is usually thought. Probably ten per cent of lobar pneumonia patients develop abdominal pain and tenderness and about half this number complain of referred pain in the neck. The only difference between the experimental and clinical picture is that the latter exhibits an associated hyperesthesia of the skin and a muscular contractibility in addition to the subjective pain.

In the study of our patients with peritonitis

we also find evidence to support the view that parietal peritonitis manifests itself by a sharp pain located over the area inflamed and not referred to distant parts.

On the other hand we have noted numerous cases of subphrenic abscess, perisplenitis and other forms of subphrenic inflammation where the pain was referred to the abdomen, to the neck or to both places. Cough and deep inspiration tend to aggravate this pain.

In obscure diseases the development of neck pain will often establish the site of the affection.

The referred pain of diaphragmatic pleurisy is often mistaken for an abdominal disease. We have records of many cases diagnosed and operated upon for appendicitis, perforated gastric ulcer, gallstones and renal calculus, that have shown no abdominal pathology, but have later developed the signs of pleurisy or lower lobe pneumonia.

The history of chill, cough, painful respiration, and the findings of a high leucocyte count, rapid breathing, herpes and even slight congestion at the base of the lung should prevent these mistakes. If the neck pain happens to be present the diagnosis is made. I know of no abdominal condition that will produce the phrenic nerve pain in the neck excepting irritation or inflammation of the diaphragm, or the presence of free gas worming its way under the diaphragm. It is often stated that this pain may arise from ulcer of the duodenum or chelecystitis, but our experience contradicts this, unless there is a complication involving the diaphragm also.

## HIGH BLOOD PRESSURE TREATED WITH SENSITIZED COLON VACCINE

By JOSEPH F BICAK, M.D.,

NEW YORK CITY

THE cases cited below were taken without any selection whatever, and treated by subcutaneous injection of a sensitized vaccine of the colon bacillus, 2,000,000,000 to the c.c. The injections varied from one-half to five minims, the first was usually two, and were given every two to seven days. The mildest cases were given only the vaccine. The others received thyroid, oxgall and bacillus acidophilus and a few of the most severe cases received small doses of nitroglycerine.

The pressure was taken in the sitting position and every effort was made to make the patient feel at ease. Only the systolic pressure will be noted as the diastolic improved in a corresponding manner in most of the cases and became normal in all in which the former did.

Case 1. Mrs. A. S., 35, U. S., family history negative, came May 14, 1923, with the statement that she had diabetes for two years,

and suffered from dizziness, headaches, palpitation of the heart and tiredness. The urine contained 144 ozs. sugar in twenty-four hours and a marked trace of albumen. The pressure was 190. After six injections, amounting to ten and a half minims, the pressure was 156 on June 12. She did not return after this. All the subjective symptoms improved with the pressure.

Case 2. Mr. H. R., 56, U. S., family history negative, had chronic bronchitis with occasional attacks of asthma, and low blood pressure for many years. He dropped out of sight for a long time and then reappeared on May 10, 1923, with the statement that he was rejected for life insurance on account of high blood pressure. The urine showed a trace of albumen and numerous calcium oxalate crystals. His pressure was 190. He received ten injections, amounting to eighteen minims, the last one on June 30. On July 17, the urine

## ORIGIN AND RADIATION OF PAIN IN THE SEROUS MEMBRANES AND ITS VALUE IN DIAGNOSIS \*

By JOSEPH A CAPPS, M D

CHICAGO ILL.

**O**F all the subjective sensations described by a patient, pain easily occupies the first place. It may be equally true that the interpretation of pain, its origin, its localization and its radiation, yields more information to the physician than any other single symptom. This applies with especial force to the understanding of disease processes in the thorax and abdomen, where the lesion is deep seated and often obscure.

For a number of years we have been engaged in a study, along experimental and clinical lines, of the pain sensation in the serous membranes of the thorax and abdomen.

The experimental observations in the thorax have been carried out in patients with a large effusion, either exudates or transudates, where the lung was retracted. A hollow trocar is inserted either in the subscapular, axillary or anterior region of the chest and before draining off the fluid a long silver wire is introduced through the canula. Under favorable conditions it is possible to bring the end of the exploring wire in contact with the visceral pleura, the parietal pleura, the diaphragmatic pleura and the lower portion of the pericardium. A brief summary of a large series of experiments is as follows:

(1) The visceral pleura gives no pain response to scratching or pressure with the wire point.

(2) The parietal pleura exhibits a prompt response to stimulation, the pain being sharp, stitch-like, and localized with remarkable accuracy over the spot irritated.

(3) The diaphragmatic pleura seems incapable of pain localization in the region of the irritated spot. The pain elicited is radiated in two different directions, depending upon the area irritated. When the stimulation is over the outer margin of the diaphragm the pain is referred to the lower costal and subcostal region, and if the stimulation is intense, to the lower abdominal region of the same side. The pain, unlike that of the parietal pleura, is dull aching in character, and upon removal of the wire passes off gradually like the toothache that disappears after the dentist desists from hammering a filling. When, on the other hand, the central part of the diaphragm is irritated the patient refers the pain to the region of the neck, usually to a spot over the trapezius ridge, less often under the mastoid, in the anterior triangle of the neck or over the coracoid process. The quality of the pain differs from the referred pain in the abdomen in being sharply localized and more acute.

We may readily understand the mechanism of the abdominal pain by recalling that the lower six thoracic nerves penetrate the diaphragm. The sensory filaments of these nerves, unable apparently, as a result of disuse or lack of education, to give expression to painless sensations in the structure itself, carry afferent impulses to the posterior portions of the cord and create foci of irritation. These foci in turn give rise to pain along the nerve fibres of the corresponding segments which supply the skin and abdominal wall from the level of the ensiform to the groin.

The central portion of the diaphragm is supplied by the phrenic nerve, which is merely a fusion of fibres from the third, fourth and fifth cervical nerves, that has been drawn down with the descent of the diaphragm during the embryonal life. The phrenic nerve endings, like wise, convey impulses to their respective cervical roots in the spine and find expression in the segments of the skin and underlying tissues supplied by the third, fourth and fifth cervical sensory nerves. The relative frequency of pain over the trapezius region, supplied by the fourth segment, probably is due to the fact that in most individuals the greatest number of afferent fibres in the phrenic nerve enter the cord at the level of the fourth spinal roots.

Stimulation of the lower portion of the pericardium, near its union with the diaphragm, also elicits the phrenic nerve type of referred pain in the neck.

The pain sense of the peritoneum had been studied by Mackenzie, Lennander and Ranstrom by instrumental irritation of the parietal surface during the course of laparotomies performed under local anæsthesia. They agreed that such irritation produces pain of a sharp character and well localized, whereas, such irritation of the mesentery or intestines causes no pain. Their field of exploration was limited, however, to the immediate region of the incision.

Experimental investigation in the abdominal cavity is beset with peculiar difficulties and dangers. The intestines and omentum impede the movement of a wire and there is always a possibility of injury. These objections were surmounted by injecting two to three litres of sterile air in suitable cases with a thin abdominal wall. The air, rising to the top, leaves a clear space for the movements of the wire. Furthermore, the air fills the space between the liver and diaphragm, thus allowing the exploration of the peritoneal surface of the diaphragm.

The results obtained by Coleman and myself by this method confirmed and extended the con-

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester, April 23, 1924.

to normal and more than four times that amount failed to lower it any more

Case 14 Miss B H, 49, Ire, family history negative, had been treated for hypertension two years before, came with the statement that she was just out of hospital, where she had a pressure of 300 on entrance and 260 on leaving, after a stay of nine weeks. She complained of headache, had a trace of albumen in the urine, and a pressure of 262. On Sept 23, 1923, after twelve injections, amounting to thirty-six minims, the pressure was 210. She had been in bed during this time and received an injection every two days. She was then allowed to get up, and all improvement stopped, the pressure ranging from 214 to 228. It was found that the patient, very stout, was gaining weight. It took some time to get the patient to cooperate. She also had several serious causes of worry and did not sleep well. Luminal was given and finally the patient began to eat less. Then the pressure dropped from 220 to 175 in four weeks. Treatment was to be continued.

Case 15 Miss R M, 46, U S, family history negative, came Aug 4, 1923, complaining of headache. The pressure was 152. On Oct 24, after eight injections, amounting to fourteen and a half minims, and given at irregular intervals, the pressure was 126, and the headache was gone.

Case 16 Mrs H R, 52, U S, husband was also treated for hypertension this year. Arose on the morning of Sept 17, 1923, and soon after was overcome by sudden weakness falling to the ground. When seen she said that she had a "trembling feeling all over the body." The pressure was 182 and an injection of two minims was given. Next day the pressure was 138.

Case 17 Mrs E B, Ger, 73, family history negative, complained of dizziness. There was a trace of albumen in the urine. She came on Sept 17, 1923, with a pressure of 182. On Sept 27, after three injections, amounting to six and a half minims, the pressure was 160 and the dizziness gone. She did not return after this, although she said that she felt better after each injection.

Case 18 Mrs L B, 63, Ger, family history negative, came Sept 22, 1923, complaining of dizziness, weakness, irritability, and seeing "looking-glasses all around her." The pressure was 210. By Nov 12, after eleven injections, amounting to thirty-three minims, the pressure was 152. All the symptoms of which she had complained were gone before this.

Case 19 Miss H K, 15, U S, had acute inflammatory rheumatism, involving the heart, at five, followed by chorea, and had rheumatic symptoms ever since. She had been treated

for high blood pressure for the past seven months, and had a headache on rising every morning. There were occasional hyaline casts in the urine. The thyroid was somewhat enlarged. She called on Oct 25, 1923, with a pressure of 148. After nine injections, amounting to nineteen minims, the pressure was 132 on Nov 28. The headache came about once in three days and she looked much better.

Case 20 Mrs J F, 50, Swed, came Oct 26, 1923, complaining of occasional headaches. The pressure was 166. Nov 12, after five injections, amounting to eight minims, it came down to 117. She looked much better, and said she felt much better and that she had not had a headache for "some time."

Case 21 Mrs E K, 63, Ire, ailing for years and probably had high pressure for years, but it is not possible to get definite information on this point. She was seen for the first time on Sept. 26, 1923, and complained of dizziness, recent deafness, cardiac pain, dyspnoea, and insomnia. She had arteriosclerosis, very much hypertrophied heart, very irregular pulse, edema of the lower extremities and ascites. There was a trace of albumen and hyaline casts in the urine. She had been in one of the large hospitals of this city for three months, had no edema on entrance but much of it when seen for the first time, which was three days after leaving. Evidently her condition grew worse while resting in the hospital. During her stay there she was told that one of her kidneys was bad. The pressure was 195. She received thirteen injections, amounting to twenty-five minims, the last one on Nov 7. On Nov 29, the pressure was 150 (diastolic 96—had been 134). In extreme cases like this it might be well to begin in the same way as in the others, but as soon as the pressure drops ten points, the vaccine should be very much reduced or stopped temporarily. It would be well to give a few minims of adrenalin solution with it except in diabetic patients. She was still very ill and the only thing that can be claimed in the case is that the pressure was reduced as in the others, and that if she had received the treatment before the vital organs became seriously affected her life would have been saved.

Case 22 C B, 57, Ire, smokes excessively. Came Nov 6, 1923, with a pressure of 170. Three weeks later, after three injections, amounting to six minims, the pressure was 160.

Case 23 L A, 63, U S, came Nov 14, 1923, complaining of headaches. The pressure was 173. Two weeks later, after two injections, amounting to four minims, the pressure was 156, and she looked and felt better.

contained no albumen and on July 19 the pressure was 148. He stated that he felt better than for many months. On Oct 8, the pressure was 142, showing a further gain without any more treatment.

Case 3 Mr F V, 25, U S, family history negative, came May 21, 1923, with the statement that he was rejected for life insurance on account of high blood pressure. His urine showed a trace of albumen. The pressure was 155. He received four injections, amounting to five minims, the last one on June 22. On July 9, his pressure was 122, and he stated that he felt better.

Case 4 Mr M J, 70, Ger, family history negative, had high pressure for one year. The urine shows a trace of albumen. He complained of dizziness, and the pressure was 179. He came on April 14, 1923. After seven injections, amounting to ten and a half minims, the last one given on May 26, the pressure was 146, and the dizziness was gone.

Case 5 Mr F B, 56, Bohemia, family history negative, had a mild cerebral hemorrhage two years before and the face and voice still show a trace of its effects. The urine showed a trace of albumen and occasional hyaline casts. The pressure was 202 on April 30, 1923, when he came for the first time. After receiving eleven injections, amounting to thirty-two minims, his pressure was 163 on July 2, and he said that he felt better than for months. He then went out of town and returned on Oct 16, with a pressure of 180, showing that after more than three months, he still retained more than half of the gain. After further treatment, on Nov 24 the pressure was 150, but the diastolic was still 118 in this case.

Case 6 Mrs E B, 47, U S, family history negative. She said that she had hypertension for two years and complained of headaches, and cardiac pain. Her face was flushed when she called for the first time, on Sept 25, 1923, and the pressure was 208. On Nov 6, after eight injections, amounting to twenty minims, the pressure was 164, the face no longer flushed, the headaches and cardiac pain gone and she said that she felt much better.

Case 7 Mr S J, 71, Rus, family history negative. Came June 10, 1923, complaining of very severe cardiac pain on the slightest exertion. He had great cardiac hypertrophy and arteriosclerosis, and a trace of albumen in the urine. The pressure was 192. On June 26, after five injections, amounting to ten and a half minims, the pressure was 176.

Case 8, Miss V H, 25, U S, family history negative, suffered for eight years from difficulty in breathing when lying down and on exertion, cardiac pain, very frequent headaches

and tiredness. Her face was flushed and there was a trace of albumen in the urine. She came on May 17, 1923, with a pressure of 145. On July 5, the pressure was 120, after seven injections, amounting to eight and a half minims. The face was no longer flushed and she felt "better than for years." She had complained of her symptoms out of all proportion to the pressure, but they were all improved very much as it came down, though not entirely relieved. Since then she received an injection almost every week to Nov 22. The symptoms continued to improve.

Case 9 Mr L B, 34, U S, father had a stroke of apoplexy. The urine showed a marked trace of albumen. On May 13, 1923, the pressure was 155 and an injection of mjs was given. A week later, the pressure was 138.

Case 10 Mrs B S, 54, U S, family history negative, came May 28, 1923, with a pressure of 170. She received a total of seven injections, amounting to sixteen minims. On Aug 7, twenty-two days after the last injection, the pressure was 146.

Case 11 Miss M C, 43, Ire, family history negative. She came Aug 2, 1923, complaining of headaches. The face was flushed and there was 9 per cent sugar in the morning urine, with a trace of albumen and occasional hyaline casts. The pressure was 195. After six injections, amounting to eleven minims, and given every two to four days, the pressure was 168. She neglected treatment for two weeks, and the pressure was 180 on Sept 3. Three more injections, amounting to three minims, brought it down to 160 on Sept 11. After another absence of twenty-four days, it was 168 on Oct 5.

Case 12 Mrs I F, 63, Rus, family history negative, had hypertension for five years. She and her daughter seemed to be under the impression that it was usually around 300. She complained of dizziness, weakness, dyspnea and constipation. She called on Sept 27, 1923, with a pressure of 292, and received an injection of two minims, and was directed to go to bed immediately. Two days later, the pressure was 252 and she looked much better. Treatment was discontinued, as she was obliged to go to her own home at a distance.

Case 13 Mr C G, 53, family history negative, was treated for hypertension before, had sciatica, but was able to work. Came Sept 4, 1923, with a pressure of 170. Five injections, amounting to nine and a half minims, and given one week apart, brought the pressure down to 138. After this injection of two to two and a half minims twice a week for ten weeks, failed to bring it down any more. It took nine and a half minims to bring it down.



of the cartilage and thickening of the sinovial membranes and at times adhesion of the opposing surfaces. In certain cases, the X-ray suggests, if not proving conclusively, that the primary process is in the soft parts. Inflammation, suppuration, caseation and sclerosis may enter into the pathology of the involved areas. In case of doubt, the production of a focal tuberculin reaction usually establishes the diagnosis.

The *syphilitic* joint likewise calls for a careful search of the patient as a whole for systemic evidence of the disease. Locally, there is the history of a chronic onset and the aid afforded by the X-ray, the characteristic subperiosteal budding and resorption areas. Moreover, the bone changes are rarely limited to the joint, but usually involve the shaft, both on the periosteal and medullary surfaces which when advanced may result in a rarifying or a thick ivory ossification. Nodes may form at the epiphyseal lines of the shafts of the long bones and grow to a size that it palpable and even visible, when congenital forming a collar around the bone. An important finding both in acquired and congenital syphilis, which so far as we know has not been recognized, and that is oftentimes of very great value in deciding the diagnosis, is the occurrence on the phalanges of the subperiosteal budding and resorption areas without necessary relation to any other syphilitic pathology. These may be so slight as to be either overlooked or disregarded till their diagnostic importance is realized. Even with a negative Wassermann reaction, so frequent with bone syphilis, their occurrence is a definite indication of syphilitic infection.

Charcot's joint, nearly always monarticular, is a special form of syphilitic manifestation that may involve the shoulder, elbow, wrist, ankle or other large joint, but most frequently the knee. It commonly develops suddenly, in a few hours, and without apparent cause, the joint swelling, fluid gathers in large amount (hydrops articuli), the ligaments relax, so that there is excessive mobility, all without fever, pain or signs of inflammation. The bones and cartilages may be rapidly destroyed and spontaneous dislocation or even fracture is apt to occur. Muscular atrophy is marked.

Another form of syphilitic joint is the monarticular adhesive type in which the opposing synovial surfaces are adherent with loss of motion. The ankylosis may be due only to fibrous adhesions (partial), to chondrification of the fibrous tissue (incomplete) or to ossification (complete). When syphilitic, such an arthritic joint must be differentiated from similar conditions due to trauma, usually monarticular, including "dry joint" or from aseptic inflammation associated with other systemic conditions.

*Gonorrhoeal* arthritis is usually ushered in as an acute process. Either the synovial membrane is mainly affected or sometimes a bursa and the effusion is intra-articular, or more commonly periarticular structures are the seat of the affection and the effusion is around rather than within the joint. It may become sero-purulent or purulent. Either form tends to become chronic and resistant to treatment. It is mono-articular, the osseous tissues are not involved. The swollen joint is a feature of the clinical picture.

An *infectious* arthritis in which the invading organism is not specific generally begins more or less acutely and commonly is the sequella of an acute process, the location of which is ordinarily clearly indicated by the clinical history. As an example, the arthritis following tonsillitis may be cited. Any other local infection may serve as well as the source of the infection or toxæmia that underlies the arthritis. In the great majority of instances, it is polyarticular, although some of the joints may be only transiently affected, the arthritis reaching a subacute or chronic stage in a relatively small number of joints. When the original focus is less acute, the arthritic manifestations are correspondingly more gradual in their onset. The process ordinarily involves all the joints to be affected in a comparatively short time, the tendency of extension to other joints being less than in some other forms of arthritis. The formation of sero-fibrinous exudate, characteristic of infection regardless of location, applies to the form of arthritis under consideration, in consequence of which there is thickening of the fibrous and synovial membranes with formation of adhesions, even to the obliteration of the synovial cavity. If the onset is acute, the adhesions predominate, if chronic with low grade inflammation, the thickening of the membranes is more marked. In certain instances, actual bacterial invasion of the joint may be demonstrated, in others, it has been held that the result is entirely brought about by the action of bacterial toxins. The X-ray affords valuable information in establishing the pathological anatomy more or less characteristic of infectious arthritis.

The organisms isolated include more commonly varieties of the staphylococcus and the streptococcus groups, occasionally the typhoid bacillus, the pneumococcus or even the diphtheria bacillus. Other organisms have also been described, to some of which special names have been ascribed.

*Still's* disease is a term applied to a form of chronic polyarticular arthritis, generally believed to be infectious, and occurring before the age of fifteen years. Not only are there enlarged joints, but marked glandular involvement, together with enlargement of the spleen, and, as a general rule, marked muscular atrophy and wasting. It should not be confused with non-infectious polyarthritis to which childhood is not immune, but which is

Case 24 D M, 55, Ire, came Nov 27, complaining of headache and dizziness. The urine contained 2 per cent albumen and frequent hyaline casts. The pressure was 252 and two minims were given. Two days later the pressure was 240 (the diastolic was reduced from 150 to 140). He said that he felt much better.

Improvement was prompt in all the cases and marked in most. In the two cases of diabetes the pressure improved as well as in the rest. Apparently the cause of the hypertension was the same as in the others. Several of the patients became uncomfortable when the pressure came down very fast, but this was very

temporary and the treatment was soon resumed. The belief that hypertension is caused by the toxins of the colon bacillus in most cases seems to be justified by the following reasons:

1 The hypertension was improved in all the cases cited by the injection of sensitized colon vaccine.

2 When the pressure reaches normal further treatment with the vaccine does not reduce it any more.

3 Dizziness is a common symptom of hypertension as well as such conditions as constipation, indigestion, etc., in which one would expect more of the toxins of the colon bacillus to be absorbed from the bowel.

## THE CHRONIC ARTHRITES \*

### THEIR DIFFERENTIAL DIAGNOSIS AND TREATMENT, WITH SPECIAL REFERENCE TO THE RELIEF OF PAIN

By BENJAMIN P RILEY, M D, and E E SMITH, Ph D, M D,

NEW YORK, N Y

IN no part of medicine have names been applied more ambiguously than in the differentiation of the arthritides. The reasons for this are associated with the historical development and our present limited knowledge of the subject. What was formerly regarded as an entity is today recognized as a group of more or less allied clinical manifestations dependent upon varied underlying etiology and pathology. Then, too, the terminology is a combination of contributions from the viewpoints of different specialties without the controlling and co-ordinating influence of a single broad comprehensive aspect. It is largely for these reasons that there is confusion at the present time. As we use the term, chronic arthritis is applied to chronic diseases of the joints in their varied manifestations. With the laity and with some practitioners, the entire group frequently continues to be referred to as chronic rheumatism. At the present time, this term should at least be limited to diseases of the joints due to the virus or organisms that are the cause of rheumatic fever.

Any classification that is at present possible must be irrational, for we have not sufficient knowledge of etiology, pathology or clinical history to make any one of these the basis of a scientific differentiation. However, by consideration of the combined knowledge available in all of these aspects, more or less definite types are indicated, the recognition of which must for the present serve for classification.

On the basis of etiology, we would first distinguish infectious and non-infectious chronic

diseases of the joints, with a classification of the former based in a measure on etiology, and of the latter, based on pathology, as follows:

#### Infectious

Tubercular

Syphilitic

Gonorrhoeal

So-called "rheumatic" infections

Still's disease

#### Non-infectious

Atrophic type (rheumatoid)

Hypertrophic type (osteo)

Villous

Gout

It is at once seen that diagnosis is dependent not only on a knowledge of the joint itself but of the patient as a whole, and further, what of necessity follows, that in most instances treatment is indicated likewise for the patient, rather than merely the joint or joints involved.

*Tuberculosis* of the joint more frequently affects a single joint, though not rarely two or more joints are involved. The condition many times is primarily a peri-arthritis, the invasion of the joint, if at all, being due to extension of the disease. It is a matter of dispute whether the joint proper is ever the beginning of the process. While more prone to occur in the very young, before ossification is complete, adults are not immune. The spine, the hip, the knee, the ankle, the elbow, the wrist and the shoulder are the order of frequency of joint involvement. The local manifestations of the arthritic joint are destructive areas in the adjacent bone and, where extension to the joint has occurred, destruction

\* Read before the Medical Association of the Greater City of New York, October 20, 1924.

of the cartilage and thickening of the sinovial membranes and at times adhesion of the opposing surfaces. In certain cases, the X-ray suggests, if not proving conclusively, that the primary process is in the soft parts. Inflammation, suppuration, caseation and sclerosis may enter into the pathology of the involved areas. In case of doubt, the production of a focal tuberculin reaction usually establishes the diagnosis.

The syphilitic joint likewise calls for a careful search of the patient as a whole for systemic evidence of the disease. Locally, there is the history of a chronic onset and the aid afforded by the X-ray, the characteristic subperiosteal budding and resorption areas. Moreover, the bone changes are rarely limited to the joint, but usually involve the shaft, both on the periosteal and medullary surfaces which when advanced may result in a rarifying or a thick ivoryoid ossification. Nodes may form at the epiphyseal lines of the shafts of the long bones and grow to a size that it palpable and even visible, when congenital forming a collar around the bone. An important finding both in acquired and congenital syphilis, which so far as we know has not been recognized, and that is oftentimes of very great value in deciding the diagnosis, is the occurrence on the phalanges of the subperiosteal budding and resorption areas without necessary relation to any other syphilitic pathology. These may be so slight as to be either overlooked or disregarded till their diagnostic importance is realized. Even with a negative Wassermann reaction, so frequent with bone syphilis, their occurrence is a definite indication of syphilitic infection.

Charcot's joint, nearly always monarticular, is a special form of syphilitic manifestation that may involve the shoulder, elbow, wrist, ankle or other large joint, but most frequently the knee. It commonly develops suddenly, in a few hours, and without apparent cause, the joint swelling, fluid gathers in large amount (hydrops articuli), the ligaments relax, so that there is excessive mobility, all without fever, pain or signs of inflammation. The bones and cartilages may be rapidly destroyed and spontaneous dislocation or even fracture is apt to occur. Muscular atrophy is marked.

Another form of syphilitic joint is the monarticular adhesive type in which the opposing synovial surfaces are adherent with loss of motion. The ankylosis may be due only to fibrous adhesions (partial), to chondrification of the fibrous tissue (incomplete) or to ossification (complete). When syphilitic, such an arthritic joint must be differentiated from similar conditions due to trauma, usually monarticular, including "dry joint" or from aseptic inflammation associated with other systemic conditions.

Gonorrhoeal arthritis is usually ushered in as an acute process. Either the synovial membrane is mainly affected or sometimes a bursa and the effusion is intra-articular, or more commonly periarticular structures are the seat of the affection and the effusion is around rather than within the joint. It may become sero-purulent or purulent. Either form tends to become chronic and resistant to treatment. It is mono-articular, the osseous tissues are not involved. The swollen joint is a feature of the clinical picture.

An infectious arthritis in which the invading organism is not specific generally begins more or less acutely and commonly is the sequella of an acute process, the location of which is ordinarily clearly indicated by the clinical history. As an example, the arthritis following tonsillitis may be cited. Any other local infection may serve as well as the source of the infection or toxæmia that underlies the arthritis. In the great majority of instances, it is polyarticular, although some of the joints may be only transiently affected, the arthritis reaching a subacute or chronic stage in a relatively small number of joints. When the original focus is less acute, the arthritic manifestations are correspondingly more gradual in their onset. The process ordinarily involves all the joints to be affected in a comparatively short time, the tendency of extension to other joints being less than in some other forms of arthritis. The formation of sero-fibrinous exudate, characteristic of infection regardless of location, applies to the form of arthritis under consideration, in consequence of which there is thickening of the fibrous and synovial membranes with formation of adhesions, even to the obliteration of the synovial cavity. If the onset is acute, the adhesions predominate, if chronic with low grade inflammation, the thickening of the membranes is more marked. In certain instances, actual bacterial invasion of the joint may be demonstrated; in others, it has been held that the result is entirely brought about by the action of bacterial toxins. The X-ray affords valuable information in establishing the pathological anatomy more or less characteristic of infectious arthritis.

The organisms isolated include more commonly varieties of the staphylococcus and the streptococcus groups, occasionally the typhoid bacillus, the pneumococcus or even the diphtheria bacillus. Other organisms have also been described, to some of which special names have been ascribed.

Still's disease is a term applied to a form of chronic polyarticular arthritis, generally believed to be infectious, and occurring before the age of fifteen years. Not only are there enlarged joints, but marked glandular involvement, together with enlargement of the spleen, and, as a general rule, marked muscular atrophy and wasting. It should not be confused with non-infectious polyarthritis to which childhood is not immune, but which is

usually not accompanied by the glandular evidences of infection. There is some reason to believe that the condition develops following a more or less general infection, in the course of which the pituitary has become involved and that the subsequent arthritis is associated with the pituitary dysfunction.

The *atrophic* type is a polyarthritis, chronic in onset, and belongs to early and middle adult life, being more frequent in women than men. Neither the onset nor search for bacterial agents suggest an infective origin. It begins in the smaller articulations, particularly of the hands, and extends to the larger joints with varying rapidity in individual cases. It begins by a hypertrophy and round cell infiltration of the normal tissue, elements of the synovial membranes, particularly of the tips of the villi, giving to the surface a velvety appearance with an irregularly roughened nap. After long periods of time, several years, the membrane takes on the characteristics of cicatrization. Shrinkage of the cartilage, even to the production of small areas of erosions, next occurs. Similar lesions in the bone are the last to appear. While this change is in active occurrence, it is claimed that calcium phosphate may be eliminated in double the amount ingested. It is recognized that nervous strain is a frequent occurrence early in these cases and it has been suggested that endocrine abnormalities may be the cause of a metabolic pathology that is responsible for the affection.

*Hypertrophic* arthritis may or may not be polyarticular. It may be general but is quite apt to be emphasized in particular locations, in which event it receives the particular designation suggestive of such location, e. g., *Heberden's nodes*, involving the phalangeal joints, remembering, however, that similar excrescences are sometimes seen in gout or even independently of arthritis of other joints, *morbus corae senilis*, involving the head and neck of the femurs, *spondylitis*, involving the articulation of some regions of the spine, not forgetting that the spine is subject to any of the various forms of arthritis described, etc. Hypertrophic arthritis more frequently attacks the middle-aged and elderly and men rather than women. The articulations involved in the order of frequency are fingers, knees, spine, hip, elbows and feet. Further, involvement of the smaller joints are more common with women and of the larger with men. This may be because occupation and exposure are probable etiologic factors. The synovial structures show very little if any change, the cartilages are irregularly hypertrophic, particularly where adjacent to bone, while hypertrophic changes in the bone, notably lipping, constitute the characteristic findings upon which the diagnosis may be based. Constitutional disturbances play a minor part in the affection. Pain is referable to the mechanical conditions established by

the pathological anatomy. There are no premonitory acute manifestations.

*Chronic villous* arthritis, or "dry joint," most commonly met with in the knee as a result of trauma or flat foot, is not due to any general disease but is purely local, a so-called "static" arthritis. There is crepitation or creaking of the joint on motion with varying degrees of pain and tenderness on movement. Villi may become engaged in the joint so that pain from pinching results. Not infrequently a joint of this description tends to become locked. The suggestion that this may be due to lack of the mucilaginous constituent because of hypothyroidism is interesting though not proven. Attention to this condition, if present, is of course indicated.

In *gout*, there is lacking the general pathology characteristic of the arthritic joints already described. When the case is advanced, with tophi involving the joint, and frequently, as well found elsewhere, as in the ears, there is little likelihood of confusion with other forms of arthritis. In the earlier history, there is considerable similarity during acute exacerbations to the infectious joint, particularly where the lesions are chiefly in the fingers, though capsular thickening is not a feature and portions of the joint remote from the line of articulation are more often concerned. The blood uric acid is relatively high, and when not accompanied by renal involvement constitutes a definite gouty factor. The osseous changes as shown by X-ray, may include destructive or absorptive changes in the shafts of the long bones, highly refractive nodules at the joint which may extend along the shafts of the bones and hyperplastic spurs, limiting motion or even producing ankylosis. The sudden onset, repeated separate attacks, and involvements of meta-tarsophalangeal articulation of the great toe or metacarpophalangeal of the thumb, are clinical features to excite suspicion.

It appears from the foregoing description of the various types of chronic arthritis, that they present a widely varied etiology and pathology. Treatment in general is (1) curative, directed to the restoration of the part to normal structure and function, or (2) palliative, directed to the relief of the effects of dysfunction, including pain. When chronic structure changes are established, surgery may intervene to correct plastic pathology and re-establish function in some instances, but as a rule there is limited or no opportunity to restore normal structure.

Palliative treatment, so far as it has to do with the removal of etiologic factors, is in a sense curative even though it makes no correction of the tissue damages already done. It includes removal or restoration to normal of all foci of infection, for even if infection be not recognized as a causative factor, it may play a secondary part in the production of pain through the action of bacteria or their toxins upon an already estab-

lished pathologic condition. In the case of tubercular, syphilitic, or gonorrhoeal arthritis, specific systemic treatment for these conditions is called for. Thus, the writers have found tuberculin administered in proper increasing dosage, over a long period of time, of very great value, as also the recognized antisyphilitic treatments, and a course of gonorrhoeal vaccine in the corresponding conditions.

With the non-specific cases, whether infectious or not, general systemic treatment is of very great importance. Unfortunately, this is frequently neglected. The sturdy individual may tolerate a certain degree of gastro-intestinal toxæmia, yet the arthritic patient finds in such a condition a constant source of irritation to his pathologic joint, oftentimes greatly exacerbating the local distress and pain by the irritating action of absorbed toxins and their disturbing influence on the nervous balance. A study of the bacterial flora of the bowels often reveals a dominating coccal or other foreign bacterial invasion of the contents that should be corrected by proper medical treatment and dietary regulations, it must be remembered too, even an apparently normal flora may at times give rise to a toxæmia by the excessive absorption of toxins. Unfortunately, the treatment of such conditions is not a simple formula and calls for varied measures suited to the individual case.

In addition to the medical treatment of the gastro-intestinal tract, surgical corrections are at times in order. These frequently include removal of apical foci by tooth extraction, the enucleation of badly infected tonsils, at times the correction of sinus infection, and also, occasionally the correction by overcoming ptosis, kinks, etc., even in extreme cases to the extent of resection of the bowel. Such operations, however, are not to be done as a routine but only when clearly and definitely indicated. The danger of exacerbation from systemic absorption must not be overlooked. It is our experience that a course of treatment with an autogenous vaccine prior to operative procedure, where such is apt to be followed by absorption of infectious material, as for example, in extensive extraction of teeth and in tonsilectomy, does much to prepare the patient for the shock of this treatment.

Systemically, treatment is to be directed to whatever pathologic condition the individual may present. If he be anemic, the condition is to be treated, if diabetic, not only must the diet be adapted to the loss of sugar utilization, but any complications, such as acidosis, even though mild in degree, must be corrected. Of particular moment is the consideration of the renal excretion. We find the existence of some degree of renal insufficiency of more frequent occurrence than is generally recognized. It is not sufficient to test the urine for albumin and conclude from

its absence that renal function is normal. It is important to compare the volume, specific gravity, chlorides and urea of the urine excreted during the two-hour periods of the day and the 12 hours night, and deduct therefrom the indicated conclusions as to renal function and even occasionally to make use of the phenol-sulphone-phthalein renal function test. Further, the blood chemistry is of value in this direction, particularly as to the uric acid, which may be our first intimation of renal insufficiency, even though the gouty factor of a high blood uric acid be not accompanied by the other factors that combine to make the joint picture that of gout.

In the genito-urinary tract, the existence of a pyelitis, even though simply catarrhal, the presence of a cystitis, either latent or active, the existence of obstruction from prostatic enlargement, any latent or active urethritis, in the female, infections of the vagina, cervix or tubes are all conditions to be determined and if present, corrected, in the relief of the localized joint symptoms presented by the chronic arthritic whose welfare we are considering.

The object sought by the patient in a majority of instances includes the relief from pain, and the treatment accorded for this symptom is an important feature of the handling of these cases. It has already been pointed out that the quality of the blood, as determined by the maintenance of a normal composition and by freedom from infections and their products, as also from undue accumulation of products of metabolic waste, are all factors tending more or less to produce or increase pain, and that its ultimate relief calls for the restoration of blood to normal. This is ordinarily a matter of time, however, and frequently of considerable time and in the interim such relief as is reasonably possible must be accomplished by more direct treatment.

Medical treatment usually constitutes a necessary part in the relief of pain and distress. The use of narcotics is not to be considered. Whatever service, if any, they may be called upon to perform in the pain of acute arthritis does not apply to the subacute and chronic joint pain, for here the danger of habituating the patient removes entirely any justification for their employment. Probably no class of drugs is so generally applicable as the salicylates. Just how they act is still not entirely clear. That they may reduce any intestinal toxæmia and that they may lower a pathological blood uric acid are undoubtedly true. That they possess a general analgesic action probably is equally certain, thereby affording relief not only at the joints proper, but to the muscles that ache from the strain resulting from the abnormal functioning of the joints. A more or less serious obstacle to their use is that they are not always well-tolerated by the stomach and usually are not for any prolonged period of

time On this account, the form of administration is a matter of moment While acetyl-salicylate (aspirin) is less open to this objection, a considerable experience with the various forms has led us to prefer the combination as the ethyl-salicylate in 5 minim capsules under the trade name Sal-ethyl, since this is less liable to produce toxic side effects and appears to have an equal or even greater efficiency The usual dosage is 10 to 20 minims three times a day

Where a high blood uric acid is a prominent factor, there are theoretical grounds for the administration of *phenyl-mcnchonnac acid*, sold under various proprietary names, such as Atophan For a brief period, say ten days, it has been shown that full doses of this drug do reduce strikingly the blood uric acid If it is employed for this purpose, the salicylate treatment should be employed during alternate ten days The drug does not have the general analgesic action of the salicylates, for which reason it does not give the same relief from pain and so is ordinarily not accounted as efficient by the patient Notwithstanding this, its employment in true gout is certainly indicated The dose of  $7\frac{1}{2}$  grains should be accompanied by 10 to 20 grains of sodium bicarbonate

The use of iodides is a time honored treatment They have no analgesic action, but they do, particularly the potassium salt, have the effect of a saline diuretic and so may to some extent indirectly relieve pain by promoting renal elimination of metabolic waste products At the same time it must be realized that they exert an irritating action on the kidneys and frequently on that account are contra-indicated Further, in cases of hypothyroidism, where this contributes to the systemic condition, the iodides tend to restore to normal the thyroid activity The danger of overstimulating this activity is alleged, but the writers have not experienced this in their use Finally, the chief claim for the iodides is their promotion of absorption of exudates and fibrous tissues involving the chronic

joint, similar to such absorption of gummatous formations in syphilis It is difficult to demonstrate whether or not they do accomplish this result, but they continue to be used and for this purpose rather than for any immediate relief of pain

In some instances *local treatment* constitutes an important part in the relief of pain, although in others it plays little or no part As is to be expected, the chronic joint is less responsive than the acute or the acute exacerbation of the chronic Rest, often, accomplished by fixation, is of first importance Fixation may be secured by application of the splint, cast, or iron brace, according to the individual case The hydrotherapeutic application of hot and cold is of value where stimulation of the joint tissues is desired The well-tried procedure of alternately applying hot water for five minutes and cold for ten, either as a spray, lavage, or with towels, accomplishes this end Other physiotherapeutic measures of greater or less efficiency include massage, heat (baking), diathermy, heliotherapy, high rectal irrigation, and electric massage Their efficiency is probably overrated in many instances and their effects, when any, are transient, although occasionally they do give comfort that persists for a time In obstinate cases they naturally will be tried The local use of methyl salicylate or oil of gaultheria, so extensively practiced, likewise comes under this head Whether its action is that of an anodyne, counter irritant, or from absorption, it plays only a minor part in relief from pain in chronic arthritis

#### REFERENCES

- Barker, Lewellys F *Monographic Medicine*, 1916, Volume XV  
 Goldthwait, Painter and Osgood *Diseases of the Bones and Joints* 1909  
 Houghton, E. M *The Pharmacology of Ethyl Salicylate*. *American Journal of Physiology*, 1905, Vol. XIII, p 331  
 Myers, Victor C. *Practical Chemical Analysis of the Blood* Second Ed, 1924

## THE POLICY OF THE NEW YORK STATE LABOR DEPARTMENT'S DIVISION OF INDUSTRIAL HYGIENE\*

By LELAND E COFER, M D,

NEW YORK CITY

I AM very grateful for the privilege of appearing before you today and I wish now to acknowledge with thanks the kindness of Dr Orrin Sage Wightman, the President of the New York State Medical Society

Before going into the matter of the policy of the Industrial Hygiene Division of the New York

State Department of Labor, I will say a word about the division itself and its functions

As a result of the interest and endeavor of the Industrial Commissioner, Honorable Bernard L Shientag, the division received an increased appropriation effective July 1, 1923, and in consequence the personnel has been increased and its scope of activities broadened

Besides a director the division now has avail-

\*Read at the Annual Meeting of the Medical Society of the State of New York, at New York City, May 22 1923

able specialists in industrial disease research, expert medical inspectors of factories, chemical engineers, mechanical engineers, chemists, expert lay factors inspectors and expert lay accident inspectors. In addition it has lately opened an industrial hygiene clinic under the joint auspices of the Reconstruction Hospital, in New York City, the College of Physicians and Surgeons, and the Division of Industrial Hygiene. The division itself has also been reorganized and is now being conducted under four heads or sections

First—Section of Expert Inspection

Second—Section of Special Research

Third—Section of Accident Prevention

Fourth—Section of Education

The Section of Expert Inspection gives expert assistance to the Bureau of Research and Codes of the Labor Department in matters relating to the character and design of the various devices for removing noxious fumes and dusts from workrooms, and also gives assistance relative to accident prevention devices. It also gives assistance on projects concerning the heating, lighting and ventilation of factory buildings.

In addition, it renders advice as to the physical condition of workers in plants or factories where conditions are alleged to be unfavorable from the standpoint of industrial hygiene standards. This includes special physical examinations where expert opinion is necessary to determine whether a special process or substance is detrimental to health.

The Section of Special Research conducts studies into the character of the diseases caused by or associated with industry, for example. It is investigating the effect of high temperatures and high humidities upon workers as in the laundry industry, also the effect of carbon monoxide upon workers who are exposed to air constantly contaminated by this gas.

It follows up by special inquiry new problems as they are met with, for example. It is investigating the probability of supplementing the mechanical methods of removing noxious fumes and gases from workrooms by chemical means. It is also holding a survey to determine the effect of industry upon children.

The Section of Accident Prevention is engaged in constantly dispatching expert accident inspectors to the scene of recent accidents, both to get a record as to the cause, details and salient point of the accident from which to find a moral, and also to advise with the employer, shop foreman and workers as to the necessary course to pursue in order to prevent further accidents of a similar nature.

The Section of Education, as its name implies, aims to disseminate where it will do the most good, knowledge concerning the hygiene of industry and the prevention of accidents. This is ac-

complished by radio talks, moving pictures, lectures, pamphlets for distribution and contributions to the magazines and newspapers.

The problem is to ascertain to what extent our knowledge of the nature, cause, prevention and treatment of the diseases caused by industry is applied in this State and to what extent the application is effective. This information will not only demonstrate what existing preventive measures are obsolete or unnecessary, but it will also indicate the necessity or not for new or additional measures. If this information can be obtained it can be used as a guide in framing new legislation, either protective or administrative.

The problem, as I see it, can only be solved by a policy of co-operation between the medical profession of our State, the State and Municipal Public Health organizations and the Industrial Hygiene Division of the State Department of Labor. This division stands ready to aid the medical practitioner in solving the disease problems in industry in order to conserve the usefulness if not the life of the worker and incidentally the interest of the employer. Let it be understood here that the Division of Industrial Hygiene does not treat patients. It acts as an intermediary on medical and hygienic matters between the State on the one hand and the worker and the employer on the other and it is now seeking the aid of the medical profession for the purpose of enlarging as far as possible the scope and effectiveness of this work. After all, who, in the long run, is likely to come into as intimate contact with the worker as the physician? We may study the literature and read papers to each other as much as we please to increase our knowledge of industrial diseases, but the two things most needed just now, let me repeat, are familiarity and interest in industrial hygiene on the part of the medical profession in our State.

While the State law requires the reporting of certain diseases and poisonings which are compensable, there are a number of diseases which are compensable but not reportable, also many poisonings and diseases directly tracable to occupation but which are neither reportable nor compensable.

At present the Division of Industrial Hygiene has knowledge only of the cases reported under Section 206 of the State Labor Law, unless occasionally some case is referred by the Compensation Bureau for attention or investigation.

Art 7, Sec 206 *Physicians' Reports of Industrial Poisonings*. Every physician attending any person whom he believes to be suffering from poisoning by lead, phosphorus, arsenic, brass, wood alcohol, mercury or other compounds, or from anthrax, or compressed air illness, contracted as the result of the nature of such person's employment, shall send to the Commissioner a report stating the name and address and place

of employment of such person and disease from which he is suffering, with such further information as may be required by the Commissioner

The results of this law in yielding data as to the number and kind of diseases caused by industry year by year in this State are as follows

For the eleven years ending with 1923 the total cases reported were 1,485 with 124 deaths, or an average of 135 cases and 11.4 deaths each year, this in a state with a total population in 1920 of 10,384,144, and an industrial population of 1,300,000

Now compare these figures with the showing made in Ohio for the fiscal year ending June 30, 1922, when 756 cases were reported out of the total population of 5,759,368. In other words, if Ohio with a total population of 5,759,368 yields 756 cases of industrial disease yearly, New York with her total population of 10,384,144 should yield, not 135 cases, but approximately 1,500 cases

As a result of an inquiry made of 10,200 physicians in this State by the Division of Industrial Hygiene of the New York State Department of

Labor as to the number of diseases caused by industry which each physician had treated during the calendar year of 1923 replies were received from 3,000 physicians, who reported a total of 217 cases of industrial disease. Now, if 3,000 physicians in New York State report 217 cases, how many should 10,200 physicians report? In Ohio in one year 178 cases of lead poisoning were reported, in New York State, 65 cases, where approximately 10,000 persons are exposed to lead poisoning in fully 150 different trades

The policy of the Industrial Hygiene Division stated concisely, is as follows

1 To develop and function on strictly scientific lines and in co-operation with the medical profession of the State, and not to use police methods if it can be avoided

2 To endeavor to stimulate interest in the early recognition of industrial diseases and use this advance information to correct the causes at the source

3 To study industrial diseases with a view to the awarding of compensation on a basis equally fair to the employer and employee.

## Deaths

BALABAN, SIEBERT, Brooklyn, Heidelberg, 1884, Member State Society. Died February 5, 1925

CALLADINE, THOMAS M., Niagara Falls, University of Maryland, 1915, Member State Society, Niagara Falls Academy of Medicine. Died January 27, 1925

CORRIGAN, DANIEL JAMES, Webster, Queens, Canada, 1898, Member State Society. Died January 6, 1925

COTTER, JOHN JAMES, New York City, College of Physicians and Surgeons of New York, 1898, Fellow American Medical Association, New York Academy of Medicine, Member State Society, Associate Laryngologist Ruptured and Crippled Hospital, Assistant Otolaryngist and Laryngologist Vanderbilt Clinic. Died February 11, 1925

CUDMORE, EDWARD FRANKLIN, New York City, Baylor University, Texas, 1920, Member State Society. Died February 8, 1925

CURTIS, CHESTER CHARLES, New York City, University of Louisville, 1914, Fellow American Medical Association, Member State Society, Assistant Surgeon Bronx and New York Eye and Ear Infirmaries. Died February 25, 1925

GIFFEN, JOHN, Albany, Albany Medical College, 1897, Member State Society. Died February, 1925

GUCK, ARAGO J., Brooklyn, New York University, 1890, Member State Society. Died March 1, 1925





# EDITORIALS



The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication.

**Editor-in-Chief**—NATHAN B VAN ETTEN, M.D., New York  
**Associate Editor**—ORRIN SAGE WIGHTMAN, M.D., New York  
**Executive Editor**—FRANK OVERTON, M.D. Patchogue

### COMMITTEE ON PUBLICATION

E. ELIOT HARRIS, M.D., *Chairman* ... New York  
ORRIN SAGE WIGHTMAN, M.D. ... New York  
EDWARD LIVINGSTON HUNT, M.D. .... New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

**President**—OWEN E. JONES, M.D. Rochester  
**First Vice President**—GEORGE A. LEITNER, M.D. Piermont  
**Second Vice President**—LUZERN COVILLE, M.D. Ithaca  
**Speaker**—E. ELIOT HARRIS, M.D. New York  
**Vice Speaker**—GEORGE M. FISHER, M.D. Utica  
**Secretary**—EDWARD LIVINGSTON HUNT, M.D. New York  
**Assistant Secretary**—WILBUR WARD, M.D. New York  
**Treasurer**—CHARLES GORDON HETD, M.D. New York

### CHAIRMAN, STANDING COMMITTEES

**Arrangements**—FREDERICK H. FLAHERTY, M.D. Syracuse  
**Public Health and Medical Education**—JOSHUA M. VAN COTT, M.D., Brooklyn  
**Scientific Work**—ANDREW MACFARLANE, M.D. Albany  
**Medical Economics**—HENRY LYER WINTER, M.D. Cornwall  
**Legislation**—JAMES N VANDER VEER, M.D. Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex President and the Councilors of the District Branches.

**First District**—EDWARD C. RUSHMORE, M.D. Tuxedo Park  
**Second District**—FRANK H. LASHER, M.D. Brooklyn  
**Third District**—ARTHUR J. BEDELL, M.D. Albany  
**Fourth District**—CHARLES C. TREMBLEY, M.D. Saranac Lake  
**Fifth District**—NELSON O. BROOKS, M.D. Oneida  
**Sixth District**—GEORGE H. FOX, M.D. Binghamton  
**Seventh District**—WILLIAM I. DEAN, M.D. Rochester  
**Eighth District**—HARRY R. TRICK, M.D. Buffalo

### COUNSEL

GEORGE W. WHITESIDE, Esq., 27 William St. New York  
Telephone, Broad 1744

### ATTORNEY

ROBERT OLIVER, Esq. 37 William St. New York

### EXECUTIVE OFFICER

JOSEPH S. LAWRENCE, M.D. 51 Chapel Street, Albany

### SECTION OFFICERS

**Medicine**  
**Chairman**—ROBERT L. LEVY, M.D. New York  
**Secretary**—L. WHITTINGTON GORHAM, M.D. Albany  
**Surgery**  
**Chairman**—MARSHALL CLINTON, M.D. Buffalo  
**Secretary**—EDWARD S. VAN DYKE, M.D. Syracuse  
**Obstetrics and Gynecology**  
**Chairman**—HAROLD C. BAILEY, M.D. .... New York  
**Secretary**—NATHAN P. SEARS, M.D. .... Syracuse  
**Pediatrics**  
**Chairman**—JOSEPH C. PALMER, M.D. Syracuse  
**Vice-Chairman**—ROGER H. DENNETT, M.D. New York  
**Secretary**—ARTHUR W. BENSON, M.D. .... Troy  
**Eye, Ear, Nose and Throat**  
**Chairman**—ARTHUR G. BENNETT, M.D. Buffalo  
**Secretary**—EUGENE E. HIRSHMAN, M.D. Albany  
**Public Health, Hygiene and Sanitation**  
**Chairman**—PAUL B. BROOKS, M.D. Albany  
**Secretary**—ARTHUR D. JACOBS, M.D. Lynbrook  
**Neurology and Psychiatry**  
**Chairman**—EUGENE N. BOUDREAU, M.D. .... Syracuse  
**Secretary**—CLARENCE O. CARMY, M.D. .... Utica

## LICENSING CHIROPRACTORS

At the recent hearing on proposed Medical Practice bills before the joint committee on Public Health of the Senate and Assembly, several questions were asked which set us thinking

"Why don't the physicians come to an agreement with chiropractors in regard to giving chiropractors licenses to practice?"

We would answer Because chiropractors disagree among themselves as to what chiropractic is

The chiropractors themselves publicly reiterate in print that they are divided into two major antagonistic groups, each condemning and repudiating the other

The original major group is led by B. J. Pal-

mer, son of the founder of chiropractic, who runs a chiropractic school in Davenport, Iowa. He and his followers claim that chiropractic means the detection of pressures on nerves at their exit from the spinal column, and the removal of the pressure by manipulation of the bones of the spinal column. He pretends to teach how to detect pressures by means of the sense of touch, the spinograph (which is the X-ray), and an instrument called the neurocalometer

If by chiropractic is meant the system that is taught and practiced by B. J. Palmer, then physicians will have nothing to do with it and will not for a moment consider entering into any agreement with a chiropractor

of employment of such person and disease from which he is suffering, with such further information as may be required by the Commissioner

The results of this law in yielding data as to the number and kind of diseases caused by industry year by year in this State are as follows

For the eleven years ending with 1923 the total cases reported were 1,485 with 124 deaths, or an average of 135 cases and 11.4 deaths each year, this in a state with a total population in 1920 of 10,384,144, and an industrial population of 1,300,000

Now compare these figures with the showing made in Ohio for the fiscal year ending June 30, 1922, when 756 cases were reported out of the total population of 5,759,368. In other words, if Ohio with a total population of 5,759,368 yields 756 cases of industrial disease yearly, New York with her total population of 10,384,144 should yield, not 135 cases, but approximately 1,500 cases

As a result of an inquiry made of 10,200 physicians in this State by the Division of Industrial Hygiene of the New York State Department of

Labor as to the number of diseases caused by industry which each physician had treated during the calendar year of 1923 replies were received from 3,000 physicians, who reported a total of 217 cases of industrial disease. Now, if 3,000 physicians in New York State report 217 cases, how many should 10,200 physicians report? In Ohio in one year 178 cases of lead poisoning were reported, in New York State, 65 cases, where approximately 10,000 persons are exposed to lead poisoning in fully 150 different trades

The policy of the Industrial Hygiene Division stated concisely, is as follows

1 To develop and function on strictly scientific lines and in co-operation with the medical profession of the State, and not to use police methods if it can be avoided

2 To endeavor to stimulate interest in the early recognition of industrial diseases and use this advance information to correct the causes at the source

3 To study industrial diseases with a view to the awarding of compensation on a basis equally fair to the employer and employee

## Deaths

BALABAN, SIEBERT, Brooklyn, Heidelberg, 1884, Member State Society Died February 5, 1925

CALLADINE, THOMAS M., Niagara Falls, University of Maryland, 1915, Member State Society, Niagara Falls Academy of Medicine Died January 27, 1925

CORRIGAN, DANIEL JAMES, Webster, Queens, Canada, 1898, Member State Society Died January 6, 1925

COTTER, JOHN JAMES, New York City, College of Physicians and Surgeons of New York, 1898, Fellow American Medical Association, New York Academy of Medicine, Member State Society, Associate Laryngologist Ruptured and Crippled Hospital, Assistant Otolgologist and Laryngologist Vanderbilt Clinic Died February 11, 1925

CUDMORE, EDWARD FRANKLIN, New York City, Baylor University, Texas, 1920, Member State Society Died February 8, 1925

CURTIS, CHESTER CHARLES, New York City, University of Louisville, 1914, Fellow American Medical Association, Member State Society, Assistant Surgeon Bronx and New York Eye and Ear Infirmaries Died February 25, 1925

GIFFEN, JOHN, Albany, Albany Medical College, 1897, Member State Society Died February, 1925

GUCK, ARAGO J., Brooklyn, New York University, 1890, Member State Society Died March 1, 1925

## UNALTERABLY OPPOSED TO SO-CALLED CULT BILLS BEFORE LEGISLATURE

The University of the State of New York  
The State Department of Education  
Albany, N Y,

March 9, 1925

Editor, NEW YORK STATE JOURNAL OF MEDICINE,  
Medical Society, State of New York

MY DEAR SIR To my surprise, a number of the newspapers in reporting the hearing on the amendments to the Medical Practice Act held last Wednesday afternoon in the Assembly Chamber, have stated that I acquiesced in the position taken by a very prominent speaker I want to disclaim any such acquiescence whatsoever and to reiterate what I stated at the hearing, that I am unalterably opposed to every one of the so-called cult bills now before the Legislature, and am, as well, everlastingly contending for the principle that no one shall be licensed to practice any phase of medicine in this State unless he shall meet the educational requirements now prescribed in the present medical practice act and the rules of the Board of Regents of the University of the State of New York.

It is true that I stated that Senator Fearon's bill is the least objectionable bill, because he concedes every proposition laid down in the Karle-Dunmore bill, but while conceding everything that we ask, his bill proposes to license under a waiver clause a certain number, a comparatively small number it is true, of men who have been practicing chiropractic in this State for eight years As I stated to him, even though the

number so admitted be small, it violates the fundamental principle for which this Department is contending, namely, that there shall be no lowering of the standards for licensing any one or any number of ones who want to practice upon the sick or afflicted

At the hearing I agreed to accept the amendments, as follows

1 That which will protect the internes to be employed in the State hospitals

2 The omission of the phrase "Sundays and legal holidays," thus giving to those in prison jail liberty on these days

3 The reinsertion of that which was omitted and which relates to contraception

4 The omission from the penalties of that sentence which provides that the provisions of the debtor and creditor law and Section 72 of the civil rights law should not apply

I also agreed to the inclusion of optometry with chiropody, dentistry and veterinary medicine, providing those practicing are legally authorized and licensed under the laws of this State so to do

With these exceptions, the Karle-Dunmore bill stands exactly as it was introduced originally and will so stand I shall not yield any further amendments to this bill, win or lose

Very respectfully yours,

(Signed) AUGUSTUS S DOWNING,  
Assistant Commissioner and Director  
of Professional Education

---

## THE ANNUAL MEETING

Physicians are already beginning to ask about the details of the Annual Meeting of the Medical Society of the State of New York, to be held on Monday, Tuesday, Wednesday, and Thursday, May 11 to 14, 1925, in Syracuse, N Y The arrangements for the various features of the meeting are in the hands of active committees and are being worked out as rapidly as possible Dr Frederick H Flaherty, of Syracuse, and his colleagues on the Committee of Arrangements have mapped out the general arrangements already, although the meeting is nine weeks in the future

The two principal features of the meeting will be the sessions of the House of Delegates and the scientific meetings A third major feature will be added this year—a complete tuberculosis exhibit and demonstration, lasting all day Thursday

There will be many minor features which in a smaller society would be classed as major There will be a stated annual meeting which will be

open to the public One evening will be given over to the annual dinner A conference of the secretaries of the County Societies is planned

The tuberculosis program for Thursday will consist of exhibits, demonstrations and lectures It is planned to bring together a comprehensive exhibit which will illustrate all phases of tuberculosis within New York State Exhibits are promised from the Departments of Health of the State and larger cities, and from the greater lay organizations and sanatoriums which are doing anti-tuberculosis work While the details are not entirely worked out, we are assured that every phase of tuberculosis work will be covered in an interesting way We are especially emphasizing the word *interesting*, because the control of tuberculosis is a goal which is in sight, and its accomplishment depends on the co-operation of the family physicians of the State

There will be a number of meetings of organizations allied to the State Medical Society, notices of which will be printed when they are received

F O

The members of the second major group of chiropractors believe that nerve pressure is not the only cause of sickness, that the manipulation of the back bone is only one among many major means for the cure of diseases, and they therefore practice massage, heat therapy, or any other form of treatment which they think best. Those who belong to the second major group of chiropractors ridicule B. J. Palmer and his narrow views and extravagant claims, and repudiate him to almost as great a degree as physicians do. They are opposed to the recognition of the graduates of the School of B. J. Palmer.

Physicians may consistently agree with the second group of chiropractors in opposing the recognition of the first group.

The second major group of chiropractors is divided into at least two sub-groups who differ in regard to the amount and kind of scientific knowledge that should be required from practitioners. The members of the most advanced sub-group profess to advocate the scientific education of chiropractors to the same degree that

physicians are educated in the preliminary subjects of anatomy, physiology, chemistry, bacteriology, pathology and diagnosis, and they would compel a candidate for a chiropractic license to pass the present Regents' examinations in these subjects.

The other sub-group of chiropractors is composed of those who advocate lesser degrees of training in scientific subjects down to no training at all.

The only chiropractor with whom physicians could come to any sort of an agreement are those belonging to sub-group one, who advocate the present Regents' standards in examination for licenses to practice.

Physicians do not believe that any chiropractors now possess these qualifications except possibly a few graduates in medicine who may have taken a chiropractic course, and therefore physicians cannot enter into any agreement with any large group of chiropractors who are now in practice.

F O

## WAIVERS IN THE MEDICAL PRACTICE ACT

If a cultist is going to practice only one therapeutic procedure, should he be required to study those methods which he will never use? In other words, should he be exempted from the Regents' examinations in such subjects as drugs, surgery and obstetrics?

Can a practitioner of chiropractic or any other drugless therapy or single view cult treat common diseases and conditions of the human body and ignore drugs?

We presume that the word *drugs* includes any liquid or chemical substance which is put on or into the body in order to be taken up by the blood or flesh.

The science of chemistry shows that there are certain substances which positively poison the body, and for which the only remedy is another substance which will counteract the poison, either physiologically or chemically, or both, as for example, bichloride of mercury.

The practitioners of drugless cults wish to be exempt from the study of toxicology, sepsis, serums, vaccines, and endocrines. Can any practitioner ignore these subjects and yet give intelligent treatment in the common run of cases which come to him?

How can any one diagnose diseases without the knowledge of drugs or surgery? Chemicals are introduced into the body for the purpose of testing the kidneys and other organs, and serums are now used for the detection and cure of certain diseases, such as scarlet fever, and of im-

munity, as for example, diphtheria. Surgery is used for taking blood specimens for examinations, for doing spinal punctures, and for detecting collections of fluids in the body. All these procedures are necessary for the detection of common diseases, and every medical student is taught them early in his course. Yet practitioners of drugless therapy claim that they will have no use for the knowledge of drugs and surgery. Physicians have need of both drugs and surgery in *diagnosing* as well as *treating* diseases. Does a drugless practitioner have some occult insight which is denied to physicians? Can the State afford to allow a drugless practitioner to make claims of powers that he does not possess, according to his own confession?

If a practitioner knows a little or nothing about drugs and simple surgical proceedings, he is limited to the methods of the practice of medicine which existed a century ago before anyone dreamed of modern procedures.

The medical profession adheres to its reiterated attitude that no one should be allowed to practice the healing art unless he shall first prove to a competent court that he is familiar with scientific methods and procedures which are in common use in the detection and treatment of diseases. As soon as the practitioner of a cult proves his attainments in science, he ceases to be a narrow cultist and is accepted as a competent chemist, or bacteriologist, or other expert in science.

J N V V

practicers to treat diphtheria and other infectious diseases according to their method, if they desire, but is there any sane man in the legislature today who would vote for such a change in our entire public health system? The legislators would like to get rid of the chiropractors who have pestered them year after year with demand for license, but they should not, for their own comfort license such to treat communicable disease, for by so doing the cost of legislators' comfort will be paid in priceless human lives

From the patience shown by the members of the Public Health Committee at the hearing, it

is difficult to believe that that important Committee of the Senate and the Assembly, that has a peculiar obligation to the health of the public, will allow themselves to be freed from the annoyance of chiropractic lobbying by passing a chiropractic bill that will give licenses without test and that will permit the treatment of communicable disease by unscientific methods

The medical profession must not weary of this fight—the cause is worthy of continued and sustained effort and now, in the closing days of the session let no vigilance relax or effort lag!

---

### LACERATION OF THE WRIST WITH RESULTANT CELLULITIS.

In this action the plaintiff claimed that he had sustained injuries to his right wrist by striking the same against a broken pane of glass, causing a cut and severing one of the main nerves and arteries of the wrist, that the defendant was engaged to treat and care for the injury, that he was so negligent and careless in his undertaking that as a result an infection set in which continued for several weeks and during which time the plaintiff suffered excruciating pain, that the defendant permitted the infection to continue without removing the pus and other matter which gathered in the injury, that the plaintiff finally consulted another physician in an adjoining city who performed an operation upon the plaintiff's wrist, but it is claimed that as a result of the defendant's mistreatment and negligence the injury to the plaintiff had progressed to such an extent that it was impossible entirely to cure the plaintiff's injury and that he was left with a permanently injured wrist, stiffness and loss of function in his hand and fingers

From the facts it appears that the defendant a physician, at about 9 30 in the evening was called on an emergency case and found the plaintiff with a deep laceration of his wrist received by having thrust his hand through a pane of glass while intoxicated and when seen the plaintiff was still in a state of drunken delirium unruly and profane and in a filthy condition. A companion of the drunken man had attempted

first aid measures by applying a tourniquet or rope, which the doctor found on the patient's arm upon arrival. It was necessary for the defendant to call another physician to his assistance as the plaintiff and his companion in their drunken condition could not be physically coped with. The defendant then took the necessary antiseptic precautions, sewed up the wound and applied moist bichloride dressings. On the following day he removed some of the sutures and found the condition satisfactory. Several days later the arm became swollen and the defendant called a physician in consultation who decided there was no necessity for changing the treatment at that time and recommended the continuance of the moist bichloride dressings. Later, upon complaint of pain from the patient and swelling of the arm, a surgeon in an adjacent city was consulted. After this the defendant rendered no further treatment or care to the plaintiff. The surgeon who treated and operated upon the plaintiff found that he had suffered from a vicious infection tending toward a deep cellulitis and that the treatment of the defendant physician was in no way responsible for the claimed bad result and that the same were merely the inevitable results of the plaintiff's original injury. After this action had been pending for some time the plaintiff consented to a discontinuance.



# LEGAL



By GEORGE W. WHITESIDE, Esq  
Counsel, Medical Society of the State of New York

## HEARING BEFORE JOINT COMMITTEE ON PUBLIC HEALTH—SENATE AND ASSEMBLY

The chiropractors were the chief objectors present on the 4th of March at the hearing before the Joint Committee on Public Health of the Senate and Assembly, when the Karle-Dunmore Medical Practice bill was being discussed. As bills are introduced for improving machinery for prosecuting unlicensed practitioners and making more certain the discovery of their offenses and more stringent the punishment, large numbers of chiropractors assemble in the assembly chamber and become a militant and noisy opposition. They appear to be satisfied with the present Medical Practice Act as it has been so ineffective in preventing their unlawful practice.

The best argument in favor of the Karle-Dunmore bill was the array of the opposition who fear its penalties. The New York Chiropractic Society, through its attorney, has no objection to the passage of the bill, provided chiropractors are specifically exempted from its penalties. Their position has always been as seekers of special privilege, who have never attempted to meet the standards required for a license to practice healing and who wish the rights and benefits that belong only to those who have earned them. The same noisy gallery that voiced its opposition to the Medical Practice Act vociferously applauded the supporters of the various chiropractic and drugless methods bills. While Senator Fearon in his chiropractic bill seeks to establish reasonably high standards for future licensing of chiropractors, he, nevertheless, seeks to license chiropractors without examination who have practiced for eight years in this state and are graduates of chiropractic schools or colleges, and those chiropractors who are veterans of the World War he proposes should be licensed without such eight years previous practice. It was stated at the hearing that this would admit from 180 to 200 chiropractors without license. There is not one of these who are to be so specially favored whose qualifications to practice are known or proved. Of this number there may be some reasonably intelligent and some woefully ignorant, some who are sincere and some who are the worst type of charlatan, some who are straight and some who are crooked. But Senator Fearon's waiver clause will not discriminate and weed out the fit from the unfit—it will license all of that class irrespective of their fitness, irrespective of their qualification and notwithstanding their previous conduct.

The Medical Society of the state as an organization made up of men who are licensed by the state, who have met every requirement as to qualification that has been imposed by the state, who stand for high educational qualifications to practice the healing art, can never compromise with anybody or any legislative or executive department on this fundamental proposition. There are no practical or political considerations that should dissuade the profession from this opposition. Banks are required to meet certain specifications before they are permitted to operate under the Banking Law, insurance companies must be organized according to the provisions of law and subject to strict executive supervision. Would any legislator seriously consider passing a bill by which banks and insurance companies that had openly flouted the law and had not met the standards or requirements necessary to receive a charter to conduct the banking or insurance business should receive such a charter by legislative act waiving the requirements of the general law applying to those engaged in these businesses, on the ground that it was a practical or political expedient? There is no practical or political expediency that justifies excusing any class in a community or any individual of the state who seeks a license to practice medicine, whether it be by drugless or other methods, from meeting the educational standards necessary to prove the qualifications of the applicant.

If the State of New York desires to license chiropractors and establish a real test of their fitness as a condition of granting a license, it doubtless has power so to do, but the State must make sure that those who seek to treat disease according to the tenets of this particular cult are sufficiently qualified to diagnose disease before they undertake treatment, and further, must make sure that communicable disease, which is a serious hazard to the public if not treated by scientific principles, shall be treated only by the application of approved scientific treatment.

In the closing hours of the hearing, near mid night, the chiropractor leaders declared their right to treat diphtheria without the use of anti toxin but by their method of adjustment. They declared their rights similarly to treat all communicable diseases which have yielded to present methods based on scientific principles. The State of New York has a right to discard science in the treatment of disease and to license the chiro-

INDEX OF LEGISLATIVE BILLS—Continued

Senate Bill No.	Assembly Bill No.	Law	Subject	Committee to which bill is referred	B—Bill printed		C—Comment	
							Page	Date
789		Public Health	Chiropractic Bill (Bouton's)	S Public Health	B		336	Feb 27
851	1027	Public Health	Dissecting Material	S Public Health	C	A Public Health	442	Mar 13
943	1167	Public Health	Laboratory Supplies	S Public Health	B	A Public Health	443	Mar 13
944	1423	Public Health	Chiropractic Bill (Fearon's)	S Public Health	B		343	Feb 27
1123	1478	Education	Foreign Licenses	S Public Education	C		386	Mar 6
1176	1348		Censors State Medical Society	S Public Health	B		386	Mar 6
127		Education	Health Service in Schools	A Public Education	B		443	Mar 13
185			Chiropractic Bill (Nicoll's)	S Public Health	C		443	Mar 13
229		Education	Mentally Retarded Children	A Public Health	B		445	Mar 13
422		Civil Practice	Professional Secrets	A Codes	C		443	Mar 13
649		Public Health	Chiropractic (Esmond's)	A Public Education	B		86	Jan 23
678		Public Health	Exam of Food Handlers	A Public Health	C		341	Feb 27
908		Penal Law	Wood Alcohol	A Public Health	B		87	Jan 23
925		Public Health	Reciprocity in Licensures	A Codes	C		443	Mar 13
987		Penal	Birth Control	A Codes	C		341	Feb 27
1321		Public Health	Vital Statistics	A Public Education	B		394	Jan 30
1343		Public Health	Defining Healing Art (Esmond Chiropractic)	A Codes	B		186	Feb 6
1351		Workmen's Comp	Injured Employees (Miller)	A Public Health	B		278	Feb 20
1377		Penal	Antivivisection	A Codes	C		278	Mar 20
1421		Public Health	Podiatry	A Public Health	B		394	Mar 6
1429		Public Health	Sale of Eyeglasses	A Labor and Industry	B		395	Mar 6
1463		Public Health	Chiropractic (Bolton's)	A Codes	B		294	Feb 20
				A Public Health	B		294	Feb 20
				A Codes	B		343	Feb 27
				A Public Health	B		396	Mar 6
				A Public Health	B		447	Mar 13
				A Labor and Industry	B		448	Mar 13
				A Codes	B		445	Mar 13
				A Public Health	B		446	Mar 13
				A Public Health	B		446	Mar 13
				A Ways and Means	B		450	Mar 13



# LEGISLATION



By JAMES N VANDER VEER, M.D.  
Chairman, Committee on Legislation

## INDEX OF LEGISLATIVE BILLS

		B—Bill printed		C—Comment	
Senate Int. No.	Law	Committee to which bill is referred		Page and Date	
		Subject			
29	Penal	Prohibition Enforcement	S Codes	A Codes	B 221 Feb 13
114		Crippled Children	Passed Both Houses to Governor		B 225 Feb 13
115	Public Health	THE NARCOTIC BILL	S Public Health	A. Public Health	C 440 Mar 13
116	Insanity	Institutions for Addicts	S General Laws	A Judiciary	B 80 Jan 23
211	Public Health	MEDICAL PRACTICE ACT	S Public Health	S Public Health	C 382 Mar 6
228	State Charities	Children's Institutions	S General Laws	A. Judiciary	C 382 Mar 6
263	Insanity	Insanity Examiners	S General Laws		C 329 Feb 27
283	County	County Nurses	S Internal Affairs	A Internal Affairs	B 174 Feb 6
302	Education	Health Service in Schools	S Public Education	A Public Education	C 382 Mar 6
380	Workmen's Comp	Choice of Physician	S Labor and Industry	A Labor and Industry	B 175 Feb 6
473	Public Health	Drugless Practitioner Bill	S Public Health		C 441 Mar 13
586	Education	Med Exam in Schools	S Public Education	A Public Education	B 176 Feb 6
594	Workmen's Comp	Choice of Physician	S Labor and Industry	A Labor and Industry	C 383 Mar 6
632	Public Health	Pharmacies	S Public Health	A Public Health	B 177 Feb 6
647	Workmen's Comp	Examination After Injury	S Labor and Industry	A Labor and Industry	C 383 Mar 6
671	Penal Law	Physically Handicapped Persons	S Judiciary	A Judiciary	B 232 Feb 13
673		County Medical Examiner	Passed Senate	A Int. Affairs	C 441 Mar 13
693	Public Health	Foreign Medical Degrees	S Public Health	A Public Health	B 276 Feb 20
701	Public Health	Revocation of License	S Public Health		B 276 Feb 20
716	Public Health	Rural Hygiene	S Finance	A Ways and Means	C 384 Mar 6
786	Public Health	Hospital for Crippled Children	S Public Health	A Ways and Means	B 332 Feb 27
787	Public Health	Study of Malignant Disease	S Public Health	A Ways and Means	C 277 Feb 20
					C 441 Mar 13



# CHANGE THE MEDICAL PRACTICE LAWS

EARDON—S 944

GIBBS—S 473

ESMOND—A 1343

BOLTON—A 1463

Amending Chapter 49,  
of 1909, Public  
Law

Amending Chapter 49,  
Laws of 1909, Public  
Health Law

Amending Chapter 49,  
Laws of 1909, Public  
Health Law

Amending Chapter 49,  
Laws of 1909, Public  
Health Law

## Fees and Expenses

and penalties paid to  
of Regents.  
es to be paid from  
and appropriations.

Expenses to be paid from  
fees and penalties

Fees and penalties to be  
paid to State Treasurer  
and retained as special  
fund from which expenses  
shall be paid.

## Licensing Board

ned by Board of  
is.

Board of 5 practitioners  
of drugless therapy, one  
to be appointed annually  
for a 5 year term

Medical examining board  
of Board of Regents  
designated "Board of Di-  
agnosis Examiners" who  
shall examine students in  
anatomy, physiology, hy-  
giene, sanitation, biological  
chemistry, dietetics, his-  
tology, embryology, bacte-  
riology, pathology diagno-  
sis, and symptomatology

Board of Chiropractor  
Examiners to consist of  
three members appointed  
by the Governor. Appoint-  
ees must have been en-  
gaged in practice of chiro-  
practic exclusively in this  
state for two years

## Waiver Conditions

Graduate of legally  
red school or college  
uropractic which in-  
d in its course of  
anatomy, physiology,  
logy, hygiene, analy-  
chemistry, obstetrics,  
theory and practice  
iropractic.  
rs practice.  
Others now in prac-  
hall take examination  
Board of Regents  
ceeding subjects

Diploma from legally in-  
corporated school or col-  
lege of drugless methods  
2 years practice, drugless  
methods exclusively

Two years practice of  
chiropractic in this state  
prior to the passage of this  
article providing applica-  
tion for license is made  
within twenty days after  
the organization of the  
board

## Qualifications for Examination

rs college course.  
r course in school of  
practic with standard  
factory to Board of  
nts

High school course or  
equivalent Three years in  
legally incorporated school  
of drugless methods 18  
months after passage of  
bill, 4 years in legally in-  
corporated school

Pass regular medical ex-  
amination for credits to  
enter upon study of any  
particular branch of the  
healing art.

High school education or  
its equivalent, 3 years of 6  
months each in school of  
chiropractic giving courses  
in anatomy, physiology,  
symptomatology, hygiene,  
sanitation, chiropractic  
analysis and principles and  
practice of chiropractic.  
Must practice nothing but  
chiropractic.

## Registration

nnually

No provision

No provision

No provision

## SUMMARY OF PROVISIONS OF BILLS PROPOSING

KARLE-DUNMORE S 211, A 307	NICOLL—A. 185	ESMOND—A 649	BOUTON—S 79
Amending Chapter No 49, Laws of 1909, Public Health Law	Define and Regulate Prac- tice of Chiropractic.	Amending Chapter No 549, Laws of 1909, Public Health Law	Define and Regulate Practice of Chiropractic

## Fees and Expenses

Fees and penalties paid to Board of Regents Expenses to be paid from fund and by appropriation.	Fees and penalties paid into State Treasury Expenses to be paid from appropriation	Fees and penalties paid into State Treasury Expenses to be paid from appropriation	Fees and penalties paid into State Treasury Expenses to be paid from appropriation.
--	---	---	--

## Licensing Board

Examination by Board of Regents	One chiropractor on Re- gents Examining Board appointed for 3 year term May not be a physician	One chiropractor on Re- gents Examining Board for 3 year term May not be a physician.	Three chiropractors ap- pointed immediately, one to be appointed annually for 3 year term.
------------------------------------	---	--	---

## Waiver Conditions

A Resident course of 2 years (12 months) of 6 months each 5 years prac- tice.	A. Resident course of 2 years (12 months) of 6 months each. 5 years practice	(A) Graduate of chiro- practic school 3 years practice.
B 3 years of 6 months each (18 months) 3 years practice, 3 years high school course	B 3 years of 6 months each (18 months), 3 years practice, 3 years high school course.	(B) High school graduate chiropractic graduate 1 year practice.
C 2 years of 4 months each (8 months) 10 years practice.	C. 2 years of 4 months each (8 months), 10 years practice	(C) Intelligence test equal to high school graduate Pass examination of Board showing practical knowledge of chiropractic 2 years practice.

## Qualifications for Examination

2 year college course. 4 year medical course	4 year high school course, or equivalent 24 months chiropractic school	4 year high school course or equivalent 24 months chiropractic school	4 year high school course or equivalent. 24 months chiropractic school.
---	--	--	--

## Registration

Annually	Annually	Annually	No provision
----------	----------	----------	--------------

# TO CHANGE THE MEDICAL PRACTICE LAWS

FEARON—S 944	GIBBS—S 473	ESMOND—A 1343	BOLTON—A 1463
Amending Chapter 49, Laws of 1909, Public Health Law	Amending Chapter 49, Laws of 1909, Public Health Law	Amending Chapter 49, Laws of 1909, Public Health Law	Amending Chapter 49, Laws of 1909, Public Health Law

## Fees and Expenses

and penalties paid to Board of Regents. Fees to be paid from special fund and appropriations	Expenses to be paid from fees and penalties	Fees and penalties to be paid to State Treasurer and retained as special fund from which expenses shall be paid.
---	---	--

## Licensing Board

Determined by Board of Regents.	Board of 5 practitioners of drugless therapy, one to be appointed annually for a 5 year term	Medical examining board of Board of Regents designated "Board of Diagnosis Examiners" who shall examine students in anatomy, physiology, hygiene, sanitation, biological chemistry, dietetics, histology, embryology, bacteriology, pathology diagnosis, and symptomatology	Board of Chiropractor Examiners to consist of three members appointed by the Governor. Appointees must have been engaged in practice of chiropractic exclusively in this state for two years
---------------------------------	--	---	--

## Waiver Conditions

Graduate of legally chartered school or college of chiropractic which included in its course of study anatomy, physiology, pathology, hygiene, analytical chemistry, obstetrics, theory and practice of chiropractic. Others now in practice shall take examination under Board of Regents preceding subjects	Diploma from legally incorporated school or college of drugless methods 2 years practice, drugless methods exclusively	Two years practice of chiropractic in this state prior to the passage of this article providing application for license is made within twenty days after the organization of the board
--	--	--

## Qualifications for Examination

Three years college course. Four year course in school of chiropractic with standard satisfactory to Board of Regents	High school course or equivalent. Three years in legally incorporated school of drugless methods 18 months after passage of bill, 4 years in legally incorporated school	Pass regular medical examination for credits to enter upon study of any particular branch of the healing art.	High school education or its equivalent, 3 years of 6 months each in school of chiropractic giving courses in anatomy physiology, symptomatology, hygiene, sanitation, chiropractic analysis and principles and practice of chiropractic. Must practice nothing but chiropractic.
--	--	---	---

## Registration

Annually	No provision	No provision	No provision
----------	--------------	--------------	--------------

## SUMMARY OF PROVISIONS OF BILLS PROPOSING

KARLE-DUNMORE S 211, A 307	NICOLL—A. 185	ESMOND—A. 649	BOUTON—S 789
Amending Chapter No 49, Laws of 1909, Public Health Law	Define and Regulate Prac- tice of Chiropractic.	Amending Chapter No 549, Laws of 1909, Public Health Law	Define and Regulate Practice of Chiropractic

**Fees and Expenses**

Fees and penalties paid to Board of Regents Expenses to be paid from fund and by appropriation.	Fees and penalties paid into State Treasury Expenses to be paid from appropriation	Fees and penalties paid into State Treasury Expenses to be paid from appropriation	Fees and penalties paid into State Treasury Expenses to be paid from appropriation.
--	---	---	--

**Licensing Board**

Examination by Board of Regents	One chiropractor on Re- gents Examining Board appointed for 3 year term May not be a physician	One chiropractor on Re- gents Examining Board for 3 year term. May not be a physician.	Three chiropractors ap- pointed immediately, one to be appointed annually for 3 year term.
------------------------------------	---	---	---

**Waiver Conditions**

A Resident course of 2 years (12 months) of 6 months each 5 years prac- tice. B 3 years of 6 months each (18 months) 3 years practice, 3 years high school course. C 2 years of 4 months each (8 months) 10 years practice.	A. Resident course of 2 years (12 months) of 6 months each 5 years practice B 3 years of 6 months each (18 months), 3 years practice, 3 years high school course. C. 2 years of 4 months each (8 months), 10 years practice.	(A) Graduate of chiro- practic school 3 years practice (B) High school course chiropractic graduate 1 year practice. (C) Intelligence test equal to high school graduate. Pass examination under Board showing working knowledge of chiropractic. 2 years practice.
---	--	--

**Qualifications for Examination**

2 year college course 4 year medical course	4 year high school course, or equivalent. 24 months chiropractic school	4 year high school course or equivalent 24 months chiropractic school	4 year high school course or equivalent 24 months chiropractic school.
--	---	--	---

**Registration**

Annually	Annually	Annually	No provision
----------	----------	----------	--------------

# TO CHANGE THE MEDICAL PRACTICE LAWS

FEARON—S 944

GIBBS—S 473

ESMOND—A 1343

BOLTON—A 1463

Amending Chapter 49,  
Laws of 1909, Public  
Health Law

Amending Chapter 49,  
Laws of 1909, Public  
Health Law

Amending Chapter 49,  
Laws of 1909, Public  
Health Law

Amending Chapter 49,  
Laws of 1909, Public  
Health Law

## Fees and Expenses

Fees and penalties paid to  
Board of Regents  
Expenses to be paid from  
fund and appropriations

Expenses to be paid from  
fees and penalties

Fees and penalties to be  
paid to State Treasurer  
and retained as special  
fund from which expenses  
shall be paid

## Licensing Board

Examined by Board of  
Regents

Board of 5 practitioners  
of drugless therapy, one  
to be appointed annually  
for a 5 year term

Medical examining board  
of Board of Regents  
designated "Board of Di-  
agnosis Examiners" who  
shall examine students in  
anatomy, physiology, hy-  
giene, sanitation, biological  
chemistry, dietetics, his-  
tology, embryology, bacte-  
riology, pathology, diagno-  
sis, and symptomatology

Board of Chiropractor  
Examiners to consist of  
three members appointed  
by the Governor. Appoint-  
ees must have been en-  
gaged in practice of chiro-  
practic exclusively in this  
state for two years

## Waiver Conditions

(A) Graduate of legally  
chartered school or college  
of chiropractic which in-  
cluded in its course of  
study anatomy, physiology,  
pathology, hygiene, analy-  
tical chemistry, obstetrics,  
and theory and practice  
of chiropractic.  
8 years practice.  
(B) Others now in prac-  
tice shall take examination  
under Board of Regents  
on preceding subjects

Diploma from legally in-  
corporated school or col-  
lege of drugless methods  
2 years practice, drugless  
methods exclusively

Two years practice of  
chiropractic in this state  
prior to the passage of this  
article providing applica-  
tion for license is made  
within twenty days after  
the organization of the  
board

## Qualifications for Examination

2 years college course.  
4 year course in school of  
chiropractic with standard  
satisfactory to Board of  
Regents

High school course or  
equivalent Three years in  
legally incorporated school  
of drugless methods 18  
months after passage of  
bill, 4 years in legally in-  
corporated school

Pass regular medical ex-  
amination for credits to  
enter upon study of any  
particular branch of the  
healing art.

High school education or  
its equivalent, 3 years of 6  
months each in school of  
chiropractic giving courses  
in anatomy, physiology,  
symptomatology, hygiene,  
sanitation, chiropractic  
analysis and principles and  
practice of chiropractic.  
Must practice nothing but  
chiropractic.

## Registration

Annually

No provision

No provision

No provision

# SPECIAL ATTENTION

To Chairmen of County Legislative Committees and  
Members of County Medical Societies:

Have you written your letters to, or personally interviewed, your  
legislators on the following legislative bills?

## FAVORING

## AGAINST

Senate Int 115, Conc Assembly Int 215—The Narcotic Bill	Senate Int 263—Examiners in Lunacy
Senate Int 116, Conc Assembly Int. 216—Requiring the licensing of private institutions for the treatment of drug addicts	Senate Int 283, Conc Assembly Int 399—County Public Health Nurses
Senate Int 211, Conc Assembly Int. 307—State Department of Education Bill on Medical Practice (See vote of House of Delegates)	Senate Int 473—The Drugless Practitioner Bill (Gibbs)
Senate Int 380, Conc Assembly Int 570—Injured employee to select his physician	Senate Int 632, Conc Assembly Int. 802—Pharmacies
Senate Int 594, Conc Assembly Int 301—Choice of Medical Attendants	Senate Int 647, Conc Assembly Int 184—Examination after injury
Senate Int 671, Conc Assembly Int 868—Physically Handicapped Persons	Senate Int 786, Conc Assembly Int 1074—Hospital for Crippled Children
Senate Int 681—Dissecting Material	Senate Int. 787, Conc Assembly Int 973—State Institutions for Study of Malignant Diseases
Senate Int 701—Revocation of license	Senate Int 789—Senator Bouton's Chiropractic Bill
Senate Int. 851, Conc Assembly 1027—Delivery of cadavers to medical colleges	Senate Int 943, Conc Assembly 1167—Laboratory Supplies
Senate Int 1176, Conc Assembly 1348—Censors of State Medical Society	Senate Int 944, Conc Assembly Int. 1423—Practice of Medicine and licensing chiropractors (Fearon)
Assembly Int 908—Control of wood alcohol	Assembly Int 127—School inspection
Assembly Int. 1351—Workmen's Compensation, Miller Bill	Assembly Int 185—Assemblyman Nicoll's Chiropractic Bill (Nicoll)
Assembly Int. 1429—Eyeglasses and Lenses	Assembly Int 422—Professional Secrets
	Assembly Int 649—Assemblyman Esmond's Chiropractic Bill (Esmond)
	Assembly Int 987—Birth Control
	Assembly Int. 1343—Defines Practice of Healing Art (Esmond)
	Assembly Int 1377—Anti-vivisection
	Assembly Int 1463—Chiropractic Bill (Bolton)

# TELEGRAM SENT TO COUNTY LEGISLATIVE CHAIRMEN

The following telegram has been sent to each County Legislative Chairman by your Committee on Legislation on Monday, March 9th, by reason of conflicting reports in newspapers and otherwise

"DISREGARD GARBLED NEWSPAPER REPORTS OF ACTION BY STATE MEDICAL SOCIETY OR ANYONE CLAIMING TO REPRESENT THEM PERIOD SEE VOTE HOUSE OF DELEGATES AND VOTE OF CONFERENCE OF CHAIRMEN PERIOD HOW COULD WE OR ANY REPRESENTATIVE OF STATE SOCIETY STOOP TO TRADE WITH CULTS PERIOD FAR BETTER IN OUR OPINION TO STAND BY RIGHT PRINCIPLE IN PROTECTION OF PUBLIC HEALTH EVEN IF DEFEATED AND THEN LATER PUT BURDEN OF CHANGE WHERE IT MAY BELONG PERIOD PERSONALLY WE HOPE COUNTY SOCIETIES WILL NOT THINK OF COMPROMISE PERIOD MEDICAL SOCIETY SHOULD STAND BY MAJORITY OF SOUND THINKING PEOPLE TO KEEP STANDARDS AT HIGHEST POINT PERIOD IF LEGISLATURE PASSES ACT OF LOWERING STANDARDS EACH LEGISLATOR IS THEN RESPONSIBLE TO HIS LOCAL CONSTITUENCY AND DOCTORS ARE ABSOLVED BY HAVING STOOD FOR HIGHEST MORAL ECONOMIC AND SCIENTIFIC PRINCIPLES"

JAMES N VANDER VEER,  
Chairman Committee on Legislation,  
Medical Society of the State of New York

---

## SUMMARY OF BILLS INTRODUCED IN LEGISLATURE IN SENATE

### Prohibition Enforcement

Senate Int No 29 (conc Assembly Int 527)  
—No further comment

### Commission on Crippled Children

Senate Int No 114 (conc. Assembly Int 226)  
—Passed both Houses, now before Governor

### The Narcotic Bill

Senate Int No 115 (conc Assembly Int 215)  
*Comment* Hearing on this bill to be held on Wednesday, March 11th, before the joint Senate and Assembly Committees on Public Health, at which your Committee on Legislation will appear in favor of the bill

At the conference of County Legislative Chairmen held on Wednesday, March 4th, an affirmative attitude was given on it

**Requiring the Licensing of Private Institutions for the Treatment of Drug Addicts**

Senate Int No 116 (conc Assembly Int 216)  
*Comment* No further comment.

**The State Department of Education Bill Amending The Medical Practice Act**

Senate Int No 211 (conc Assembly Int 307)  
*Comment* At the conference of County Legislative Chairmen but one dissenting vote representing a County Society was heard against this bill

Your Committee on Legislation was instructed to continue to work in behalf of the bill in conjunction with the State Department of Education

The last returns on going to press show that a majority of the delegates of your State Society have voted in favor of the bill

The hearing on this bill was held March 4th before the combined Public Health Committees of the Senate and Assembly, and the following were heard in opposition to the bill

Dr Joseph A Driscoll, representing Kings County Medical Society, which were in opposition to several features of the bill—in general relative to the omission of Section 170-d of the old bill which had to do with the advice against contraceptive measures, second, the supersession of the local District Attorney by the Attorney General at his discretion, being more of a local objection because of the excellent co-operation which the District Attorney gives to the Kings County Medical Society, and lastly, the matter of registration, which is considered unnecessary and uncalled for

Mr H A Bull, an attorney from Buffalo, N Y, spoke in opposition, representing the New York State Drugless Practitioners Society, but dwelt more upon the wish to pass the Gibbs bill, stating that these practitioners were not doctors of medicine, and if the Gibbs bill were adopted and licenses were issued to drugless practitioners, then there would be no serious objection on the part of his Society to the Karle-Dunmore bill, but the terms of the Karle-Dunmore bill were so broad that if it was adopted and the Gibbs bill defeated then they were against it, because the definition of the practice of medicine as it stands today from a lawyers point of view is a joke, being wild in its comprehensiveness. He acknowledged that it included chiropractors in its definition

Mr N B Vanderzee, of Albany, N Y, appeared for the New York State Chiropractic Society with no objection to the bill *provided the lists of exceptions also bore the words "or the practice of chiropractic"* He also made some remarks concerning the doctors regulating themselves

Mr Burton D Esmond, Assemblyman from Saratoga County, then attacked the bill from a legal standpoint, along the lines of the arguments which have been heard before, dwelling constantly upon the animus in the bill

Mr J W Malone, of Brooklyn, N Y, then spoke in opposition on behalf of the Professional Guild of Kings and Queens County, and read as his objections the ten objections published by the Kings County Society in its report of its Legislative Committee

Those who appeared in favor of the bill, by letter or otherwise, were

Frank P Graves, Commissioner of Education, State of New York, and Floyd C Haviland, M D, President State Hospital Commission, who wrote of their inability to be present, but were heartily in favor of the bill,

Owen E Jones, M D, President, Medical Society of the State of New York, who was interrupted by Assemblyman Esmond with a question,

Mary Dunning Rose, M D, representing the Women's Medical Society of the State of New York and the New York City Women's Medical Society, who advanced the arguments by comparative methods as to the necessity of safeguarding the public health as exhibited in the bill,

Matthias Nicoll, Jr, M D, Commissioner of Health, State of New York, then spoke in favor of the bill,

Ralph H Williams, D O, of Rochester, N Y, represented the New York State Osteopathic Society, who was questioned at some length by Assemblymen Berg and Esmond

Mr George W Whiteside, Counsel for the Medical Society of the State of New York, discussed the legal side of the bill and was questioned at some length by Assemblyman Esmond

Jacob Diner, M D, Ph G, Chairman of the Legislative Committee of the New York City Pharmaceutical Association, and former president of the New York State Pharmaceutical Association spoke in favor of the bill

Dr Augustus S Downing, Assistant Commissioner of Education and Director of Professional Education, State of New York, then spoke closing the arguments in favor of the bill, being interrupted by Assemblyman Esmond with a number of questions

An effort will be made to publish the minutes of the hearing, if the Society so desires

**Inspection by State Charities Boards of Children's Institutions**

Senate Int No 228

*Comment* No further comment as yet



### Qualifications of Examiners in Lunacy

Senate Int. No 263

A bill introduced in the Senate by Senator James A Higgins of Kings County, would amend section 61, Insanity Law, relative to qualifications of examiners in lunacy

Referred to General Laws Committees

*Comment* By motion of the County Legislative Chairmen at the conference it was unanimously voted to oppose this bill

### County Public Health Nurses

Senate Int No 283 (conc Assembly Int 399)

*Comment* This bill was also opposed in its present form at the conference of County Legislative Chairmen and it was hoped, as so expressed in the conference, that certain amendments which had been suggested by various members of the State Society would be incorporated in the bill and would be accepted by the introducer of the same in the Senate, Mr Webb, but he has seen fit only to hold the bill up pending the report as coming from the conference of County Legislative Chairmen, but no particular change has yet been made

The bill was introduced by the State Charities Aid Association and it is presumed that the Association is anxious to have it passed in its original form and that this is one of the principal reasons because of which no change has yet been made

### Health Service in Schools

Senate Int No 302 (conc Assembly Int 748)

*Comment* No further comment

### Injured Employee to Select His Physician

Senate Int No 380 (conc Assembly Int. 570)

*Comment* No further comment since at the date of going to press there is a hearing called on this measure for Wednesday March 11, before the joint Senate and Assembly Committees on Labor and Industry

### The Drugless Practitioner Bill (by Gibbs)

Senate Int No 473

*Comment* At the hearing on March 4th, the representatives of this cult appeared before the Public Health Committees and urged the passage of this bill, which it is admitted would allow of the practice of chiropractic and all other cults

It is an omnibus bill covering all phases of anti-medical (so-called) practice, and its proponents claim they are not practicing medicine, but take refuge under the "healing art" term as so used in another of the cult bills

To date no concurrent bill has made its appearance in the Assembly, and it is hoped that the good sense of the legislators will forbid of its being brought out even from committee, though a persistent fight must be maintained against its provisions

### Inspection of School Children

Senate Int No 586 (conc. Assembly Int. 850)

*Comment* Senate bill reported on March 4th, concurrent Assembly bill still in committee

### Free Choice of Physician

Senate Int No 594 (conc Assembly Int 301)

*Comment* See comment on Senate Int 380

### In Relation to Pharmacies

Senate Int No 632 (conc Assembly Int 802)

*Comment* It has been ascertained that this bill has been introduced in the interests of certain commercial groups who would establish so-called drug stores or pharmacies for the outlet of intoxicating liquors

Physicians are unlikely in such an instance to have their prescriptions properly filled in such commercial stores and, therefore, the bill is recalled to your attention in order that we may be recorded as against the same, and thus be assured of proper filling of prescriptions in legitimate pharmacies and drug stores

### Practical Tests of Injured Persons

Senate Int No 647 (conc Assembly Int 184)

*Comment* Hearing on this bill to be held on Wednesday March 11th, at which your Committee on Legislation will be represented to oppose the bill in its present form, in view of the fact that the present verbiage might be so construed legally as to admit of physical examinations being held by incompetent and lay persons

### Physically Handicapped Persons

Senate Int No 671 (conc Assembly Int 868)

*Comment* No further comment

### Abolishing Office of Coroner, Westchester County

Senate Int No 673—Senate bill reported February 18th, February 19th, third reading, February 23rd, passed; February 24th, to Assembly Internal Affairs Committee, March 4th, reported, March 5th, third reading

### Admission of Foreign Practitioners

Senate Int No 693 (conc Assembly Int 950)

*Comment* No further comment

### Revocation of License to Practice Medicine

Senate Int No 701

*Comment* No further comment

### Hospital for Crippled Children at West Haverstraw, N Y

Senate Int No 786 (conc Assembly Int 1074)

*Comment* At the conference of County Legislative Chairmen this bill and the succeeding bill in relation to the State Institute for the Study of Malignant Disease at Buffalo, were considered,

and it was unanimously carried that the legislators be importuned to defer action on these measures for a year, inasmuch as the physicians believe such important questions should not be acted upon without deliberation, in view of Senate Bill Int No 671, which has to do with physically handicapped persons and is in itself a complicated measure which should have a year of trial at least

#### **State Institute for Study of Malignant Disease**

Senate Int No 787 (conc Assembly Int. 973)

*Comment* See comment on Senate Int 786

#### **Rural Hygiene**

Senate Int 716 (conc Assembly Int 969)

*Comment* No further comment

#### **The Bouton Chiropractic Bill**

Senate Int 789—A bill introduced in the Senate by Senator Arthur F Bouton of Roxbury, N Y, would define and regulate the practice of Chiropractic

Referred to Public Health Committee

*Comment* At the Conference of County Legislative Chairmen it was voted unanimously to maintain the position taken heretofore by the Medical Society of the State of New York, that the definition of the practice of medicine is broad enough to include all who would practice the healing art, provided that the requirements of a basic education in the fundamentals were fulfilled, and that he who would practice a certain type of healing had proven to the satisfaction of competent judges in all lines of scientific endeavor that that special type of practice desired to be followed was based on scientific facts of the present day and squared itself with all of the sciences in its various features of application

The Medical Society of the State of New York is opposed to cultism of any type or form which does not recognize these broad fundamentals, and with this declaration your Committee on Legislation and other speakers appeared at the Legislative hearing on March 4th before the joint Senate and Assembly Committees on Public Health and opposed all of the cult bills which have been introduced thus far

At the hearing, the following spoke against these cult bills

Orrin S Wightman, M D, of New York, former President Medical Society of the State of New York

James N Vander Veer, M D, Chairman Committee on Legislation, Medical Society of the State of New York, who was questioned at some length concerning the features of the reasons why the medical profession were so solicitous as to the care of the public health

George R Critchlow, M D, of Buffalo, member of the Committee on Legislation, Medical

Society of the State of New York, dwelt especially upon the scientific advancements in medicine and the prevention and cure of many of the present diseases, which formerly were wide spread He was questioned by Assemblyman Berg and Senator Fearon regarding the latter's bill to which attention is called later in the comments During the course of his argument, he was interrupted by Mr John Nathanson, a drugless practitioner of Buffalo, who wished again to plead the cause of the drugless practitioner

James F Rooney, M D, former President of the Medical Society of the State of New York, then brought out the various waiver clauses in the various cult bills and spoke in opposition to them along the line of education and particularly of training, pointing out that one might cram for an examination, but that in training there enters in the experiences of the preceptor and the contact between student and patient

He drew an analogy between the medical profession and the legal profession and the jealousy with which the legal profession at the present time guards its portals In this he portrayed the reasons why anyone who practices any part of the healing art must be schooled to know the diagnosis as in the cases seen of a pregnant woman or one who has a fibroid tumor of the uterus, as well as why it would be necessary for cultists to recognize and be able to diagnose cases of cancer Also he objected to the admission of cultists of chiropractic type under a waiver clause in the Fearon bill who had practiced for 8 years since having had certain preliminary educational qualifications and supposed experience in practice, they most of all should be able to pass a reasonable examination in fundamentals

Thomas R Thorburn, D O, President of the New York State Osteopathic Society, then read excerpts in his argument, which tended to show that chiropractic was evolved from osteopathy and that if chiropractors really had anything in their system of treatment it was along the lines of osteopathy and should be recognized as such and they should be required to pass an examination equivalent to the present osteopathic examination and closed his argument with the three statements "that the branch of the healing art which is based upon the correction of vertebral subluxations as a cure for disease is already regulated,"

Second, "That the bills under consideration advocate lowering the standards of education for the non-drug practitioners,"

Third, "That it is distinctly class legislation, inasmuch as it extends equal privileges to the chiropractor and osteopath, while requiring a greater professional education of the osteopath"

Dr Thorburn also was questioned at great length, as well as was Dr Downing, relative to the admission of osteopaths in 1907

Matthias Nicoll, Jr, M D, Commissioner of Health, State of New York, closed the arguments against the bills by making statements that chiropractors and other drugless healers, without let or hindrance, were practicing on every kind of case and, speaking from the standpoint of the public health as he viewed it, stated that there were numbers of people who evidently wanted their spines adjusted, their backs rubbed and so forth, and he did not believe it could be stopped by any process of law.

In fact, he had reached the conclusion with sadness and humiliation that while he did not approve of any of the bills that were before them he believed that it was possible for members of the committees on Public Health to get up some kind of a bill that would let in just as few of these people as could be limited, but that as Commissioner of Health he felt that in standing pat the health of the public was suffering through the practices of cultists, who were untrained in matters of health and communicable diseases, and he made the statement that he was against any bill which admitted anyone to practice on any case of any disease listed as communicable in the State or City Departments of Health

Dr Augustus S Downing closed the arguments for the individuals who had spoken against the bill and there ensued a dialogue between Dr Downing and Senator Fearon, relative to the Fearon bill

The Commissioner of Health of the City of New York was represented in opposition to all of the cult bills, except the Fearon bill, if it could be amended to jibe with the lines suggested by Commissioner Nicoll, by Mr O'Sullivan

The hearing adjourned at 7 45 P M and reconvened at 8 55 P M, when the proponents for the various cult bills spoke again in behalf of their bills, the arguments of which were that the scientific men of the present day, as represented in the various sciences making up the practice of medicine, do not understand the practice of chiropractic and drugless healing and,

therefore, examinations, if any, should be given only by members of that cult through legalizing the cult and then in some manner having examining boards

#### Dissecting Material

Senate Int No 851—*Comment* We take up this bill once more and ask County Legislative Chairmen to write in favor of the bill, as it has to do with benefiting laboratories, hospitals and institutions where dissection is carried on for the promotion of scientific investigation

#### Laboratory Supplies

Senate Int. No 943 (conc Assembly Int. 1167) —Bill printed in full in Feb 27th JOURNAL, under Assembly Int No 1167, page 343

*Comment* The Conference of County Legislative Chairmen went on record as opposed to this bill, for many of the reasons as stated in previous issues

#### A Chiropractic Bill by Mr. Fearon

Senate Int No 944

*Comment* See comment of hearing March 4th, under Senate Int No 789

#### Foreign Licenses

Senate Int No 1123 (conc. Assembly Int 1478)

*Comment* No comment will be offered, as this is essentially an educational bill and inserts the privilege of a physician coming from a foreign country on an equality with a physician entering New York state from another state.

#### Censors State Medical Society

Senate Int No 1176 (conc Assembly Int 1348)

*Comment* This bill is one introduced by Senator Karle and Assemblyman Lattin at the request of the Medical Society of the State of New York, and the County Legislative Chairmen are urged to write the members of the Public Health Committees of Senate and Assembly asking that it be advanced rapidly, since it has to do only with the governing body of the State Society

### IN ASSEMBLY

#### Health Service in Schools

Assembly Int 127—*Comment* Since the previous comment on this bill it has been amended by the addition of the word "podiatrist," and recommended to the Assembly Public Education Committee

#### Practical Tests of Injured Persons

Assembly Int No 184 (conc Senate Int 647) —See concurrent Senate Int No 647 for comment

#### The Nicoll Chiropractic Bill

Assembly Int 185—A bill introduced in the Assembly by Assemblyman William Nicoll of

Schnectady County, would define and regulate the practice of Chiropractic

Referred to Public Health Committee

*Comment* See comment under Senate Int 789

#### The Narcotic Bill

Assembly Int No 215 (conc Senate Int 115) —See concurrent Senate Int No 115 for comment

#### Institutions for Addicts

Assembly Int No 216 (conc Senate Int 116) —See concurrent Senate Int No 116 for comment

**Mentally Retarded Children**

Assembly Int 229—A bill introduced in the Assembly by Assemblyman A Spencer Feld of New York County, would add new section 579-a, Education Law, providing for county supervisors to supervise education of children with retarded development

Referred to Public Education Committee

*Comment* No further comment

**Children's Institutions**

Assembly Int No 236 (conc Senate Int 228)  
—See concurrent Senate Int No 228 for comment

**Free Choice of Physician**

Assembly Int No 301 (conc Senate Int 594)  
—See concurrent Senate Int 594 for comment.

**The State Department of Education Bill Amending the Medical Practice Act**

Assembly Int No 307 (conc Senate Int 211)  
—See concurrent Senate Int 211 for comment

**County Public Health Nurses**

Assembly Int No 399 (conc Senate Int 283)  
—See concurrent Senate Int No 283 for comment

**Disclosure of Confidential Communications**

Assembly Int No 422—A bill introduced in the Assembly by Assemblyman Samuel Rosenman of New York County would amend section 352, Civil Practice Act, by providing physicians and nurses may disclose professional information as witnesses in action to annul marriage on ground of fraud

Referred to Codes Committee

*Comment* No further comment

**Prohibition Enforcement**

Assembly Int No 527 (conc Senate Int 29)  
—See concurrent Senate Int No 29 for comment

**Free Choice of Physician**

Assembly Int No 570 (conc Senate Int 380)  
—See concurrent Senate Int No 380 for comment

**Vaccine Virus**

Senate Int No 351 (conc Assembly Int 536)  
—*Comment* Assembly bill reported Feb 19th, Feb 20th, third reading, Feb 26th, passed, Mar 2nd to Senate Public Health Committee

**Chiropractic Bill by Esmond**

Assembly Int No 649—A bill introduced in the Assembly by Assemblyman Burton D Esmond of Saratoga County would amend sections 164, 149, 170, 173, adding new article 8-b Public Health Law, relative to the practice of medicine and to chiropractic

Referred to Public Health Committees

*Comment* See comment under Senate Int No 789

**The Periodic Health Examination of Food Handlers**

Assembly Int No 678—A bill introduced in the Assembly by Assemblyman Harry A. Samberg of Bronx County, would add new section 343-d Public Health Law, requiring that every person employed in preparing or handling of food in any factory or other place shall, at time of entering employment and every six months thereafter, be examined by a physician to determine whether person has a communicable disease

Referred to Public Health Committee

Still in committee.

**Health Service in Schools**

Assembly Int No 748 (conc Senate Int 302)  
—See concurrent Senate Int No 302 for comment

**Medical Inspection in Schools**

Assembly Int No 850 (conc Senate Int 586)  
—See concurrent Senate Int No 586

**Physically Handicapped Persons**

Assembly Int No 868 (conc Senate Int 671)  
—See concurrent Senate 671 for comment

**Regulating Sale of Wood or Methanol Alcohol**

Assembly Int 908—A bill introduced in the Assembly by Assemblyman Frank H Lattin of Orleans County, would add new sections 416, 447, 447-a Penal Law, forbidding sale of wood or methyl alcohol except as methanol, and making it a felony to sell goods or drink or medicinal or toilet preparations for internal use in which there is methanol

Referred to Codes Committee

Feb 23rd, amend and recommit

No further comment

**Reciprocity in Licensure**

Assembly Int No 925—A bill introduced in the Assembly by Assemblyman Edward J Coughlin of Brooklyn, N Y, would amend section 169 Public Health Law, relative to licenses of practice medicine who have received the license in another state

Referrer to Public Health Committee

No further comment

**Rural Hygiene**

Assembly Int No 969 (conc Senate Int 716)  
—See concurrent Senate Int 716

**Admission of Foreign Practitioners**

Assembly Int No 950 (conc Senate Int 693)  
—See concurrent Senate 693

**Dissecting Material**

Assembly Int No 986 (conc Senate Int 681)  
—See concurrent Senate 681

### The Birth Control Bill

Assembly Int No 987—A bill introduced in the Assembly by Assemblyman John Boyle, Jr, of Suffolk County, would amend section 1145, Penal Law, by permitting use of instruments for contraceptive treatment of married persons

Referred to Codes Committee

*Comment* A hearing has been called on this bill for March 17 At the Conference of County Legislative Chairmen a unanimous vote was recorded against the bill

### CENSORS STATE MEDICAL SOCIETY

No 1460

Int 1348

IN ASSEMBLY,

March 2, 1925

Introduced by Mr Lattin—read once and referred to the Committee on Public Health

#### AN ACT

To repeal section three of chapter two hundred and six of the laws of eighteen hundred and eighteen, entitled "An act to amend an act, entitled 'An act to incorporate medical societies for the purpose of regulating the practice of physic and surgery in this state as amended by chapter six hundred and forty-seven of the laws of eighteen hundred and eighty-seven,'" relating to the appointment of censors by the state medical society

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section three of chapter two hundred and six of the laws of eighteen hundred and eighteen, entitled "An act to amend an act entitled 'An act to incorporate medical societies for the purpose of regulating the practice of physic and surgery in this state'" as repealed in part by chapter six hundred and forty-seven of the laws of eighteen hundred and eighty-seven, is hereby repealed

§ 2 This act shall take effect immediately

For comment, see Senate Int 1176

#### Antivivisection Bill

Assembly Int No 1377—A bill introduced in the Assembly by Assemblyman John L. Buckley of New York City, would amend section 185, Penal Law, by prohibiting scientific experiments on living dogs

Referred to Codes Committee

No 1494

Int 1377

IN ASSEMBLY,

March 3, 1925

Introduced by Mr Buckley—read once and referred to the Committee on Codes

#### AN ACT\*

To amend the penal law, in relation to experiments upon living dogs

*The People of the State of New York, represented in Senate and Assembly do enact as follows*

Section 1 Section one hundred and eighty-

five of the penal law is hereby amended to read as follows

§ 185 Overdriving, torturing and injuring animals, failure to provide proper sustenance A person who overdrives, overloads, tortures or cruelly beats or unjustifiably injures, maims, mutilates or kills any animal, whether wild or tame, and whether belonging to himself or to another, or deprives any animal of necessary sustenance, food or drink, or neglects or refuses to furnish it such sustenance or drink, or causes, procures or permits any animal to be overdriven, overloaded, tortured, cruelly beaten, or unjustifiably injured, maimed, mutilated or killed, or to be deprived of necessary food or drink, or who wilfully sets on foot, instigates, engages in, or in any way furthers any act of cruelty to any animal, or any act tending to produce such cruelty is guilty of a misdemeanor Nothing herein contained shall be construed to prohibit or interfere with any properly conducted scientific experiments or investigations, which experiments shall be performed only under the authority of the faculty of some regularly incorporated medical college or university of this state, *but such experiments or investigations shall not be made upon a living dog*

§ 2 This act shall take effect immediately

*Comment* This is our old friend the Antivivisection bill and County Legislative Chairmen are forewarned that unless they oppose it vigorously to the Codes Committee of the Assembly of which Mr Burton D Esmond is the Chairman, although it has not as yet made its appearance in the Senate but will without doubt do so shortly

#### Practice of Chiropraxy and Podiatry

Assembly Int No 1421—A bill introduced in the Assembly by Assemblyman Morris Weinfeld, of New York County, would add new sections 281-b, 281-c, Public Health Law, making it a misdemeanor to practice chiropraxy and podiatry without a license and providing for revocation of license for certain advertising

Referred to Public Health Committee

No 1538

Int 1421

IN ASSEMBLY,

March 3, 1925

Introduced by Mr Weinfeld—read once and referred to the Committee on Public Health.

#### AN ACT

To amend the public health law, in relation to the practice of chiropraxy and podiatry

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Article thirteen of chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health,

\* Matter in italics is new matter in brackets [ ] is old law to be omitted.

constituting chapter forty-five of the consolidated laws," is hereby amended by adding thereto two new sections, to follow section two hundred and eighty-one-a, to be sections two hundred and eighty-one-b and two hundred and eighty-one-c, respectively, to read as follows

§ 281-b Unlawful practice of chiropody Any person who shall advertise to practice chiropody, without being lawfully licensed and registered as a chiropodist, or as a duly licensed physician or any business corporation which shall practice chiropody or advertise to practice chiropody, or any person who shall practice or advertise to practice chiropody under a certificate of trade name shall be guilty of a misdemeanor, and shall, on conviction, for each and every offense be punished by a fine of not less than fifty dollars nor more than one hundred dollars or by imprisonment for a term not less than thirty days and not more than one year or by both fine and imprisonment

This section shall not be construed to forbid or prevent the employment by any person, association or corporation of a duly licensed and registered chiropodist to treat employees or members thereof at the expense of said person, association or corporation, nor shall this act apply to any persons or manufacturers who mechanically fit or sell artificial limbs or foot apparatus or appliances

§ 281-c Chiropodist, revocation of license Any licensed and registered chiropodist who shall use, distribute, or display upon any card, sign or advertisement, the words, or any of them, "Foot specialist," "Surgeon," "Orthopedic Specialist," or in any manner upon any card, sign, or advertisement hold himself out as being able to treat all diseases or all ailments or all conditions of the foot, shall be subject to the revocation of his license and the annulment of his registration in the manner provided by section two hundred and eighty-one for proceedings for the revocation of a license and the annulment of a registration

§ 2 This act shall take effect immediately

*Comment* It will be seen by this bill that the chiropodists and podiatrists would raise their standard of ethics and the bill is printed for the information of the medical profession

#### Fearon-Jenks Chiropractic Bill

Assembly Int No 1423 (conc Senate 944)—A bill introduced in the Assembly by Assemblyman Edmund B Jenks, of Broome County, would amend sections 164, 165, 167, 169, 170, 173, 174, repeal section 171, Public Health Law, relative to practice of medicine and to licensing chiropractors

*Comment* See comment under Senate Int No 789

Assembly Int No 1429—A bill introduced in the Assembly by Assemblyman John J Meegan, of Erie County, would amend section 308, renumbers old section 308 as 309 and amends it, Public Health Law, prohibiting sale of eyeglasses and lenses at retail in any store unless a duly licensed physician or qualified certified optometrist is in charge

Referred to Public Health Committee

No 1546

Int 1429

IN ASSEMBLY,

March 3, 1925

Introduced by Mr Meegan—read once and referred to the Committee on Public Health

#### AN ACT\*

To amend the public health law, in relation to sales of spectacles, eye glasses and lenses, as merchandise, at retail

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," is hereby amended by inserting therein, in article fifteen thereof, a new section, to be section three hundred and eight, to read as follows

§ 308 Sales of eye glasses, spectacles and lenses at retail It shall be unlawful for any person, firm or corporation to sell, at retail, as merchandise, in any store or established place of business in the state, any spectacles, eyeglasses or lenses, unless a duly licensed physician or duly qualified optometrist, certified under this article, be in charge of and personal attendance at the booth, counter or place, and each booth, counter or place, where such articles are sold in such store or established place of business The peddling of spectacles, eyeglasses or lenses from house to house or on the streets or highways, by a person other than such an optometrist or physician, also shall be unlawful, notwithstanding any law providing for licensing peddlers

§ 2 Section three hundred and eight of such chapter is hereby renumbered section three hundred and nine and amended to read as follows

§ [308] 309 Construction of article Nothing in this article shall be construed to apply to duly licensed physicians authorized to practice medicine under the laws of the state of New York nor to persons who neither practice nor profess to practice optometry, who sell spectacles, eyeglasses

\* Matter in italics is new matter in brackets [ ] is old law to be omitted

or lenses [either] only on prescription from such physicians or from such duly qualified optometrists [, or as merchandise from permanently located and established places of business]

§ 3 This act shall take effect September first, nineteen hundred and twenty-five

*Comment* This bill is an attempt to protect the public health still further as its text indicates

For the time being there will be no further comment

Assembly Int No 1450—A bill introduced in the Assembly, by Assemblyman Mark T Lambert, of Niagara County, would amend section 196, Public Health Law by providing for registration and licensing of a dental hygienist of a woman fulfilling certain conditions

Referred to Public Health Committee

*Comment* As in the medical profession there are sub-practitioners with the title of "nurse," so in the dental practice are there sub-practitioners with the title of "dental hygienist" and this bill has to do with raising the standard of the latter

The bill is not printed since it does not concern the medical profession to any great degree

#### Laboratory Supplies

Assembly Int No 1167 (conc Senate Int 943)—See concurrent Senate Int 943 for comment

#### Another Esmond Chiropractic Bill

Assembly Int No 1343—A bill introduced in the Assembly, by Assemblyman Burton D Edmond of Saratoga County, would add new article 7-a, amends section 160, Public Health Law, defining practice of the healing art and providing for diagnosis examinations by a State Board

Referred to Public Health Committee

No 1455

Int 1343

IN ASSEMBLY,

March 2, 1925

Introduced by Mr Esmond—read once and referred to the Committee on Public Health

#### AN ACT\*

To amend the public health law, in relation to the practice of the healing art.

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," is hereby amended by inserting therein a new article, to follow article seven, to be article seven-a, to read as follows

\* Matter in italics is new matter in brackets [ ] is old law to be omitted

#### ARTICLE 7-A

#### Practice of the Healing Art

#### Section 146 Definitions

147 Diagnosis examinations

148 Further examinations required to practice any particular branch of the healing art.

149 Construction of this article

§ 146 "Practice of the healing art" is defined as follows a person practices the healing art within the meaning of this chapter who holds himself out as being able to diagnose, treat, operate, or prescribe for any human disease, pain, injury, deformity, or physical condition, and who shall offer or undertake, by any means or method, to diagnose, treat, operate or prescribe for any human disease, pain, deformity or physical condition

§ 147 Diagnosis examinations No person shall practice the healing art, or any branch thereof, until he shall have passed an examination by the board of diagnosis examiners in the following diagnosis subjects anatomy, physiology, hygiene, sanitation, biological chemistry, diathetics, histology embryology, bacteriology, pathology, diagnosis, and symptomatology The board of diagnosis examiners shall until otherwise provided by law consist of the board of medical examiners Said board shall examine all applicants who present proof of the qualifications required for admission to examination in any branch of the healing art prescribed in this chapter Such examinations shall be uniform in respect to subjects, questions, grading, time and place, papers, values given to answers, method and manner of marking, percentages required for passing, and personnel of board or committee of board, for all branches of the healing art, including physicians and surgeons Each applicant must pass such examination with a rating of at least seventy-five per centum in each subject. Upon passing such examination each applicant must be certified by the board to the regents to have so passed such examination, and the Regents must thereupon credit the same to such applicant upon any further examination of such applicant to practice any particular branch of the healing art as herein defined

§ 148 Further examinations required to practice any particular branch of the healing art No person shall practice any branch of the healing art until he shall have passed the further examination prescribed in this chapter governing admission to practice that particular branch thereof

§ 149 Construction of this article This article shall not be construed to affect commissioned medical officers serving in the United States army, navy or marine hospital service, while so commissioned, nor any one while actually serving

constituting chapter forty-five of the consolidated laws," is hereby amended by adding thereto two new sections, to follow section two hundred and eighty-one-a, to be sections two hundred and eighty-one-b and two hundred and eighty-one-c, respectively, to read as follows

§ 281-b Unlawful practice of chiropody Any person who shall advertise to practice chiropody, without being lawfully licensed and registered as a chiropodist, or as a duly licensed physician or any business corporation which shall practice chiropody or advertise to practice chiropody, or any person who shall practice or advertise to practice chiropody under a certificate of trade name shall be guilty of a misdemeanor, and shall, on conviction, for each and every offense be punished by a fine of not less than fifty dollars nor more than one hundred dollars or by imprisonment for a term not less than thirty days and not more than one year or by both fine and imprisonment

This section shall not be construed to forbid or prevent the employment by any person, association or corporation of a duly licensed and registered chiropodist to treat employees or members thereof at the expense of said person, association or corporation, nor shall this act apply to any persons or manufacturers who mechanically fit or sell artificial limbs or foot apparatus or appliances

§ 281-c. Chiropodist, revocation of license Any licensed and registered chiropodist who shall use, distribute, or display upon any card, sign or advertisement, the words, or any of them, "Foot specialist," "Surgeon," "Orthopedic Specialist," or in any manner upon any card, sign, or advertisement hold himself out as being able to treat all diseases or all ailments or all conditions of the foot, shall be subject to the revocation of his license and the annulment of his registration in the manner provided by section two hundred and eighty-one for proceedings for the revocation of a license and the annulment of a registration

§ 2 This act shall take effect immediately

*Comment* It will be seen by this bill that the chiropodists and podiatrists would raise their standard of ethics and the bill is printed for the information of the medical profession

#### Fearon-Jenks Chiropractic Bill

Assembly Int No 1423 (conc Senate 944)—A bill introduced in the Assembly by Assemblyman Edmund B Jenks, of Broome County, would amend sections 164, 165, 167, 169, 170, 173, 174, repeal section 171, Public Health Law, relative to practice of medicine and to licensing chiropractors

*Comment* See comment under Senate Int No 789

Assembly Int No 1429—A bill introduced in the Assembly by Assemblyman John J Meegan, of Erie County, would amend section 308, renumbers old section 308 as 309 and amends it, Public Health Law, prohibiting sale of eyeglasses and lenses at retail in any store unless a duly licensed physician or qualified certified optometrist is in charge

Referred to Public Health Committee

No 1546

Int 1429

IN ASSEMBLY,

March 3, 1925

Introduced by Mr Meegan—read once and referred to the Committee on Public Health

#### AN ACT\*

To amend the public health law, in relation to sales of spectacles, eye glasses and lenses, as merchandise, at retail

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," is hereby amended by inserting therein, in article fifteen thereof, a new section, to be section three hundred and eight, to read as follows

§ 308 Sales of eye glasses, spectacles and lenses at retail It shall be unlawful for any person, firm or corporation to sell, at retail, as merchandise, in any store or established place of business in the state, any spectacles, eyeglasses or lenses, unless a duly licensed physician or duly qualified optometrist, certified under this article, be in charge of and personal attendance at the booth, counter or place, and each booth, counter or place, where such articles are sold in such store or established place of business The peddling of spectacles, eyeglasses or lenses from house to house or on the streets or highways, by a person other than such an optometrist or physician, also shall be unlawful, notwithstanding any law providing for licensing peddlers

§ 2 Section three hundred and eight of such chapter is hereby renumbered section three hundred and nine and amended to read as follows

§ [308] 309 Construction of article Nothing in this article shall be construed to apply to duly licensed physicians authorized to practice medicine under the laws of the state of New York nor to persons who neither practice nor profess to practice optometry, who sell spectacles, eyeglasses

\* Matter in italics is new matter in brackets [ ] is old law to be omitted.



§ 80 Treatment and care of injured employees The employer shall promptly provide for an injured employee such medical, surgical or other attendance or treatment, nurse and hospital service, medicine, crutches and apparatus for such period as the nature of the injury or the process of recovery may require. If the employer fail to provide the same, after request by the injured employee such injured employee may do so at the expense of the employer. The employee shall not be entitled to recover any amount expended by him for such treatment or services unless he shall have requested the employer to furnish the same and the employer shall have refused or neglected to do so, or unless the nature of the injury required such treatment and services and the employer or his superintendent or foremen having knowledge of such injury shall have neglected to provide the same, nor shall any claim for medical or surgical treatment be valid and enforceable, as against such employer, unless within twenty days following the first treatment, the physician giving such treatment, furnish to the employer and the industrial commissioner a report of such injury and treatment, on a form prescribed by the industrial commissioner. All fees and other charges for such treatment and services shall be subject to regulation by the commissioner as provided in section twenty-four of this chapter, and shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living.

§ 81 Medical director There shall be a medical director. He shall be a licensed physician in good professional standing, a graduate of a recognized medical college and he shall be appointed by the industrial commissioner from a group of at least three such physicians, proposed by the New York State Medical Society as being qualified for the position. He shall receive an annual salary of eight thousand dollars. It shall be the duty of the medical director to (1) advise the board and the referees on medical questions arising in their work, (2) to examine fee bills and recommend settlements of those in dispute, (3) to supervise and supplement the work of the examining physicians, (4) to put into effect recommendations and decisions approved by the board, (5) to advise with physicians treating compensation cases as to the best methods of treatment and to acquaint them with new developments and trends in the treatment of industrial cases.

§ 82 Examining physicians Examining physicians shall be appointed by the medical director in such number as shall be reasonably necessary for the proper administration of the medical provisions of this chapter. They shall be licensed graduates of recognized medical schools who are in good professional standing. It shall be the

duty of examining physicians to make examinations of injured workers at such time or times as shall be prescribed by the board or the referees or the medical director, to determine the extent and probable duration of disability and the extent of permanent impairment, if any, and such other duties as the medical director may prescribe. Fees of examining physicians shall be recommended by the medical director and determined by the board.

§ 83 Conflicts of medical evidence If, on the hearing of a claim for compensation or for death benefits, a conflict of medical evidence shall arise upon a material issue, the entire record, at the completion of the hearing or hearings, shall be referred to the medical director, who shall nominate a disinterested medical specialist (or, if the medical question involved is not one upon which there is specialization, a disinterested medical authority), to be agreed upon by the parties in interest, to review the testimony, re-open and determine the issues and decide the medical question involved. Such medical specialist or authority may make such physical examination of the claimant as he may deem necessary or proper. The fee of such specialist or authority, when approved by the medical director, as to amount, shall be a proper charge against the insurance carrier or the employer.

§ 2 Section nineteen of such chapter is hereby re-numbered section eighty-four and is transferred from article two to article four-b.

§ 3 Section twelve of such chapter is hereby amended to read as follows:

§ 12 Compensation not allowed for first seven days No compensation shall be allowed for the first seven days of disability, except the benefits provided for in section [thirteen] *eighty* of this chapter, provided, however, that in case the injury results in disability of more than forty-nine days, the compensation shall be allowed from the date of the disability.

§ 4 Section thirteen of such chapter is hereby repealed.

§ 5 This act shall take effect immediately.

*Comment* Attention is especially called to this bill and County Legislative Chairmen and others through County Society action should put their weight behind this bill in asking for its passage.

Especially should members of the Medical Society of the State of New York read over sections 81, 82 and 83, for in these sections Mr. Miller has to a large degree solved the crux of the conflict which has existed in the labor laws relative to medical attendance, judgment, supervision, advice to the industrial board, examination of fee bills, examining physicians, employment of specialists and the like.

without salary or professional fees on the resident medical staff of any legally incorporated hospital *or any one while actually serving as an interne in a state hospital or other state institution in which medical service is provided*, or any person or manufacturer who mechanically fits or sells lenses, artificial eyes, limbs or other apparatus or appliances, or is engaged in the mechanical examination of eyes, for the purpose of constructing or adjusting spectacles, eye glasses and lenses, or any lawfully qualified physician in other states or countries meeting legally registered physicians in this state in consultation, or any physician residing on a border of a neighboring state and duly licensed under the laws thereof to practice medicine therein, whose practice extends into this state, and who does not open an office or appoint a place to meet patients or receive calls within this state, or any physician duly registered in one county called to attend isolated cases in another county, but not residing or habitually practicing therein, or the furnishing of medical assistance in case of emergency, or the domestic administration of family remedies, or the practice of the religious tenets of any church, or any person who shall at the time this act takes effect be licensed to practice any branch of the healing art in the state of New York

§ 2 Section one hundred and sixty of article eight of such chapter as last amended, is hereby amended to read as follows

§ 160 Definitions As used in this article

1 "The education department" means the education department of the state of New York as provided for by the education law

2 "University" means university of the state of New York

3 "Regents" means board of regents of the university of the state of New York

4 "Board" means the board of medical examiners of the state of New York

5 "Medical examiner" means a member of the board of medical examiners of the state of New York

6 "Medical school" means any medical school, college or department of a university, registered by the regents as maintaining a proper medical standard and as legally incorporated

7 The practice of medicine is defined as follows A person practices medicine within the meaning of this article[, except as hereinafter stated,] who holds himself out as being able to diagnose [, treat, operate or] *and prescribe medicine or drugs* for any human disease, pain, injury, deformity or physical condition, and who shall either offer or undertake [, by any means or method,] to diagnose[, treat, operate or] *and prescribe medicine or drugs* for any human dis-

ease, pain, injury, deformity or physical condition

8 "Physician" means a practitioner of medicine

9 "Surgeon" means one who treats diseases, malformations or deformities of the human body by manual operations or by surgical appliances, other than by the practice of dentistry, registered nurse, chiropody, optometry, midwifery, podiatry, osteopathy, chiropractic, medicine, or other branch of the healing art in this chapter defined

10 Practice of surgery No one but a duly licensed physician shall practice surgery

§ 3 This act shall take effect January first, nineteen hundred and twenty-six

*Comment* See comment under Senate Int No 789

#### Medical Treatment of Injured Employees

Assembly Int No 1351—A bill introduced in the Assembly by Assemblyman Charles P Miller of Genesee County, would add new article 4-b, amends section 12, repeals section 13, Workmen's Compensation Law, relative to medical treatment of injured employees and to procedure Referred to Labor and Industries Committee

No 1463 Int 1351  
IN ASSEMBLY, March 2, 1925

Introduced by Mr C P Miller—read once and referred to the Committee on Labor and Industries

#### AN ACT\*

To amend the workmen's compensation law, in relation to medical procedure.

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Chapter eight hundred and sixteen of the laws of nineteen hundred and thirteen, entitled "An act in relation to assuring compensation for injuries or death of certain employees in the course of their employment, constituting chapter forty-seven of the consolidated laws," as re-enacted by chapter forty-one of the laws of nineteen hundred and fourteen, and further re-enacted and amended by chapter six hundred and fifteen of the laws of nineteen hundred and twenty-two is hereby amended by the insertion therein of a new article, to be article four-b, to read as follows

#### ARTICLE 4-B

##### Medical Procedure

Section 80 Treatment and care of injured employees

81 Medical director

82 Examining physicians

83 Conflicts of medical evidence

84 Physical examination

\* Matter in italics is new matter in brackets [ ] is old law to be omitted.

and fairly mark and grade the answers thereto, all of which shall be done solely for the purpose of determining whether the applicant is reasonably qualified to practice Chiropractic. All applicants reasonably qualified to practice Chiropractic shall be granted a license

**Section 189-g Licenses** All licenses shall be signed by the president and secretary of the Board, and shall be attested by the official seal of the Board. The licensee shall pay to the secretary of the Board before the license is issued a fee of five dollars. Every license to practice Chiropractic shall, before the licensee begins practice thereunder, be registered in a book kept in the clerk's office of the county where such practice is to be carried on, with name, residence, place and date of birth, and source, number and date of license to practice

Every licensee shall be required to pay to the secretary of Board an annual renewal license fee of two dollars

**Section 189-h Licenses Without Examination** Any person of good moral character who has been continuously engaged in the practice of Chiropractic in the state for two years prior to the passage of this article shall be licensed without examination, upon payment to the secretary of the Board of a fee of twenty dollars, if he applies for a license within twenty days after the organization of the Board

**Section 189-i Reciprocity** Any person of good moral character, licensed by a Chiropractic Board of any other state or territory or holding a certificate from the National Board of Chiropractic Examiners, shall be licensed without examination, upon payment to the secretary of the Board of a fee of twenty dollars

**Section 189-j Revocation** Upon complaint to the Board, after twenty days' notice of time and place of trial has been given to any licensee, if it shall be found that he practices anything other than Chiropractic to cure or relieve disease or to remove the cause thereof without having a separate license therefor, or, if it be found that he no longer possesses a good moral character or is addicted to the use of narcotic drugs or in any way is guilty of deception or fraud in the practice of Chiropractic, his license shall be revoked

The action of the Board shall be reviewable by certiorari proceedings

**Section 189-k Finances** Within ten days after the close of every meeting of the Board, the treasurer of the Board shall turn over to the state treasurer all fees and money received by the Board, and take his receipt therefor

The state treasurer shall keep the same in a separate fund, to be used in paying running expenses of the Board and a per diem compensation of fifteen dollars to the members thereof for such time as they may actually spend in the discharge of their official duties and traveling expenses

Payment from such fund shall be made by the state treasurer on the warrant of the comptroller and the vouchers of the president of the Board

If, at the close of any fiscal year, there remains in the hands of the state treasurer from moneys received from the Board, one thousand dollars in excess of all indebtedness of the Board, the same shall be turned over to the public school fund

**Section 189-l Penalties** Any person violating any of the provisions of this article shall be deemed guilty of a misdemeanor and upon conviction thereof shall be punished by a fine not to exceed three hundred dollars or by imprisonment for a term not to exceed three months, or by both such fine and imprisonment

**Section 2 Repeal** All acts or parts of acts in conflict with this article, are hereby repealed

**Section 3 When Act to Take Effect** This act shall take effect immediately

*Comment* See comment under Senate Int No 789

This bill is the lowest grade bill thus far introduced

#### **Time for Filing Claims for Personal Injuries**

Assembly Int 1502—A bill introduced in the Assembly by Assemblyman Irwin Steingut of Kings County, would amend section 51, Civil Practice Act, by requiring notice of claim for personal injury to be filed within three months after accident

Referred to Codes Committee

*Comment* Attention of members of the medical profession is called to this bill since it is a general bill which affects all the citizens of this state who carry accident insurance and would limit the legal time for filing of claims in case of accident to three months, wherein some of our accident policies which unlimited time might be changed so as to accord with the shorter time as evidenced in this bill

Comment is simply made because of the fact it is one of the types of legislation that presents itself and affects the individual

It is now put squarely up to the Medical Society of the State of New York to show its good faith in handling the medical situation which has heretofore been so baffling

From all sources there has come a wave of congratulation to Mr Miller for his sound thinking and thus his attempt to place the burden of the medical features of the board squarely where they belong

Letters should be sent to Mr Miller personally, and to the Committee on Labor and Industry as well as to the individual legislators asking for this type of legislation

Assembly Int 1463—A bill introduced in the Assembly, by Assemblyman Richard J Bolton, of Warren County, would add new article 8-b, Public Health Law, creating board of chiropractic examiners and regulating practice of chiropractic

Referred to Ways and Means Committee

Int No 1463

IN ASSEMBLY,

AN ACT

Introduced by Mr Bolton—To amend the Public Health Law creating a Board of Chiropractic Examiners and regulating the practice of Chiropractic and prohibiting the practice of any other mode or system under the name of Chiropractic.

Section 1 Chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," is hereby amended by inserting therein a new article, to follow article eight-a, to be article eight-b, to read as follows

#### ARTICLE 8-B

Section 189 Creation of a Board There is hereby created a Board of Chiropractic Examiners, to be known as the State Board of Chiropractic Examiners

The Board of Chiropractic Examiners shall consist of three members who shall be appointed by the Governor within thirty days after this article takes effect

The appointees shall meet within ten days after their appointment and organize by electing a president, secretary and treasurer, and adopting reasonable rules and regulations for the transaction of business

The appointees shall have the qualifications set forth in Section 189-h of this article Subsequent appointees shall be graduates of Chiropractic Schools or Colleges giving a course of at least three years of six months each, in anatomy, physiology, symptomatology, hygiene, sanitation, Chiropractic analysis and the principles and practice of Chiropractic and requiring actual attend-

ance upon the classes No one may be appointed who practices anything but Chiropractic, as hereinafter defined

The term of office of the first member shall be one year, the second, two years, the third, three years Appointees after the first shall serve for three years, and until their successors shall have been duly appointed and qualified Vacancies shall be filled by the Governor within thirty days

Section 189-a Meetings The Board shall hold regular meetings to examine applicants and the transaction of business, commencing on the first Mondays of March, August, and November in each year Special meetings may be called by the president and secretary upon thirty days notice printed in a newspaper of general circulation in the State

Section 189-b Officers The superintendent of public buildings shall, at the request of the Board, provide an office where meetings may be held Special meetings may be called anywhere in the State

Section 189-c. Eligibility Any person of good moral character, who is a graduate of a Chiropractic School or College teaching Chiropractic, and giving a course of at least three years of six months each in the subjects enumerated in Section 189, and requiring actual attendance upon the classes, shall be eligible to examination, provided he possesses preliminary education or experience equivalent to a high school education, and provided further, that he practices nothing but Chiropractic, as hereinafter defined

Section 189-d Chiropractic Defined Chiropractic is defined to be the science of palpating and adjusting the articulations of the human spinal column by hand only This definition is inclusive and any and all other methods are hereby declared not to be Chiropractic

Section 189-e Practitioners No person shall practice Chiropractic without a license, which license shall not entitle him to practice anything else And, no one may hold himself out as a chiropractor without having a license

Section 189-f Examinations Anyone desiring an examination, shall, at least fifteen days prior to the meeting of the Board, make written application to the secretary Such application shall be accompanied by an examination fee of fifteen dollars The application shall state the name, age, sex, and place of residence of the applicant, the name and location of the school or college from which he graduated, the length of time devoted to the study of Chiropractic, the date of graduation, together with such other data as the applicant may desire to give In case an applicant fails in the first examination, he shall be entitled to a second one, without further fee Application shall be signed and sworn to by the applicant

The Board shall prepare reasonable questions,

is entitled to license. This provision alone is sufficient to condemn the bill.

*In Assembly by Mr Esmond, Int No 649*—This bill seeks to exempt chiropractors from the Medical Practice Act as proposed for amendment under the Karle-Dunmore bills and adds a new article for the licensing of chiropractors. The regents are required, under this bill, to *appoint examiners from the members of the New York Chiropractic Society*, irrespective of their educational qualifications, so that virtually the New York Chiropractic Society is made the licensing power. None of the schools or colleges from which members of such society hold diplomas are recognized by the regents, nor have their standards been the subject of any approval by the regents. So that the Chiropractic Society practically prepares and grades the examination papers to be submitted to applicants for license.

The bill contains, likewise, a provision for exempting from examination chiropractors who have practiced in this state for various periods specified, who are graduates of such chiropractic schools, irrespective of the standard set by such schools or the previous educational qualification of such graduate. None of such schools are under the jurisdiction of the regents. Their standards are not recognized by the regents. Under this bill, upwards of a thousand chiropractors would be licensed without any test of fitness and certified to as qualified without the authorities having any basis for such certification. The educational standards set for licenses in the future have only the effect of benefiting those receiving licenses without examination, by restricting the number that thereafter might be licensed. Chiropractors licensed in other states under a waiver clause, provided their bill is similar to the proposed bill, would be licensed in this state.

*By Mr Fearon, Senate Int No 944*—This bill is somewhat like Assemblyman Esmond's bill, in that it is ingrafted upon the Karle-Dunmore Medical Practice Act, which specifically exempts from the operation of that act chiropractors and provides for licensing chiropractors after examination, but permits a thousand or more to be licensed without examination. Chiropractors who have been practicing in this state for eight years and who are graduates of chiropractic schools, irrespective of the time they spent in study at such schools, or the standards of such schools, or the previous educational qualifications of such graduates. Those who cannot qualify in this way for licenses without examination are required to have only a preliminary educational qualification from a secondary school and graduation from a chiropractic school of a course of study of eighteen months. This would permit a large number of chiropractors who are unqualified educationally to be licensed to engage in the practice of healing.

*By Mr Nicoll, Assembly Int No 185*—This

bill provides for adding to the present medical examining board chiropractors whose qualifications are not the subject of any test by the regents whatever. It contains the same vice as the other chiropractic bills by which the present practitioners of chiropractic are licensed without examination, irrespective of the standards of such school or how the chiropractor got his diploma. It is well known that many of them got their diplomas with practically no educational qualifications. The effect of this bill is likewise to grant licenses to diploma mill graduates. Chiropractors are given the right to use the title of "Doctor," which is a title they have never earned under any standard that has been set in this state—a title conferred by legislative act, rather than by educational qualifications. Chiropractors licensed in other states will be permitted to be licensed in this state, so that those so licensed under similar waiver clauses could come into this state and practice.

This act confers upon licensees all rights of professional persons under the Civil Practice Act and Judiciary Law and establishes them as physicians and confers the title of "Doctor" upon such licensees granting them the right to be appointed as alienists upon commissions to inquire into the sanity of persons accused of crime.

Each of these bills seeks to divest the constituted state authorities of discretion and power to determine the qualification of applicants under the waiver clause. If a man had spent the time specified in the kind of school specified and had practiced for the time specified, whether his time was well spent, the school good or bad, the practice criminal or otherwise, would be entitled to receive a license. These waiver clauses that seek to make the state accept the results of these privately-owned schools, operated for profit, without power to rate the schools or pass upon their standards and, furthermore, that make licensure utterly lacking in any real test of fitness, are wholly arbitrary, and as measures for the regulating of the practice of a branch of healing, are not in anywise adapted to the end intended, and are mere cloaks for conferring a special privilege and are in contravention of the Constitution.

These bills permit chiropractors legally to masquerade before the public by virtue of a legislative decree, as educated and trained and to pretend that they are doctors for their own pecuniary advantage.

These bills propose to grant as a special privilege to a favored class under their waiver clauses, without reference to the qualifications of such class, practically all the honor, title, privileges and rewards that physicians enjoy only after meeting the highest mental, moral and scientific tests.

The privately-owned and operated-for-profit chiropractic schools whose standards are not tested by the regents of this state, are made the

**MEMORANDUM SUBMITTED IN BEHALF OF THE MEDICAL SOCIETY OF THE  
STATE OF NEW YORK TO THE JOINT COMMITTEE ON PUBLIC HEALTH  
OF THE SENATE AND ASSEMBLY ON BILLS RELATING  
TO CHIROPRACTIC**

By **GEORGE W. WHITESIDE**, Counsel, Medical Society of the State of New York

By Mr Bouton, Senate Int No 789, entitled "An Act to Define and Regulate the Practice of Chiropactic" This bill creates a separate board of examiners for the purpose of licensing chiropactors only and establishes lower standards than those applying to other methods of healing. The adopting of a lower measure of educational qualification based upon the use of a particular method of treatment is wrong in principle, as it omits consideration of the necessity of proper educational and scientific qualifications for the purpose of making diagnosis. Fundamental educational qualifications requisite for the making of proper diagnoses cannot be omitted as a requirement for license in order to favor those engaging in a particular form of treatment.

The bill establishes a machinery for licensing chiropactors which is controlled and operated by the New York Chiropactic Society, which is composed of members whose educational qualifications have never been the subject of any tests by the regents of this state and whose fitness to perform the function of examiners is not subject to control or regulation by the regents. The board of chiropactic examiners so controlled by this society have entire charge of preparation and grading of examination papers and, therefore, of the licensing of chiropactors. Under this bill, hundreds, possibly upwards of a thousand chiropactors now practicing whose educational qualifications are unknown, many of whom are without educational standards or qualifications, would be licensed without test of their fitness. Accepting as a standard for licensure without examination, the diploma of chiropactic schools, over which the regents have no control and whose standards are unknown to the regents, is equivalent to license without standard. Any person who has received a diploma from any school teaching chiropactic, irrespective of the time spent in such school, or the standard of such school, or the previous educational qualification of the person receiving such diploma, would be entitled to be licensed without examination.

This bill practically licenses diploma mill graduates and turns them loose upon the public with a stamp of the state's approval, with a certification of their fitness, despite the fact that the state has made no test to justify the giving of such certificate. The provisions by which educational standards are set for future applicants for license has merely the effect of giving those who receive license without examination a special privilege in a non-competitive field of operation by causing a virtual exclusion of those who are not so favored.

The regents are practically made the rubber stamp of the New York Chiropactic Society and the board of chiropactic examiners in the conduct of any examinations under this act and the regents are required to select the questions to be submitted to candidates from a list of questions submitted by such examiners. So, in effect, the chiropactic society is made the licensing power. Chiropactors from other states may be licensed here without examination. This would admit large numbers who have been licensed in other states without examination.

By Mr Gibbs, Senate Int No 473 This is known as the "Drugless Practice Act." A separate board to license drugless practitioners is created. The choice of membership in this board is made from irresponsible societies, whose members have no legal right of practice or status, whose educational qualifications are unknown and untested. It has the same defects as the Bouton bill, only worse, in that it again makes licensure dependent upon the method of treatment alone. All methods of treatment, by hand or mechanically, without the use of drugs, osteopathy, surgery or Christian Science, come under this bill. Thus, the treatment of fractures, other than by open operation, would come under this bill. The use of the laryngoscope, cystoscope and oesophagoscope, which is operated by hand, would come under this bill. The passage of such a measure multiplies the number of licensing agencies in the state based upon the false assumption that the method of treatment shall be the basis of license.

Any one holding a diploma from an incorporated school or college of drugless methods, no matter how the diploma was obtained, what his educational qualifications are, how much or how little he had studied, is eligible to become an examiner, irrespective of any test by the regents. Examination papers would be made up by such an unqualified board. From the list of questions submitted, the regents would be compelled to accept therefrom the questions to be submitted to the candidate. This deprives the regents of power and places the power of examination in the hands of unqualified persons. The same unqualified persons pass upon the answers to the questions. This bill, as practically all other bills of this character, contains the usual provisions of licensing practitioners without examination. Under this bill, any person 21 years of age, who is vouched for by four citizens and who for two years has practiced drugless methods and who has a diploma from a drugless school or college, no matter how obtained or how little study was done to earn it and who pays \$25 to the board,

# Medical Society of the State of New York

## HOUSE OF DELEGATES

The regular annual meeting of the House of Delegates of the Medical Society of the State of New York will be held on Monday, May 11, 1925, in the Hotel Syracuse, Syracuse, N. Y.

OWEN E. JONES, M.D., *President*

E. ELIOT HARRIS, M.D., *Speaker*

EDWARD LIVINGSTON HUNT, M.D., *Secretary*

## 119TH ANNUAL MEETING

The regular annual meeting of the Medical Society of the State of New York will be held in Syracuse, May 12 to 14, 1925.

OWEN E. JONES, M.D., *President*

EDWARD LIVINGSTON HUNT, M.D., *Secretary*

## SUMMARY OF SCHEDULE

*House of Delegates, Monday afternoon and evening, and Tuesday morning. Section meetings, Tuesday afternoon and Wednesday morning and afternoon. Tuberculosis demonstration all day Thursday.*

## SECTION PROGRAMS

### SECTION ON MEDICINE

Chairman—ROBERT L. LEVY, M.D., New York City  
Secretary—L. WHITTINGTON GORHAM, M.D., Albany  
Place of Meeting—Hotel Syracuse.

#### Tuesday, May 12th, 2 30 P.M.

"Some Observations on Constitutional Factors in Disease," George Draper, M.D., New York City

"The Present Status of Insulin Therapy," Elliott P. Joslin, M.D., Boston, Mass. (by invitation)

Discussion opened by H. Rawle Geyelin, M.D., New York City

"The Specific Serum Treatment of Scarlet Fever," Francis G. Blake, M.D., New Haven, Conn. (by invitation)

Discussion opened by Augustus B. Wadsworth, M.D., Albany

"The Therapeutic Value of Oxygen in Pneumonia," Carl A. L. Binger, M.D., New York City (by invitation)

Discussion opened by Nelson G. Russell, M.D., Buffalo

#### Wednesday, May 13, 9 30 A.M.

Joint Session with Section on Neurology and Psychiatry

#### Symposium on "Mind and Medicine."

"Psychological Aspects of Medical Research," Thomas W. Salmon, M.D., New York City

"Mental Hygiene and Its Relation to General Medicine," Charles MacFie Campbell, M.D., Boston, Mass. (by invitation)

"Mental Factors in General Medical Diagnosis," Le-wellys F. Barker, M.D., Baltimore, Md. (by invitation)

"Uses of Psychotherapy in General Medical Treatment," Austen Fox Riggs, M.D., Stockbridge, Mass. (by invitation)

Discussion opened by George Draper, M.D., New York City

#### Wednesday, May 13, 2 30 P.M.

Joint Session with Sections on Pediatrics and Public Health, Hygiene and Sanitation

#### Symposium on "The Problem of the Chronic Cardiac Cripple."

"General Survey of the Problem," James B. Herrick, M.D., Chicago, Ill. (by invitation)

"Statistical Aspects of the Problem," Louis I. Dublin, Ph.D., New York City (by invitation)

"A Program of Procedure," Homer T. Swift, M.D., New York City

"The Organization of a Cardiac Clinic," John Wyck-off M.D., New York City

Discussion opened by Haven Emerson, M.D., New York City

#### Thursday, May 14th

Tuberculosis demonstration

### SECTION ON SURGERY

Chairman—MARSHALL CLINTON, M.D., Buffalo  
Secretary—EDWARD S. VAN DYKE, M.D., Syracuse  
Place of Meeting—Hotel Syracuse.

#### Tuesday, May 12th, 2 30 P.M.

"Etiology of Cancer," Isaac Levin, M.D., New York City

"Surgical Treatment of Malignancy," George W. Crile, M.D., Cleveland, Ohio (by invitation)

"Present Status of Radium Radiation," Burton J. Lee, M.D., New York City

"Present Status of X-Ray Therapy," Bernard F. Schreiner, M.D., Buffalo

"Present Status of Treatment of Cancer," Burton T. Simpson, M.D., Buffalo (by invitation)

#### Wednesday, May 13th, 9 30 A.M.

"Syphilis," Ralph Mellon, M.D., Rochester (by invitation)

"Diagnosis of Tertiary Lesions," Grover Wende, M.D., Buffalo

judges of fitness for license, rather than the officials of the State of New York. These institutions are not essentially educational institutions, but business enterprises. The requirement that such chiropractor shall have practiced for a given time in this state as a prerequisite to license without examination constitutes a reward for violating the present Medical Practice Act, as such practice of chiropractic is a violation of that act. In this way, these acts make a virtue of such offenses against the law and reward continuous practice in violation of the law by granting to the wrongdoer a license without examination. The diploma-mill graduate must be exempted from examination, if he can prove attendance upon a chiropractic school for the required time. The exemption clauses of these bills are not part of any

plan for the regulation of the practice of chiropractic, but constitute a grant of special privilege to certain individuals now defying the laws of this state, to whom the bills are to be a reward for their transgression, rather than a test of their fitness.

These chiropractic licensing bills are similar to all the bills that have been submitted from the same source in the last ten years and are typical of the kind of medical legislation that is made possible by popularizing, through clever publicity, scientifically false claims. The legislature should not mistake the noise and agitation of a small majority of selfish men, through systematic and well-recognized effort, in the spreading of false propaganda for expressions of popular opinion.

Wherefore, it is asked that these bills be not approved.

## HEARINGS

Wednesday, March 11—Joint Hearing before Senate and Assembly Labor and Industry Committees

Senate Int No 380 (conc Assembly Int 570) (Dunn-Farrell)—Workmen's Compensation Law, medical attendance

Senate Int No 594 (conc Assembly Int 622) (Love-Lattin)—Workmen's Compensation Law, medical attendance

Senate Int No 647 (conc Assembly Int 184) (Johnson-F A Miller)—Workmen's Compensation Law, physical examinations

Senate Int No 1078 (Reiburn)—Workmen's Compensation Law, disability

Senate Int 1103 (Reiburn)—Workmen's Compensation Law, occupational disease

Senate Int. No 1104 (Reiburn)—Workmen's Compensation Law, claims

Senate Int No 1105 (Reiburn)—Workmen's Compensation Law, presumptions

Senate Int No 1106 (Reiburn)—Workmen's Compensation Law, earnings

Senate Int No 1113 (Whitley)—Workmen's Compensation Law, subrogation

Senate Int No 1114 (Whitley)—Workmen's Compensation Law, interest

Senate Int No 1115 (Whitley)—Workmen's Compensation Law, when due

Senate Int No 1117 (Whitley)—Workmen's Compensation Law, appeals

Assembly Int No 152 (Weinfeld)—Workmen's Compensation Law, medical service

Assembly Int No 1335 (Galgano)—Workmen's Compensation Law, aliens

Assembly Int No 1350 (C P Miller)—Workmen's Compensation Law, appeals

Assembly Int No 1351 (C P Miller)—Workmen's Compensation Law, medical practice.

Assembly Int No 1354 (Phelps)—Workmen's Compensation Law, occupational disease

Assembly Int No 1407 (C P Miller)—Workmen's Compensation Law, interests

Assembly Int No 1452 (C P Miller)—Workmen's Compensation Law, define board

### Public Health Committee

March 11

Senate Int No 115 (conc Assembly Int 215) (Kennedy-Weinfeld)—Drugs, habit forming

Senate Int No 632 (J F Williams)—Health Law, Pharmacies

Senate Int No 851 (conc Assembly Int 1027) (Karle-Lattin)—Health Law, cadavers

Assembly Int No 802 (Donohue)—Pharmacies, drug stores

Assembly Int No 678 (Samberg)—Food, persons handling

9 30 A M

Assembly Int No 925 (Coughlin)—Health Law, practice medicine

Assembly Int No 1348 (Lattin)—State Medical Society, censors

Assembly Int No 1450 (Lambert)—Dental hygienist, women

Assembly Int No 1539 (Lattin)—Pharmacy, practice of

### Codes Committee

March 17

Assembly Int No 987 (Boyle)—Penal Law, Contraceptive treatment



"Mental Factors in General Medical Diagnosis,"  
Lewellys F Barker, M D, Baltimore, Md (by invitation)

"Uses of Psychotherapy in General Medical Treatment," Austen Fox Riggs, M D, Stockbridge Mass (by invitation)

Discussion opened by George Draper, M D, New York City

**Wednesday, May 13th, 2 30 P M**

"Epidemic Encephalitis and the Vegetative Nervous System," Foster Kennedy, M D, New York City

"Chronic Symptoms Following Acute Epidemic Encephalitis," illustrated by Moving Pictures, S Philip Goodhart, M D, New York City

"The Effect of Producing Aseptic Meningitis upon Dementia Praecox," Everett Sperry Barr, M D, Philadelphia, Pa. (by invitation)

"Treatment of Paresis by Malaria," Henry A. Bunker, M D, New York City (by invitation)

"New Observations upon Drug Therapy in the Psychoses," William W Wright, M D, Utica

"Mental Mechanism in Mental Disease," William C Garvin, M D, Binghamton (read by title)

"Physiological Action of Luminal, Preliminary Report on Animal Experimentation," Professor M S Dooley, M D, Eugene N Boudreau, M D, Syracuse (read by title)

**Thursday, May 14th**

Tuberculosis demonstration

**SECTION ON PEDIATRICS**

Chairman—JOSEPH C PALMER, M D, Syracuse.

Secretary—ARTHUR W BENSON, M D, Troy

Place of Meeting—Hotel Syracuse.

**Tuesday, May 12th, 2 30 P M**

Joint Session with Sections on Neurology and Psychiatry and Public Health, Hygiene and Sanitation

"The Part of Prevention in Pediatric Practice," J H Mason Knox, M D, Chief Bureau of Child Hygiene, Baltimore, Md (by invitation)

"Mental Hygiene of the Child and Its Relation to Mental Stability in Adult Life," Douglas A. Thom, M D Boston, Mass (by invitation)

"Mental Hygiene of the Child and Its Relation to the Development of Character," Ira S Wile, M D, New York City

"The Serum Treatment of Poliomyelitis," Wardner D Ayer, M D, Syracuse

**Wednesday, May 13th, 9 30 A.M.**

"Growth and Development, Their Influence Upon Normal Progress and the Expression of Disease in Childhood," Herbert B Wilcox, M D, New York City

"Pediatric Viewpoint in Treatment of Diabetes Mellitus," Roger H Dennett, M D, New York City

"Chronic Ulcerative Colitis in Childhood," Henry F Helmholtz, M D, Rochester, Minn (by invitation)

Discussion opened by Henry L K Shaw, M D, Albany

"Trichinosis in Children A Report of Cases" John Ackman, M D, Rochester

Discussion opened by W Parker Stowe, M D Rochester

**Wednesday, May 13th, 2 30 P M**

Joint Session with Sections on Medicine and Public Health, Hygiene and Sanitation

Symposium on "The Problem of the Chronic Cardiac Cripple"

"General Survey of the Problem," James B Herrick, M D, Chicago Ill (by invitation)

"Statistical Aspects of the Problem," Louis I Dublin, Ph D, New York City (by invitation)

"A Program of Procedure," Homer F Swift, M D, New York City

"The Organization of a Cardiac Clinic," John Wyckoff, M D, New York City

Discussion opened by Haven Emerson, M D, New York City

**Thursday, May 14th**

Tuberculosis demonstration

**SECTION ON PUBLIC HEALTH, HYGIENE AND SANITATION**

Chairman—PAUL B BROOKS, M D, Albany

Secretary—ARTHUR D JAKES, M D, Lynbrook.

Place of Meeting—Hotel Syracuse.

**Tuesday, May 12th, 2 30 P M**

Joint Session with Sections on Pediatrics and Neurology and Psychiatry

"The Part of Prevention in Pediatric Practice," J H. Mason Knox, M D, Chief Bureau of Child Hygiene, Baltimore, Md. (by invitation)

"Mental Hygiene of the Child and Its Relation to Mental Stability in Adult Life," Douglas A. Thom, M D, Boston, Mass. (by invitation)

"Mental Hygiene of the Child in Its Relation to the Development of Character," Ira S Wile, M D, New York City

"The Serum Treatment of Poliomyelitis," Wardner D Ayer, M D, Syracuse.

**Wednesday, May 13th, 9 30 P M.**

Session for health officers, school medical inspectors and other public health workers

Principal Discussion Limited to 5 Minutes

"How can the County Laboratory Best Serve the Interests of Physicians and of the Public," Morris Mason M D Glens Falls

"Organization of the Hornell Breast Feeding Demonstration" Bertis R Wakeman, M D, Hornell.

"Morbidity and Mortality Among Breast Fed and Artificially Fed Babies," Elizabeth M Gardner, M D, Albany (by invitation)

"The Washington County Public Health Clinic," Miss Virginia A. Kilrain, Hudson Falls (by invitation)

"The Pre-tubercular Child as a Factor in the Control of Tuberculosis," Jonathan Pearson, M D Schenectady

"The Newspaper as an Aid in Local Public Health Work," Leo F Schiff, M D, Plattsburg

**Wednesday, May 13th, 2 30 P M**

Joint Session with Sections on Medicine and Pediatrics

Symposium on "The Problem of the Chronic Cardiac Cripple"

"General Survey of the Problem," James B Herrick, M D, Chicago Ill (by invitation)

"Statistical Aspects of the Problem," Louis I Dublin, Ph D, New York City (by invitation)

"A Program of Procedure," Homer F Swift, M D, New York City

"The Organization of a Cardiac Clinic," John Wyckoff, M D, New York City

Discussion opened by Haven Emerson, M D, New York City

**Thursday, May 14th**

Tuberculosis demonstration

"Spinal Cord Tumors," Arthur H. Stein, M.D., Albany

"Regional vs. Inhalation Anesthesia in Prostatectomy," Oswald S. Lowsley, M.D., and H. Earl Rogers, M.D., New York City (by invitation)

"Resume of Prostatectomy," Parker Syms, M.D., New York City

### Wednesday, May 13th, 2 30 P.M.

"Uses of Enterostomy in Cases of Acute Ileus," Frederick van Beuren, Jr., M.D., New York City

"Pyloric Obstruction in Infancy," Thew Wright, M.D., Buffalo

"Present Status of Surgery for Ulcer," Charles H. Peck, M.D., New York City

"Study of Gastric and Duodenal Ulcers with Especial Reference to Hemorrhage," Fordyce B. St. John, M.D., New York City

### Thursday, May 14th

Tuberculosis demonstration

## SECTION ON OBSTETRICS AND GYNECOLOGY.

Chairman—HAROLD C. BAILEY, M.D., New York City

Secretary—NATHAN P. SEARS, M.D., Syracuse, N. Y.

Place of Meeting—Hotel Syracuse

### Tuesday, May 12th, 2 30 P.M.

"Idiopathic Uterine Bleeding from the Pathological Standpoint," Emil Novak, M.D., Baltimore, Md. (by invitation)

"Idiopathic Uterine Bleeding from the Clinical Standpoint," William P. Healy, M.D., New York City

"Fertility and Health," Donald Macomber, M.D., Boston, Mass. (by invitation)

"Pregnancy Following Transuterine Insufflation," Isidor C. Rubin, M.D., New York City

"Endocrine Treatment of Sterility in Women," Timothy F. Donovan, M.D., Buffalo

### Wednesday, May 13th, 9 30 A.M.

"The End Results following the Sturmdorff Operation," Harvey B. Matthews, M.D., Brooklyn

"Preliminary Report of the Radium Work at the Woman's Hospital," Lillian K. P. Farrar, M.D., New York City

"Protein Injections in Gynecological Infections," Reginald M. Rawls, M.D., New York City

"Teratomata—Ovarian and Retroperitoneal," Onslow A. Gordon, Jr., M.D., Brooklyn

"Onset of Labor," Isidor Kross, M.D., New York City

### Wednesday, May 13th, 2.30 P.M.

"Use of Paralehyd in Obstetrics," William Edgar Caldwell, M.D., New York City

"Morphine in Eclampsia," Hervey C. Williamson, M.D., New York City

"Syphilis in Pregnancy," Alfred C. Beck, M.D., Brooklyn

"Use of the Kiehland Forceps," James Knight Quigley, M.D., Rochester

"The Version and Spinal Cord and Cerebral Injuries," William E. Caldwell, M.D., and Richard N. Pierson, M.D., New York City

"Elective Version and Extraction," Paul T. Harper, M.D., Albany

### Thursday, May 14th

Tuberculosis demonstration

## SECTION ON EYE, EAR, NOSE AND THROAT

Chairman—ARTHUR G. BENNETT, M.D., Buffalo

Secretary—EUGENE E. HINMAN, M.D., Albany

Place of Meeting—Hotel Syracuse

### Tuesday, May 12th, 2 30 P.M.

"Thyroid Feeding in Pituitary Disease," Frank W. Marlow, M.D., Syracuse

"Relation of Diet to the Eye," Arthur M. Yudkin, M.D., New Haven, Conn. (by invitation)

"The Efficiency Values of Visual Acuity as Determined by the Snellen Text," Albert C. Snell, M.D., Rochester

"Rapid Muscle Testing without Apparatus," James W. White, M.D., New York

### Wednesday, May 13th, 9 30 A.M.

"Correction of Nasal Deformities," William Wesley Carter, M.D., New York City

"Bronchoscopic Treatment of Bronchial Asthma," William Moore, M.D., Philadelphia, Pa. (by invitation)

"Value of Blood Transfusion in Sinus Thrombosis," Harold Hays, M.D., New York City

"Some Nasal Problems," Roy S. Moore, M.D., Syracuse

### Wednesday, May 13th, 2 30 P.M.

"Local Anesthesia of the Eye," Edmund Blaauw, M.D., Buffalo

"Local Anesthesia of the Nose and Throat," Clayton M. Brown, M.D., Buffalo

"Local Anesthesia of the Nose and Throat by Cocainization of the Naso-Palatine Ganglion," Simon L. Ruskin, M.D., New York City

"The Clinical Significance of Orbital and Intraocular Tumors," Conrad Berens, M.D., New York City

### Thursday, May 14th

Tuberculosis demonstration

## SECTION ON NEUROLOGY AND PSYCHIATRY

Chairman—EUGENE N. BOUDREAU, M.D., Syracuse

Secretary—CLARENCE O. CHENEY, M.D., Utica

Place of Meeting—Hotel Syracuse

### Tuesday, May 12th, 2.30 P.M.

Joint Session with Sections on Pediatrics, Public Health, Hygiene and Sanitation

"The Part of Prevention in Pediatric Practice," J. H. Mason Knox, M.D., Chief Bureau of Child Hygiene, Baltimore, Md. (by invitation)

"Mental Hygiene of the Child and Its Relation to Mental Stability in Adult Life," Douglas A. Thom, M.D., Boston, Mass. (by invitation)

"Mental Hygiene of the Child in Its Relation to the Development of Character," Ira S. Wile, M.D., New York City

"The Serum Treatment of Poliomyelitis," Wardner D. Ayer, M.D., Syracuse

### Wednesday, May 13th, 9 30 A.M.

Joint Session with Section on Medicine

## Symposium on "Mind and Medicine"

"Psychological Aspects of Medical Research," Thomas W. Salmon, M.D., New York City

"Mental Hygiene and Its Relation to General Medicine," Charles MacFie Campbell, M.D., Boston, Mass. (by invitation)

before the first of January of each year may have his license revoked or suspended by the State Board of Regents."

While the Karle-Dunmore Bill does not contain this provision, it could all too easily be amended after registration was once a law—as has occurred in the case of the nurses and podiatrists

2. Section 170-d, which has to do with the use of contraceptive measures, should be restored to the bill

3 The penalties are objectionable, too severe, give arbitrary power, and in our opinion, are for contempt only

4 The bill is unnecessary, unremedial uncalled for. Our present laws are sufficient. We should go slowly about any change in the Medical Practice Act as physicians in general are not acquainted with such proposed changes

5 We should reject anything covered by existing law. We believe we would be making more laws without enforcing the present ones

6. While calling for registration of all honest physicians with payment of a fee, etc., for five years, and then registering annually for the rest of our natural lives without payment of a fee, it does not register cults

7 We believe the public health is better protected today than ever before. This bill empowers the attorney-general to deprive the district attorney of the right to prosecute—an unwarranted centralization of power

8. We have a vested interest in our state license as practitioners of medicine which should not be jeopardized by even the color of discretionary power

9 In our opinion, this bill would be an entering wedge for compulsory health insurance and other forms of State Medicine

10 The only good that might presumably be obtained now would be to prosecute cults at the cost of great personal inconvenience

About midnight your Committee cast one vote in unanimous opposition to the Karle-Dunmore Bill

(Signed) JOSEPH A. DRISCOLL, M.D.,  
*Chairman Legislative Committee*

Dr Harris Moved that the motion passed be reconsidered in order that the resolutions presented by Dr Lasher might be incorporated in the minutes and also opportunity given for discussion thereon. Seconded and Carried

Dr Harris Moved that the Council order a referendum of the House of Delegates on the Karle-Dunmore Bill Senate Int No 211, Assembly Int No 307, and that a Committee of three be appointed by the President to draw up the form to be sent to the members of the House of Delegates and canvass the vote. Seconded and carried

The President appointed the following committee: Dr Harris, Chairman, Dr Van Cott and Mr Whiteside

Dr Harris presented the following form which had been drawn up by the Committee

WHEREAS, There has been introduced in the Senate by Mr Karle a bill, introductory number 211 (see Journal, January 30th, 1925, page 123), entitled "An Act to Amend the Public Health Law in relation to the practice of medicine" and a similar Act by Mr Dunmore in the Assembly known as introductory number 307, and a hearing on these bills is to be held in the Assembly Chamber before a joint committee on Public Health of the Senate and the Assembly on March 4 1925 and

WHEREAS, These bills are sponsored by the Department of Education of the State of New York and provide for amendments to the Medical Practice Act, providing for an accurate official list of licensed physicians by means of annual registration, the clarifying of the exemptions of different classes of persons under the Act so as to limit such exemptions and make the Act more effective, providing for adequate, civil and criminal penalties for the practice of medicine by the unlicensed practitioners, prohibiting the use of the title "Doctor" by those not legally entitled to the same, curtailing improper medical advertisements, providing for recovery of damages against unlicensed practitioners for injury to those treated by them, simplifying the procedure for revocation and annulment of registration of physicians, and providing for state wide inspection and prosecution of illegal practitioners, and

WHEREAS, That at the hearing on March 4, 1925 by the Joint Committee, it is desirable that the Medical Society of the State of New York should officially record its position on said measures.

Therefore, Be It Resolved, That the Council hereby approves said measures and recommends the passage of the same subject to a favorable referendum vote of the House of Delegates of the Medical Society of the State of New York confirming said action

Further Resolved, That pursuant to Section 24 of the By-Laws of the Medical Society of the State of New York, a referendum vote of the said House of Delegates be, and is hereby ordered, and said vote shall be completed by mail on or before the 5th day of March 1925, and that the question submitted for such vote shall be as follows

The Medical Society of the State of New York hereby endorses the said Karle and Dunmore bills and urges their passage by the Legislature.

Vote by marking X in blank space

Yes [☐  
No [☐

Officer or Chairman, Standing Committee.

Delegate from  
County of the Medical Society of the  
State of New York

Note A majority vote before March 4th is necessary to be of any value. Vote and return at once to the Secretary

New York City, February 18, 1925

By order of the Council,

EDWARD LIVINGSTON HUNT,  
*Secretary*

Moved, seconded and carried that it be approved

Dr Vander Veer presented a bill which had been drawn up by the Counsel in accordance with the resolution of the House of Delegates

"That the Council, with the aid of the legal counsel, examine all the statutes, and all other acts which effect the Medical Society of the State of New York, and prepare bills to be introduced in the Legislature with the object of simplifying the operation of the law and of removing the objectionable features in the statutes and providing, if possible, a codification of the laws gov-

## MEETING OF THE COUNCIL

A meeting of the Council of the Medical Society of the State of New York was held at the State Society rooms, 17 West 43d Street, New York City, on Wednesday afternoon, February 18th, 1925. Dr Owen E Jones, President in the Chair, Dr Edward Livingston Hunt, Secretary

The meeting was called to order at 2 P M and on roll call the following answered to their names Drs Owen E Jones, E Elhot Harris, George M Fisher, Edward Livingston Hunt, Joshua M Van Cott, Frank H Lasher, Nelson O Brooks, James N Vander Veer, Orrin Sage Wightman

Mr George W Whiteside, Counsel for the State Society, and Dr Joseph S Lawrence, Executive Officer, were also present

A quorum being present, Dr Jones announced the meeting open for business

Moved and seconded that the reading of the minutes of the last meeting be dispensed with Carried

The Secretary presented letters and telegrams from Drs Arthur J Bedell, Wilham I Dean, George H Fox, Henry Lyle Winter, and Luzerne Coville regretting their inability to be present

Moved and seconded that Drs Bedell, Dean, Fox, Winter and Coville be excused Carried

The Secretary stated that Dr Williams, Director of the Academy of Medicine, had sent him the floor plan of the new building showing the space which had been assigned to the State and County and other medical societies and asking that representatives from the various societies agree upon some method of dividing the space allotted so that partitions could be arranged to suit their needs

Moved and seconded that a committee of three be appointed by the President, including the Secretary, to confer with the Academy authorities and to report at the next meeting of the Executive Committee Carried

Dr Vander Veer presented a communication from Dr Woodward, Secretary of the Bureau of Legal Medicine and Legislation of the American Medical Association in regard to the Reorganization Bill pending in the U S Senate and asking that action be taken in opposition to this bill by the State Society

Moved and seconded that it be referred to the Executive Committee Carried

Dr Vander Veer presented the program of the Annual Congress on Medical Education, Medical Licensure, Public Health and Hospitals, to be held in Chicago, March 9th to 12th, 1925, and asked if the Council thought it desirable to send a representative to this meeting

Moved and seconded that it be placed on file Carried

Dr Harris stated that the Council has been called together to take action on the bill to amend the medical practice act which has been formulated and introduced into the Legislature by the State Department of Education and refer said action to referendum vote of the House of Delegates

Dr Vander Veer moved that the Council go on record as approving the bill drawn up by the Education Department known as the Karle-Dunmore Bill

Dr Harris moved that the Council order a referendum of the House of Delegates in accordance with section 24 of the by-laws on the Medical Practice Act, and that the form of referendum be determined by a sub-committee of three appointed by the President Seconded and carried

Dr Lasher stated that he would like to present a report containing resolutions showing why the bill should not be approved

### Medical Society of the County of Kings

The following report of the Legislative Committee of the Medical Society of the County of Kings was unanimously accepted at the Stated Meeting of the Society held on February 17, 1925. It was moved, seconded and carried that a copy of the report be transmitted to all the County Societies in the State of New York, and also that a copy of the report be sent to the NEW YORK STATE JOURNAL OF MEDICINE for publication.

Ten days after the January meeting of the Medical Society of the County of Kings your Legislative Committee held a meeting to consider the 1925 Medical Practice Act, sponsored by the State Department of Education, and known as the Karle-Dunmore Bill, Senate Introductory 211, Assembly Introductory 307

Pursuant to the request of the Society, the Committee was advised by counsel for the Society, Judge John G Dyer

Judge Dyer took up with the Committee a calm, cold analysis of the new matter in the bill line by line. After the Judge had finished his analysis a lengthy discussion was entered into by the Committee. The good points in the bill were brought out. The reasons why we might support the bill are as follows

- 1 In union (with the State Society) there is strength
- 2 The penalties imposed would have a healthful effect on illegal practitioners

- 3 Under existing law the work of the Committee on Illegal Practice of the Medical Society of the County of Kings is voluntary and might not always function. Also, the activity of the District Attorney of Kings County is exceptional

- 4 The added protection to the title of "Doctor" is good

- 5 The State Department of Education would have what it wants, viz, a check-up on all doctors practising today

The objections to the bill are as follows

- 1 We are opposed to registration in principle. The principle of law applying in dentistry and podiatry is as follows

'Any dentist (nurse, optometrist, or podiatrist—Pars 199 and 201, 251-a, 278-a, 304, of the Public Health Law) whose name does not appear in the registry on or



# State Department of Health



## SUSPECTED "POLIO" PROVES TO BE BROKEN ARM

On February 13, a local health officer telephoned to the district state health officer that he had a case of suspected poliomyelitis in a child living on a dairy farm. The health officer stated that the child had lost the use of the right arm and had had a fever for about ten days.

The district state health officer replied that he would hesitate to consider a diagnosis of poliomyelitis if the case had had such a long period of fever, although he had seen relapsing cases which had lasted about the same length of time. In

view, however, of the fact that the child lived on a dairy farm, it was requested that great care should be exercised until the diagnosis was determined.

Later the health officer stated that he had discovered the patient had suffered an injury, and that the case of suspected "polio" was one of greenstick fracture of the humerus. He explained the history of fever by saying that it was probably due to "grippe," as other members of the family had suffered from this disease.

## INCREASE IN CONGENITAL SYPHILITIC CASES TREATED AT CLINICS

There is no part of the venereal disease program which makes a stronger appeal to the public than the treatment of infants and little children who have come into the world infected with syphilis. That these cases are quite prevalent and distributed in every part of the State is shown by the fact that there was not a clinic in the State last year which did not treat some cases of congenital syphilis while a number of clinics

found it advisable to arrange separate hours for the children. In addition to the clinic cases various health officers and physicians in rural districts have treated congenital cases with arsenic and mercury preparations supplied by the Division of Venereal Diseases of the State Department of Health. During 1924 an average of 251 cases of congenital syphilis was treated monthly at the state clinics as compared with 240 in 1923.

## QUARANTINE BROKEN HEALTH OFFICER HAS PARENT ARRESTED

In a small town in Oneida County, the health officer discovered that quarantine regulations were being broken in a home where scarlet fever existed. As the violations did not cease after due warning had been given, the health officer

had the father of the family arrested and brought before a Justice of the Peace. He pleaded guilty and was given a suspended sentence of fifteen days in the county jail.

## MEDICAL SOCIETY WILL ASSIST IN DEVELOPING RURAL MATERNITY HYGIENE STANDARDS

The technique of maternity hygiene work has been highly developed in many cities, and the standards established by the Maternity Center Association of New York City, after years of study and practical experience in city work are accepted generally. The rural community, however, is a comparatively new field and practical standards suitable for general application have not yet been established. With a view to developing a practical rural program and at the

same time demonstrating the value of this line of work, the department, through the Division of Infancy, Maternity and Child Hygiene, has assigned to work in Tioga County two nurses who have had special training in the Maternity Center Association. The County medical society is interested in the undertaking and has appointed three of its members to serve as a medical advisory committee.

## NO EVIDENCE OF TULAREMIA IN RABBITS RECENTLY EXAMINED

A short time ago Mr. John T. McCormick, Deputy Chief of the Division of Fish and Game of the State Conservation Commission, discovered that a number of diseased rabbits were being found in various parts of the state and ordered some of them sent to the laboratory to be examined for evidence of tularemia. Among sev-

eral received recently, one had a broken leg which had become infected, while the others were found to have multiple abscesses from which staphylococci were isolated. The abscesses resembled those noted at times in animals that have received skin infections when fighting. No evidence of tularemia was found.

erning the Medical Society of the State of New York"

Moved and seconded that the bill as drawn up by the Counsel, be introduced into the Legislature Carried

Dr Harris presented the following

#### REPORT OF THE COMMITTEE ON PUBLICATION

A meeting of the Committee on Publication was held at the State Society rooms, 17 West 43rd Street, New York City, on Saturday, December 20, 1924

Moved and seconded that the Committee approve of the "Policy of the NEW YORK STATE JOURNAL OF MEDICINE" as published on page 999 of the December issue of the STATE JOURNAL Carried.

Moved and seconded, that the educational policy of the NEW YORK STATE JOURNAL OF MEDICINE be formulated as indicated in the proposals, the developments or the events which affect the medical profession The Editor-in-Chief shall co-operate with the Committee on Legislation and the officers of the Society before sub-

mitting the policy to the Committee on Publication. Carried

Moved and seconded, that all editorials, articles or communications for the JOURNAL must be sent to the State Society office, 17 West 43rd Street, New York City, and be approved by the Editor-in-Chief, before publication, in his discretion they may be first submitted to the Committee on Publication for action. Carried

Moved and seconded, that the Executive Editor be authorized to go to Albany, as occasion requires, to obtain information on legislation for publication in the JOURNAL. Carried

(Signed) E. ELIOT HARRIS, *Chairman*  
ORRIN S. WIGHTMAN  
EDWARD LIVINGSTON HUNT

Moved and seconded that it be approved Carried

There being no further business the meeting adjourned at 4 35 P M

EDWARD LIVINGSTON HUNT,  
*Secretary*

---

### RICHMOND COUNTY MEDICAL SOCIETY

A regular meeting of the Richmond County Medical Society was held at the Staten Island Academy on Wednesday, February 11, 1925

The meeting was called to order at 9 15 with Dr Presley in the Chair

Those present were Drs Mord, Diamond, Lemuelson, Buntin, Edward Klauber, Coonley, Becker, Janeway, Kingsley, Nichols, Washington, Callahan, Smith, Cochrane, Driscoll, Randall, Rieger

The minutes of the previous meeting were accepted as read

The dinner committee reported that a dinner would be given in recognition of the fortieth year of practice of Dr Walker Washington, at the Masonic Club on March 11th

The Legislative Committee spoke on the Chiropractic and the Public Health bills now pending at Albany

A motion was made that the American Medical Association be invited to hold its 1926 meeting in New York City A motion was made to go on record as favoring the Public Health Bill, including re-registration, and against the Chiropractic Bill Motion made that Dr Smith, Chairman of the Legislative Committee, be given power to answer telegrams and decide on Legislative policies of the Society in emergency at his discretion

The scientific paper of the evening was given by Dr Allen K Krause on the "Historic Relation of Tuberculosis to General Medicine," in which he traced the history and method of treatment of tuberculosis from the Phthisis known to Hippocrates to the present day The paper was thoroughly enjoyed and a vote of thanks was given to Dr Krause

The meeting adjourned at 11.20 to the Staten Island Club

---

### MEDICAL SOCIETY OF ULSTER COUNTY

A regular meeting of the Medical Society of Ulster County was held at McCabe's Restaurant, Kingston, N Y, on February 17, 1925

Meeting called to order at 9 P M by President Dr O D B Ingalls

The minutes of last meeting were read and accepted as read

A motion was duly made, seconded and carried that the Ulster County Medical Society start proceedings against Mr X for illegal practice of medicine in Ulster County, and that the Chairman of the Comitia Minora should confer with District Attorney concerning this matter

A motion was duly made, seconded and carried that the Society contribute annually the sum of twenty dollars (\$20 00) to the Physicians' Home, Inc, at Canadea, N Y

In the scientific session, Dr H L Van Nostrand, Chairman, Dr F A Johnston of Kingston, N Y, read an interesting paper on Syphilis "as is" in Kingston The paper was well thought of by all members present. Dr Johnston was urged to send a copy of his paper to the Editor of the STATE JOURNAL for publication

After the meeting refreshments were served  
J. H. Voss, *Secretary*



# State Department of Health



## SUSPECTED "POLIO" PROVES TO BE BROKEN ARM

On February 13, a local health officer telephoned to the district state health officer that he had a case of suspected poliomyelitis in a child living on a dairy farm. The health officer stated that the child had lost the use of the right arm and had had a fever for about ten days.

The district state health officer replied that he would hesitate to consider a diagnosis of poliomyelitis if the case had had such a long period of fever, although he had seen relapsing cases which had lasted about the same length of time. In

view, however, of the fact that the child lived on a dairy farm, it was requested that great care should be exercised until the diagnosis was determined.

Later the health officer stated that he had discovered the patient had suffered an injury, and that the case of suspected "polio" was one of greenstick fracture of the humerus. He explained the history of fever by saying that it was probably due to "grippe," as other members of the family had suffered from this disease.

## INCREASE IN CONGENITAL SYPHILITIC CASES TREATED AT CLINICS

There is no part of the venereal disease program which makes a stronger appeal to the public than the treatment of infants and little children who have come into the world infected with syphilis. That these cases are quite prevalent and distributed in every part of the State is shown by the fact that there was not a clinic in the State last year which did not treat some cases of congenital syphilis while a number of clinics

found it advisable to arrange separate hours for the children. In addition to the clinic cases various health officers and physicians in rural districts have treated congenital cases with arsenic and mercury preparations supplied by the Division of Venereal Diseases of the State Department of Health. During 1924 an average of 251 cases of congenital syphilis was treated monthly at the state clinics as compared with 240 in 1923.

## QUARANTINE BROKEN HEALTH OFFICER HAS PARENT ARRESTED

In a small town in Oneida County, the health officer discovered that quarantine regulations were being broken in a home where scarlet fever existed. As the violations did not cease after due warning had been given, the health officer

had the father of the family arrested and brought before a Justice of the Peace. He pleaded guilty and was given a suspended sentence of fifteen days in the county jail.

## MEDICAL SOCIETY WILL ASSIST IN DEVELOPING RURAL MATERNITY HYGIENE STANDARDS

The technique of maternity hygiene work has been highly developed in many cities, and the standards established by the Maternity Center Association of New York City after years of study and practical experience in city work are accepted generally. The rural community, however, is a comparatively new field and practical standards suitable for general application have not yet been established. With a view to developing a practical rural program and at the

same time demonstrating the value of this line of work, the department, through the Division of Infancy, Maternity and Child Hygiene, has assigned to work in Tioga County two nurses who have had special training in the Maternity Center Association. The County medical society is interested in the undertaking and has appointed three of its members to serve as a medical advisory committee.

## NO EVIDENCE OF TULAREMIA IN RABBITS RECENTLY EXAMINED

A short time ago Mr. John T. McCormick, Deputy Chief of the Division of Fish and Game of the State Conservation Commission, discovered that a number of diseased rabbits were being found in various parts of the state and ordered some of them sent to the laboratory to be examined for evidence of tularemia. Among sev-

eral received recently, one had a broken leg which had become infected, while the others were found to have multiple abscesses from which staphylococci were isolated. The abscesses resembled those noted at times in animals that have received skin infections when fighting. No evidence of tularemia was found.

erning the Medical Society of the State of New York."

Moved and seconded that the bill as drawn up by the Counsel, be introduced into the Legislature Carried

Dr Harris presented the following

#### REPORT OF THE COMMITTEE ON PUBLICATION

A meeting of the Committee on Publication was held at the State Society rooms, 17 West 43rd Street, New York City, on Saturday, December 20, 1924

Moved and seconded that the Committee approve of the "Policy of the NEW YORK STATE JOURNAL OF MEDICINE" as published on page 999 of the December issue of the STATE JOURNAL Carried.

Moved and seconded, that the educational policy of the NEW YORK STATE JOURNAL OF MEDICINE be formulated as indicated in the proposals, the developments or the events which affect the medical profession The Editor-in-Chief shall co-operate with the Committee on Legislation and the officers of the Society before sub-

mitting the policy to the Committee on Publication. Carried

Moved and seconded, that all editorials, articles or communications for the JOURNAL must be sent to the State Society office, 17 West 43rd Street, New York City, and be approved by the Editor-in-Chief, before publication, in his discretion they may be first submitted to the Committee on Publication for action Carried.

Moved and seconded, that the Executive Editor be authorized to go to Albany, as occasion requires, to obtain information on legislation for publication in the JOURNAL Carried

(Signed) E ELIOT HARRIS, *Chairman*  
ORRIN S WIGHTMAN  
EDWARD LIVINGSTON HUNT

Moved and seconded that it be approved. Carried

There being no further business the meeting adjourned at 4 35 P M

EDWARD LIVINGSTON HUNT,  
*Secretary*

### RICHMOND COUNTY MEDICAL SOCIETY

A regular meeting of the Richmond County Medical Society was held at the Staten Island Academy on Wednesday, February 11, 1925

The meeting was called to order at 9 15 with Dr Presley in the Chair

Those present were Drs Mord, Diamond, Lemuelson, Buntin, Edward Klauber, Coonley, Becker, Janeway, Kingsley, Nichols, Washington, Callahan, Smith, Cochrane, Driscoll, Randall, Rieger

The minutes of the previous meeting were accepted as read

The dinner committee reported that a dinner would be given in recognition of the fortieth year of practice of Dr Walker Washington, at the Masonic Club on March 11th

The Legislative Committee spoke on the Chiropractic and the Public Health bills now pending at Albany

A motion was made that the American Medical Association be invited to hold its 1926 meeting in New York City A motion was made to go on record as favoring the Public Health Bill, including re-registration, and against the Chiropractic Bill Motion made that Dr Smith, Chairman of the Legislative Committee, be given power to answer telegrams and decide on Legislative policies of the Society in emergency at his discretion

The scientific paper of the evening was given by Dr Allen K Krause on the "Historic Relation of Tuberculosis to General Medicine," in which he traced the history and method of treatment of tuberculosis from the Phthisis known to Hippocrates to the present day The paper was thoroughly enjoyed and a vote of thanks was given to Dr Krause

The meeting adjourned at 11.20 to the Staten Island Club

### MEDICAL SOCIETY OF ULSTER COUNTY

A regular meeting of the Medical Society of Ulster County was held at McCabe's Restaurant, Kingston, N Y, on February 17, 1925

Meeting called to order at 9 P M by President Dr O D B Ingalls

The minutes of last meeting were read and accepted as read

A motion was duly made, seconded and carried that the Ulster County Medical Society start proceedings against Mr X for illegal practice of medicine in Ulster County, and that the Chairman of the Comitia Minora should confer with District Attorney concerning this matter

A motion was duly made, seconded and carried that the Society contribute annually the sum of twenty dollars (\$20.00) to the Physicians' Home, Inc, at Caneadea, N Y

In the scientific session, Dr H L Van Norstrand, Chairman, Dr F A Johnston of Kingston, N Y, read an interesting paper on Syphilis "as is" in Kingston The paper was well thought of by all members present. Dr Johnston was urged to send a copy of his paper to the Editor of the STATE JOURNAL for publication

After the meeting refreshments were served  
F H Voss, *Secretary*



sical examination? The size of the heart is of the first importance, and in determining its size, the location of the apex beat is of the greatest importance. The apex beat is the lowermost and outermost point at which a pulsation can be determined either by sight or touch. This is usually half or three quarters of an inch outside of the point of the maximum impulse.

Percussion gives doubtful information regarding the size of the heart. Always use light percussion. The X-ray and fluoroscope are of great value for they afford the only sure determination of the size of the heart.

In auscultating the heart the first thing to think of is not murmurs, but the quality of the first sound. The normal heart sound has a definite tone, duration, intensity, and quality. An impairment of the normal nature of these qualities is of greater diagnostic value than murmurs and arrhythmias.

In determining murmurs, it is important to have the patient take exercise during the examination in order to bring out all the adventitious sounds.

The electro-cardiograph may also give valuable information, and both it and the X-ray should be employed in every uncertain case.

Arteriosclerosis and hypertension are produced by the same causes that result in heart disease. The most marked cases of arteriosclerosis—the involutionary type—are not associated with hypertension, and the presence or absence of increased blood pressure does not exclude arteriosclerosis.

The physician must determine arteriosclerosis by an examination of the accessible arteries. The

radial and the brachials are the best for examination. The retinal vessels are also to be examined, and the ophthalmoscope is a valuable instrument for the determination of arterial disease.

Little is known about the cause of hypertension except that heredity is a factor, and yet increased blood pressure is of great importance in clinical medicine.

When increased blood pressure is found, the function of the kidneys is to be determined. An excellent test is that of taking the specific gravity of specimens of urine every two hours during the day and comparing them with all of the urine passed during the night. Normally there will be a variation of ten or more points, but a variation of only five points is an indication of probable renal degeneration. With nephritis the night urine is increased in quantity (normally 400-500 c c), and the specific gravity is comparatively low.

It is important that cases of heart disease be examined frequently—once in every three or six months—and that the patient's occupation and habits of life be adjusted so as to spare the tissues from wear and tear.

It is also important that the physician should follow-up those cases, and even to send them notices of the date when the next call is due. Physicians have a false sense of modesty in following them up and getting them to come for examination. A physician does not discharge his obligations to a patient with heart disease unless he sees that they are properly guided, instructed, and treated.

---

## CONFERENCE OF CHAIRMEN OF COUNTY LEGISLATIVE COMMITTEES

A conference of the chairmen of the legislative committees of the county medical societies was held in the Ten Eyck Hotel, Albany, N. Y., on Wednesday, March 4th, 1925. The chairmen from most county societies were present. Officers of the State Society, and other members interested in medical legislation, made a total of about seventy in attendance.

The conference was opened at 9.25 A. M. by Dr. Critchlow of Albany, member of the Committee on Legislation. The first speaker was Dr. Owen E. Jones of Rochester, President of the Medical Society of the State of New York, who said that the medical profession was united and active to a greater degree than ever before. Since the referendum vote of the members of the House of Delegates stood 94 to 27 in favor of supporting the Medical Practice Act, the spokesmen of the Medical Society of the State of New York would give active support of the Act in the

hearing before the joint public health committees of the Senate and Assembly in the afternoon after the conference.

Dr. James N. Vander Veer, Chairman of the Committee on Legislation of the Medical Society of the State of New York, explained the machinery of the Society. The House of Delegates was the body which was authorized by the Constitution and By-Laws of the State Society to express the policies and standards of the Society, and when the House of Delegates was not in session, the spokesmen of the Society was either the Council, which meets three or four times a year, or the Executive Committee of the Council, which meets monthly.

The House of Delegates had delegated the action on matters of medical legislation to the Committee on Legislation, which acts in cooperation with the Legislative Committees of the county medical societies. The Committee on Legislation



# NEWS NOTES



## THE HEART AND CIRCULATION

By WALTER L. NILES, M.D.,

NEW YORK CITY

Abstract of the third lecture in the symposium on Periodic Health Examinations given in the New York Academy of Medicine on January 8, 1925, under the auspices of the Medical Society of the County of New York.

The subject of the heart and circulation is becoming increasingly important, for last year in New York City organic heart disease killed three times as many people as did tuberculosis, twice as many as cancer, and fifty per cent more than pneumonia. During the past fifty years the mortality from heart disease has increased forty-two per cent, while that from tuberculosis has decreased forty-four per cent.

Many cases of heart disease are entirely preventable, and some are curable.

Infection is the cause of heart disease in from seventy to ninety-five per cent of the cases. Of these infective cases fifty to sixty per cent are rheumatic, fifteen to twenty per cent are syphilitic, and about fifteen per cent arise from focal infections.

Old age may be accompanied by sclerotic degenerations of the circulatory system, probably the result of a very large number of infections, each of which leaves its mark and finally does so much damage that crippling or death follows.

The poisons of alcohol, tea, coffee, and tobacco are minor causes of cardio-vascular disease.

We must also mention as causes of heart disease poor habits, especially indolence, obesity, and extreme exertion without preparation for the strain.

Defects of the circulatory system are sometimes congenital, and yet the defects may be the result of infections during fetal life.

Since the rheumatic group of causes of heart disease is by far the most common, it is necessary to remember some of the closely allied rheumatic infections, particularly acute tonsillitis, chorea, torticollis, erythema nodosum, and growing pains. There is also a group of cases occurring especially in small children in which there is no conspicuous joint trouble.

Are the diseases of the rheumatic group communicable? Some studies have shown that as many as fifteen per cent of cases of acute rheumatic infections are contact cases.

A practical point to be considered is that the prevention of rheumatic conditions comes from such simple means as cleaner mouths, fewer diseased tonsils and decayed teeth, early recognition and treatment of sore throats, attention to the child with aching muscles, and repeated examina-

tions of the heart after any acute infectious disease of childhood.

It is obvious that the periodic health examinations may be of the greatest importance not only in the diagnosis of cardio-vascular-renal disease itself in its early stages, but also in the recognition of its underlying causes, especially foci of infection in the head which may be detected and eradicated. These foci are to be sought in the head (teeth, tonsils, and sinuses) and also in the lungs, gall bladder, appendix, intestine, rectum, anus, uterus, and Fallopian tubes. All of these organs should be carefully searched in any comprehensive health examination.

What are the early, or pre-clinical, signs of heart disease? In young people physical signs that are evident to the physician usually precede symptoms of which the patient complains. The usual signs are those of deformities of the valves of the heart.

In older persons the subjective symptoms felt by the patient usually precede the signs discovered by the physician. It is important for the physician to give due value to the symptoms felt by the patient. Complete history taking and an analysis of the symptoms are absolutely necessary in every examination.

The first subjective symptom of heart disease is usually dyspnoea on exertion. Choking sensations in the chest and weakness of the legs may also be present. A slight, dry cough may also be an early symptom.

An important point is that the symptoms of cardiac insufficiency may be delayed for as much as twenty-four hours after severe exertion.

Pain in the heart region—stenocardia, or angina pectoris—is a common early symptom of heart disease. The terrible so-called true angina pectoris is rarely seen but mild degrees of pain are common. A heart pain felt after exercise or after a hearty meal demands serious consideration.

The first indication of serious heart disease may be paroxysmal dyspnea, or cardiac asthma, usually coming on at night and often after exertion. Edema of the legs, palpitation, vertigo, and fainting may also be early symptoms.

What are some of the early signs of heart disease to be discovered by a physician on a phy-

medicine, and the administration of first aid by a boy scout would be breaking the law. In answer to a question, he said that the practice of drugless therapy would include chiropractic. He said that if any person could pass the drugless therapy examination, he should be given a license to practice medicine in order to see what he could do, and afterward laws could be made if damage was done.

A member of the joint committee that was holding the hearing objected to the feature of the bill in which the Attorney General could supersede the District Attorney in a prosecution of an illegal practitioner, and said that if a district attorney failed to prosecute, a complaint should be made to the Governor who would order an investigation of the conduct of the district attorney's office. The same member also objected to the provision of accumulated fines and punishments, and restriction of jail liberties of illegal practitioners, and said that there was animus behind the bill, and that the bill could not be enacted if it was to prevent murder.

Dr. Downing then introduced as speakers in favor of the Medical Practice Act, Dr. Owen E. Jones, President of the Medical Society of the State of New York, Dr. Mary Dunning Rose, President of the Women's Medical Society of the State of New York, Dr. Matthias Nicoll, Jr., State Commissioner of Health, Dr. Ralph W. Williams, representing the Osteopathic Society of the State of New York, and Mr. George W. Whiteside, Counsel for the Medical Society of the State of New York. Dr. Downing also presented arguments for the Medical Practice Act.

At this point the representative of the Drugless Therapy School presented a fifteen-year-old girl as evidence of the efficacy of drugless therapy. The girl had been taken with pain, paralysis, atrophy, and contractures of the leg, in 1922, and after a few months of treatment the girl was nearly well. The speaker said, "The point is that the drugless therapists have something worth while." Later Dr. Orrin S. Wightman, Past President of the Medical Society of the State of New York, answered a question put to him by one of the members of the joint committee, and said that the girl probably had gone through a form of meningitis in which this sequence of events was known to occur. The questioner further asked, "If there was no change before treatment, and after it a change began, would you say that treatment had something to do with it?"

The Drugless Therapy bill and the Chiropractic bills were considered together, and those in opposition to them were heard first. The speakers against the bills were Dr. Orrin S. Wightman, Dr. George R. Critchlow, and Dr. James F. Rooney. These speakers were subjected to a running fire of questions which came largely from the members of the Joint Committee. Among the questions were the following: Have the doctors ever investigated the system of chiropractic and tested its usefulness?

Will you object to a waiver exempting the present chiropractors?

If a man has practiced chiropractic or any other system of healing for eight years, would he not become experienced?

If a chiropractor passed a Regents examination in medical subjects, will you let him practice in those subjects?

Is it necessary that a chiropractor shall study obstetrics?

Is appendicitis a medical or a surgical case?

If doctors are willing to admit chiropractors who can pass a Regents examination, then is not the only question to be determined that of how present chiropractors should be recognized?

Our impressions of the hearing were somewhat confusing. While the cults tried to create a partisan atmosphere which was not conducive to the settlement of the weighty questions of medical practice, yet the hearing had the very great value of allowing everybody an opportunity for the free expression of opinion.

We sat next to a jolly chiropractor who hailed from the Bay Ridge section of Brooklyn, and swapped information with him regarding the names of the speakers, and the recognition of repartee which we could not catch owing to the exceedingly poor acoustics of the Assembly chamber. This chiropractor repudiated B. J. Palmer, and all his apparatus, including the neurocalameter. He said he was a "mixer" and would use any means to get his patients well. He took only chronic cases, and turned over his diphtherias and pneumonias to medical friends. He had been in practice five years, and would be excluded from practice by the compromise proposed by one branch of the chiropractors, but he said he would do some hard studying for a few weeks or months, and would pass the Regents' examinations.

F. O.

collects information regarding proposed legislation which affects public health, and transmits it to the physicians throughout the State, mainly through the Journal and by bulletins consisting of advance copies of the matter which will appear a few days later in the Journal

The Committee on Legislation also endeavors to inform the legislators regarding the attitude of the medical profession relative to proposed bills. The Committee had accordingly called together the chairmen of the legislative committees of the county medical societies in order that they might make available the collective opinion of the physicians throughout the State, and in cases of differences of opinion, might try to reach a common conclusion.

Dr Matthias Nicoll, Jr., State Commissioner of Health, spoke of the cordial relations between the State Department of Health and the State Medical Society, and reiterated his desire to cooperate with the physicians of the State in every way. He spoke of the aggravating effects which a division of opinion among physicians had among members of the Senate and Assembly, and pointed out the possibility that the legislators would pass a bill recognizing a limited number of chiropractors—probably those who had been in practice eight years—numbering somewhat less than two hundred. He also said that a united stand for the Medical Practice Bill and no compromise with the chiropractors would show the legislators that the physicians were actuated by unselfish, scientific motives.

Dr Augustus S. Downing, of the State Department of Education, Deputy Commissioner for Professional Education, explained the procedure

that would be followed at the legislative hearing in the afternoon, and mentioned some minor changes which would be necessary in the Medical Practice Act.

Dr William A. Howe, Director of the Medical Examination of School Children, explained the objects of the bills which related to the examinations. Most of the bills simply followed the natural evolution of the scheme of medical examinations, and most of the plans are already in operation in many places, and have been found desirable.

Dr George W. Whiteside, Counsel of the Medical Society of the State of New York, made a strong plea for a united stand for the passage of the Medical Practice Act with no exemption from its provisions to any one.

At eleven o'clock the conference went into executive session, and for an hour Dr Critchlaw and Dr Vander Veer led a discussion on forty bills which had been listed on the program. A vote was taken on the attitude of the members of the conference toward the bills in which the features of the Medical Practice Act were combined with the exemptions of present chiropractors and with added sections which would require future chiropractors to conform to the same educational standards as physicians except in surgery and obstetrics. The vote was unanimous in favor of the unamended Medical Practice Act.

The conference was marked with entire harmony and good fellowship, and was a demonstration of the unity which is being attained by physicians.

The members of the conference dined together in the Ten Eyck at noon.

F O

## THE HEARING ON THE MEDICAL BILLS

A hearing on the Medical Practice Bills before the Legislature was held by the joint Public Health Committees of the Senate and Assembly on the afternoon of Wednesday, March 4, 1925, in the Assembly Chamber. It was attended by the chairmen of the legislative committees who had been holding a conference in the morning. About one hundred representatives of the chiropractors and drugless therapy cults were also present. The chamber was well filled, and many onlookers were standing, but the room could not be considered crowded.

The hearing was begun in a dignified way by the presentation of arguments against and for the Medical Practice Act. Dr Augustus S. Downing, Assistant Commissioner and Director of Professional Education had charge of the speakers' program, and at the outset, he invited any physician who was opposed to the Bill to present his argu-

ments. The one physician who responded said his objections were along three lines: 1, Section 170-d, relating to contraceptive measures, was not in the Bill; 2, the Attorney General should not have the power to supersede the County District Attorney; and 3, the annual re-registration feature was unnecessary because there were other ways of securing lists of active physicians.

A representative of the Professional Guild presented the ten objections which were originated by the Legislative Committee of the Medical Society of the County of Kings, and which were printed on page 349 of the February 27th issue of the Journal.

A representative of a school for drugless therapy said that the Medical Practice Act defined the practice of medicine in such a way that many things now done in households, such as taking one's temperature, was the practice of



# THE DAILY PRESS



The sanitary quality of oysters continues to receive attention in the daily newspapers, although now the articles are rare. The *New York Times* of February 20th contains an account of a national conference on the subject of oyster pollution which was held in February 19th in Chicago. This conference adopted the following suggestions:

1 The beds on which shellfish are grown must be determined, inspected and controlled by some state and federal official agency

2 The plants in which shellfish are shucked or otherwise prepared or packed by the shipper must be inspected and controlled by some state and federal official agency

3 The freedom from typhoid bacilli of the workers who handle shellfish must be determined by some official governmental agency

4 Failing to secure sufficiently high standards to protect the people as regards beds, floating and plumping practices and methods of shucking or other methods of preparation, a satisfactory practical method of pasteurization or other heat treatment, or chemical, or biological method which produces satisfactory results, must be installed and operated under proper governmental supervision

5 There must be such governmental supervision and such trade organization as will make plain the source of shellfish and will prevent shellfish from one source being substituted for those from another source. This will be chiefly a problem of the individual state

6 The methods of shipping must be supervised, inspected, controlled and approved by the proper official federal and interstate agency

7 The methods of storing, displaying for sale and dispensing must be determined, inspected and controlled by the proper state or city agency

8 The product must conform to an established bacterial standard, and must meet federal, state and local laws and regulations relative to salinity, water content, food proportion and conform to the Pure Food Laws standards. There should be a revision of the existing bacteriological standards for oysters."

We have assurances from some of the large growers of oysters that they are in favor of regulations and inspections by which the quality of oysters may be "certified" by official authority in the same way that milk of the highest grade is certified. If these suggestions are carried out, buyers of oysters may be assured of the wholesomeness of oysters which they buy, and will purchase them in greater quantities than ever before.

The *Brooklyn Citizen*, February 23d, comments on the use of disease germs in war and quotes Dr. W. H. Park, chief of the Bureau of Laboratories, New York City Department of Health:

"Annihilation of millions by disease germs might sound simple to the layman, but Dr. Park thinks execution of such a plan would be very difficult. For one thing, he points out, healthy persons are continuously resisting disease attacks and many adults are immune.

"For another, there would be quite a problem to scatter them. If by explosive bombs, the heat of the explosion would make them sterile. If released from airplanes, much time would elapse before they reached the earth, and the air and sunlight very likely would make them inert.

"Then, too, an enemy would have to prepare himself against whatever bacteria he planned to use. All his forces would have to be immunized.

"It might even be that an entirely new disease would have to be discovered, such is the resistance we have built up against most of the known ills."

The *Binghamton Press*, February 19th, contains an editorial which is suggestive of ways in which medical organizations may make the influence of physicians felt in the community. The editorial criticizes the Committee on Law and Health of the Common Council for its failure to take action regarding fire risks in tenement houses, and meat inspections. The Editor says:

"The members of the committee not only have invited that attention but have fairly forced it upon themselves by their method of handling two or three important measures committed to their tender care.

"Crowded apartment buildings exist in this city without fire escapes. This is contrary to the spirit of the regulations passed by the council, and is contrary to the express letter of one of its ordinances.

"But, since there is a conflict between sections of the law, it is necessary to draft a new measure.

"Following the fatal fire at Court and Carroll Streets steps were taken to correct the faulty ordinances. A new measure was presented in the council and was referred, as a matter of form, to the committee on law and health.

"There it has remained to this day.

"We don't know whether the meat inspection measure is more important than the proposal for fire escapes. It is charged (and nobody cares to deny it) that the food inspectors of the city are powerless to enforce the law against the bringing in of impure meat for city consumption.

"They are given authority in an ordinance

## THE GORGAS MEMORIAL

The Gorgas Memorial has been endorsed by practically every outstanding scientific medical organization in the United States. At the 75th annual session of the American Medical Association, June 9-13, 1924, the following resolution was duly passed

*"Resolved, That the House of Delegates of the American Medical Association, convinced of the great promise which the Gorgas Memorial contains of benefit to humanity through improved knowledge of preventive medicine and tropical disease, and of its peculiar adequacy as a tribute to our great leader and sanitarian, recommend to the organized profession of the country, through its constituent state and county societies, the enthusiastic support of the project*

*"J A Witherspoon, Tennessee*

*"Joseph Rilus Eastman, Indiana*

*"Thomas Cullen, Maryland*

*"W H Mayer, Pennsylvania*

*"F B Lund, Massachusetts*

*"Chairman"*

Among other organizations endorsing the Gorgas Memorial are The Fifth International Conference of American States, The Society of Alumni of Bellevue Hospital, American College of Surgeons, American Dermatological Association, American Laryngological Association, American Public Health Association, American Society of Tropical Medicine, American Association of Industrial Physicians and Surgeons, Medical Women's National Association, Congress of States, American Institute of Homeopathy, Southern Medical Association, Southern Surgical Association, State Health Officers, State and County Medical Societies, Tri-State Medical Association (Wisconsin, Iowa, Illinois), Southern Commercial Congress, Daughters of the Southern Confederacy

As far afield as Seattle, Washington, comes an interesting endorsement of the work of the Gorgas Memorial. We quote from a recent issue of the bulletin of the Kings County Medical Society

*"The Work of the Gorgas Memorial Fund being based on modern business principles, should be supported by the medical profession*

*"Through the income from \$5,000,000 the Gorgas Memorial is going to make a definite organized effort to 'familiarize the public with such facts as will enable it to recognize the fallacies of the cultists*

*"A constant fund of proper health information carried to the individual through the pages of his daily newspaper, the columns of the general magazines, by means of moving pictures, lectures,*

*and the radio, will direct him to the proper source for medical advice and gradually eliminate these irregulars'*

*"Twenty-five per cent of the Gorgas Memorial work may be classed as potential and considered under the head of Pre-Clinical Medicine. The day is not far distant when the physician will keep his patients fit by means of periodic health examinations, by proper hygienic advice, and by the practical application of health and dietary knowledge. Pre-clinical medicine already forms quite a part of the work of the obstetrician and pediatrician*

*"A report of the Metropolitan Life Insurance Company demonstrated that people who have a periodic health examination and follow the advice given, have a death rate 28 per cent less than people who are not examined and advised*

The Gorgas Memorial has to date 2,500 scientific medical men on its various State Governing Committees throughout the United States. This number will be gradually increased to 5,000 as it is essential that the control of the organization be in the hands of the medical profession. Each committee is formed on a basis of 75 per cent scientific medical membership. Representative of the lay membership of the organization are Adolph Ochs, owner of The New York Times, Mr Bernard Baruch, financier, Mr Haley Fiske, President of the Metropolitan Life Insurance Company, and Mr George Gordon Battle, New York City

It is the purpose of the Gorgas Personal Health movement, controlled by the medical profession, to operate in close co-operation with influential laxity

News items of interest to New York members of the Gorgas Memorial are. First, that leading newspapers throughout the country are featuring a 'Gorgas Better Health Column,' being talks by well-known physicians and surgeons on current health problems

Dr George David Stewart is to make an address the evening of March 18th at a public forum at the Fifth Avenue Hospital, New York City, entitled, "The Gorgas Memorial Personal Health." Dr William Francis Honan will discuss Dr Stewart's paper

On March 20th, at 7 P M, Dr Stewart, who is Chairman of the Gorgas Memorial New York State Governing Committee, will launch the Gorgas radio program by a short address over WEF

Dr Edward Sherrerd Rimer is to speak before an assembly on "The Gorgas Memorial" Sunday afternoon, March 22nd, at the home of Mrs William G Willcox, Staten Island

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 10

NEW YORK, N Y

MARCH 20, 1925

## THE INCIDENCE OF INFECTIONS IN TONSILLECTOMIZED CHILDREN \*

By ALBERT D KAISER, M.D

ROCHESTER N Y

ONE of the common causes given for the removal of tonsils is the prevention of infections related to the tonsils. It is generally assumed that the removal of tonsils will lessen the chances for the repetition of infections or prevent certain ones where they have not occurred before. Inasmuch as tonsillectomy is performed on an increasing number of children each year, the incidence of certain infections should be lessened, provided this assumption is warranted.

There is practically no difference of opinion as to the justification for tonsillectomy where the tonsils are definitely obstructive or obviously causing repeated throat infections. However, where tonsils are removed because they appear diseased and yet are causing no particular discomfort to the child there is room for debate. But this is the type of child that is subjected to tonsillectomy in the great majority of cases. They represent the so-called average child and not the extreme case recommended for operation. Our study is based on the average operated child and not on the children who showed definite disease before operation.

The opportunity to observe a large number of operated children was given in a special clinic organized to examine and operate on about eight thousand children. At the time of operation a careful history of previous infections was taken from the parents and the child was given a complete physical examination. The children were selected from all the school children, about forty thousand being examined, either because their tonsils and adenoids appeared obstructive and diseased or because the child's history suggested tonsillar infection. Twelve hundred of this operated group were examined three years after operation and the incidence of infection ascertained during this period. At the time of the clinic a large number of children who were recom-

mended for operation for the same reason as those who were operated on failed to accept the invitation for various reasons. They have continued in school along with the operated group exposed to the same infections. From this group have been taken twelve hundred children as controls in our study. They have been examined three years after the recommendation for operation and the incidence of infection learned. A comparison of these two groups as related to infections during the last three years has been made. Consideration has been given to local infections, such as sore throat, head colds, infected ears and swollen glands, to respiratory infections, laryngitis, bronchitis and pneumonia, to general infections, measles, scarlet fever and diphtheria and to the rheumatic syndrome, rheumatism, chorea and cardiac disease.

The most common infection in the operated child elicited at the time of operation was frequent attacks of sore throat and tonsillitis. Out of the 1,200 operated children, 674, or more than half of the group, had been subject to tonsillitis previous to operation. During the last three years since the operation only 10 per cent complaining of this symptom failed to get relief from the operation.

Frequent head colds were complained of by nearly half of the children in this group previous to operation. During the last three years 146, or 27%, were still subject to frequent head colds. Obviously head colds are not eliminated when tonsils and adenoids are removed.

Enlarged or swollen cervical glands are generally looked upon as due to infections originating in the throat, ears, teeth or scalp. The presence of enlarged glands is frequently the chief indication for the removal of tonsils. It is indeed a common infection in children, for in the 1,200 operated children there was evidence of enlarged cervical glands in 81% of the children. Of this number 66% were only moderately enlarged, while 15% were consid-

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester April 23, 1924

which was introduced in the council three or four months ago. But this ordinance was referred to the same committee, and the committee has made no report on it."

Law and Health matters make a curious mixture for one committee to handle. The lawyers look backward to see what some one has written about a subject in a book years ago. Physicians go to the research workers who have made investigations of the subject within the last few months.

A lawyer bases his action on *precedent*, or what has been said and done in the past. A physician creates his own precedent by up-to-date research.

Probably the physicians of Binghamton have not been consulted regarding either fire risks or meat inspections. The officials of the Medical Society of the State of New York are reiterating the suggestion that those who have charge of public health matters shall consult the physicians regarding their plans of action. They are also urging the physicians through their societies to offer their services in solving public health problems. We believe that in the face of the present criticisms of the daily press, the officials of the city of Binghamton would be willing that the organizations of physicians should assume some of the burden of responsibility for the solution of the health problems of the city, and that the physicians would be willing to advise the city fathers if their opinions were sought, or assurances were given that the advice would be welcomed.

The New York *Sun*, February 23, contains an editorial comparison of the death rates of London with those of New York City, and says

"The London County Council's report on public health is being made the basis for the assertion that the British capital is one of the healthiest of great cities. The statistics for 1923 show a death rate of only 11.4 per 1,000 of population, and an infant mortality rate of only 61 per 1,000. London and New York have been running a close race in health statistics for some time. The figures quoted above give the former city a slight advantage.

"New York expects to reduce her present death rate. Organized work for health here has been largely responsible for cutting down in twenty-five years a general death rate from 20 or more per 1,000, to less than 12. The future holds promise of reductions fully as astonishing. Meanwhile, it is rather a fine thing that the two largest cities in the world should show health statistics better by far than that of most country districts in their own nations (the death rate for the United States was 12.3 in 1923, and that of the United Kingdom (1920) 12.8), and better than the statistics for most of the civilized countries of the world. The modern city has its great

health problems, but it is making headway with them as never before."

Americans and Englishmen have a high sense of personal liberty and individual independence, and yet the greatest advances in public health are among the people of these two nations. The explanation is that both people also have a high sense of regard for the rights and opportunities of the "other fellow." The great progress in health matters in the past has been along the lines of sanitation, and the control of communicable diseases by means of governmental agencies, both by assistance and compulsion. The present methods in the United States consist largely in education of the young by public agencies, with a big compulsory factor still in use, as in the medical examination of school children.

The greater progress in store for the future will probably be along the lines of the voluntary adoption of health measures by all persons, adult as well as children. This is the aim of the campaign for periodic health examinations. An increasing proportion of governmental budgets of the future will probably be for the promotion of health.

The New York *Times*, February 22d, contains an editorial on "Where Our Taxes Go," and says that health matters account for 14 per cent of the budget of New York City. The allied activity of charity takes 7 per cent, that of education and recreation takes 31 per cent, and fire protection, 7 per cent.

The *Times* then comments on the various items of expenditure of the Federal Government, and says

"It is at Washington that we encounter an expenditure of nearly 30 per cent in interest on the public debt, nearly 20 per cent on army and navy, nearly 15 per cent on veteran rehabilitation. These are the items which account for the familiar graphs showing that perhaps 75 per cent of the taxes paid to Washington go, as the phrase has it, for past or future wars. With this expenditure are contrasted the ridiculous sums devoted by the Federal Government to education, health and other constructive services."

It is often said that three-fourths of our national expenditures go for activities based on the destruction of life. The *Times* editorial goes on to explain this condition.

"If the municipality spends 80 per cent of its taxes on constructive service and the Federal Government spends only 20 per cent, the reason is found in the division of functions as between local and Federal Government. Washington spends comparatively little on education because that has been virtually left to the municipalities and States. The cities spend little on army and navy and past wars because that has been left to the nation."



adenoids is probably the big factor in reducing the incidence of this infection

Enlarged cervical glands were found in 1,056 of the 1,200 control children. All glands have been considered enlarged that are easily palpable. This infection would be dependent upon the season, but both groups of children were examined during the same months so that the comparison is reliable. Of this large number of children with palpable glands 158 showed glands considerably enlarged. At the time of operation 179 of the operated children had large cervical glands. The operation had reduced this number to 54 as against 158 in the unoperated group. Conditions other than infected tonsils might cause swollen glands. It was found that the teeth of the unoperated group were in as good condition as the tonsillectomized children. The high incidence of swollen glands in the two groups would seem to indicate that a tonsillectomy does not prevent the swelling of the glands nor do they rapidly subside after tonsillectomy. However, there is definitely a lessened incidence in the operated group which suggests that a certain percentage of children with enlarged glands are infected through the tonsils.

Discharging ears were reported to have existed in 75 of the unoperated during the last three years while in the operated group 42 children had discharging ears. The tonsillectomized child is not immune to ear trouble although the chances for obtaining infected ears is somewhat lessened.

Recurrent attacks of laryngitis were not effected by the operation. In the unoperated group there were 112 children subject to these attacks as against 57 in the operated group. Tonsillectomy does not lessen the chances for attacks of laryngitis.

Bronchitis occurred in fewer of the unoperated than in the operated group. The same is true of pneumonia. Pulmonary infections do not appear to be influenced by tonsillectomy. It so happened that no cases of lung abscess developed in the 1,200 children studied, but this unfortunate complication does occur. The incidence is about one lung abscess in 2,000 operations in our series.

Scarlet fever had been reported in 97 of the 1,200 unoperated children and in 97 operated children. It is not likely that tonsillectomy offers any great chance to escape this infection, but the tonsillectomized child should be better prepared to withstand the throat manifestations of this disease.

Measles was found to have existed in more of the operated than unoperated children. Removal of the tonsils confers no immunity to withstand this infection.

Diphtheria was reported in 83 unoperated children and 56 operated. Only three cases

had occurred since the operation. It would seem that the tonsillectomized child is less likely to develop this disease probably because there is less opportunity for the diphtheria bacillus to grow.

Much is hoped from tonsillectomy in reducing the incidence of the so-called rheumatic syndrome. Many years must elapse before definite conclusions can be drawn as to the real value of tonsillectomy in preventing these infections. Chorea had existed in seven of the unoperated children and in eight of the operated. Six of the eight children developed it since the removal of the tonsils. A history of rheumatism, joint pains or growing pains was obtained in 128 unoperated children and in 129 operated. Of the operated group 116 developed their trouble since the removal of the tonsils. Cardiac disease was based upon the physical findings. In the control group 52 children presented evidence of cardiac disease while in the operated group there were 44 cases, of which number 13 had developed since the operation. Considering these facts no great decrease in the incidence of the rheumatic syndrome can be expected. With the marked lessening of the incidence of tonsillitis, it is hoped that cardiac disease will be less common in the operated children as the years go on.

An attempt has been made in this study to determine if tonsillectomy protects a child from the common infections. The average operated case has been compared with the same type of child who was denied operation. Based on the data collected, one must conclude that—

(1) Tonsillectomy offers great relief from attacks of sore throat and tonsillitis.

(2) It offers considerable relief to the child subject to head colds, especially where much adenoid tissue is present.

(3) It will lessen the chances for glandular infection, but is no guarantee against it nor does it assure the immediate disappearance of large glands.

(4) It lessens the chance for ear infections, but they do occur frequently in spite of it.

(5) It does not influence favorably or unfavorably infections of the larynx, bronchi and lungs, as they occur in both groups.

(6) It does not prevent scarlet fever or measles, but may influence the severity of the infection.

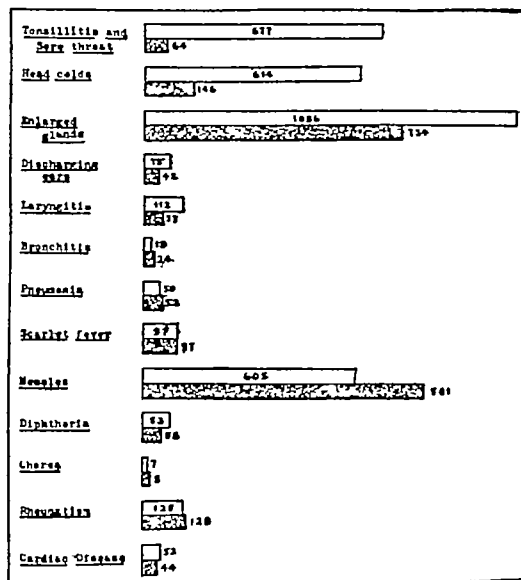
(7) It seems to lessen the incidence of diphtheria by removing fertile soil for the diphtheria bacillus.

(8) It has not influenced the incidence of chorea or rheumatism.

(9) It has shown a lessened incidence of heart disease over a period of three years.

erably enlarged. A previous re-examination of these children showed that there was no great reduction in the incidence of swollen glands one year after operation, but in the next two years there was a considerable reduction, for at the end of the third year after operation the incidence had been reduced to sixty per cent. The 15% incidence of large cervical glands has been reduced to 4.5%. Since the operation 48 children, or 4%, who had never had swollen glands before developed enlarged cervical glands.

White areas—unoperated  
Shaded areas—operated



Incidence of infection in 1,200 tonsillectomized children and the same number not operated on

Discharging ears is a common complaint in a child and frequently given as a reason for tonsillectomy. Out of the 1,200 operated children 136 had a history of either acute or chronic discharge from the ears. During the three years subsequent to the operation 42 children had a similar complaint. Of this number 26 had discharging ears for the first time after their tonsillectomy.

Chronic hoarseness or laryngitis had been complained of by 54 of the children before operation. No improvement was found in the operated children, for three years later 57 children still complained of chronic laryngitis. Only four of this number had developed it since their operation.

At the time of operation it was learned that 69 children gave a history of repeated attacks of bronchitis. The incidence of this infection during the three years following operation was 24 cases, 18 of whom had their repeated attacks since the operation and never any before.

Pneumonia had existed in 44 of the children

previous to operation and eight cases had been reported in this group since operation.

Before operation 93 children had had scarlet fever. Within the last three years since the operation four cases of scarlet fever have developed.

Measles had infected 800 children before operation, so a high incidence would not be expected since operation. Forty-eight children contracted measles since their operation.

Before the operation 53 children were reported to have had diphtheria. During the last three years since the operation three cases of diphtheria developed.

Chorea had existed in two children before operation. During the last three years six cases had developed in the operated children.

A history of joint pains, growing pains and rheumatism was obtained from 46 children previous to operation. Three years later 129 had similar complaints, and of this number 116 had their first attack of rheumatism after the operation.

Cardiac disease existed in 31 of the 1,200 operated children. This was based on physical examination and not on history. Three years later examination of the same group revealed evidence of cardiac disease in 44 children showing 13 new cases in tonsillectomized children.

It would seem from these figures that since the operation the incidence of most infections has been lessened during the three year period. However, in order to be sure that the improvement was not due to something else other than the operation an equal number of children of approximately the same ages and station in life in whom the tonsils had not been removed were studied. The control children received the same type of examination, and the history was taken in a similar way. It must be borne in mind that these controls were candidates for operation three years before, but for lack of interest on the part of the parents were never operated.

Tonsillitis and sore throat was one of the most common infections before operation. A marked decrease in the incidence was noted during the three years subsequent to operation. Of the 1,200 unoperated children 677 complained of sore throat as against 64 of the tonsillectomized children. Obviously the incidence of this common infection is favorably influenced by tonsillectomy.

Frequent head colds were reported in 614 of the unoperated children. In the same number of operated children 146 were still subject to frequent head colds. The incidence of head colds is by no means eliminated by a tonsil and adenoid removal, but about two-thirds of the children have had relief from this infection subsequent to operation. Removal of

(4) Often the pain fails to involve the whole segmental area of the skin, but finds expression in one or more points of maximal tenderness and spontaneous pain

Cope of London has attempted to establish a localizing correspondence between the part of diaphragm irritated and the part of shoulder to which pain is referred. However, in most of our cases the pain has been on the right side and usually at the outer border of clavicle

*Clinical Findings*—The medical man is well aware of the referred pain in the abdomen due to chest pathology, but few surgeons note little connection between pain in shoulder and abdominal pathology

However, phrenic nerve pain is not peculiar to free fluid in abdomen but may be due to any condition that irritates the diaphragm. The following is a list of conditions in which shoulder pain is described: pneumonia, pleurisy, pericarditis, pulmonary infarct, actinomycosis of lung, liver abscess, perforated gastric or duodenal ulcers, subphrenic abscess, cholecystitis with peritonitis, perforated gall bladder, perisplenitis, rupture of spleen, acute pancreatitis, appendicitis, ruptured intra-uterine pregnancy, pressure of drainage tube, and supra-renal tumor

In reviewing the cases I will illustrate a few which are typical for the different lesions

*Perforated Duodenal Ulcer*—T R, age 30, admitted 3/16/23

Always in good health, no indigestion, no previous stomach trouble

Suddenly seized about 3 hours after dinner with sharp pain in pit of stomach. Was taken home and put to bed. Pain in stomach became worse every minute—took some peppermint water, but no relief

Two hours later I saw him at his home—his mother was putting on hot packs to his right shoulder and he was crying out with terrific pain in stomach and a deep boring pain in right shoulder (acromio-clavicular joint). He said the pain in shoulder just started about an hour previously

On examination patient's temperature was 98°, pulse, 120, respiration, 20, it was impossible to make a physical examination because of intense pain. He dreaded to have anyone touch him, except to put on hot packs to shoulder which he said seemed to help a little

His abdomen was as rigid as a board and very little examination was allowed, a diagnosis of perforated ulcer was made. He was given morphine gr  $\frac{1}{2}$  and taken to the hospital and immediately operated by Dr McMullen, who found

a ruptured duodenal ulcer with abdomen full of peppermint water, etc

The ulcer was closed with Mattress & Lambert sutures and patient made an uneventful convalescence. He has had no further trouble

Mr J S, age 40

Had stomach trouble for years. Had two previous operations—one for appendicitis with no relief, later for a suspected ulcer. At both operations it was impossible to find an ulcer

Patient went to work in morning, two hours later suddenly had sharp pain in pit of stomach. Taken home and put to bed. Family doctor was called who prescribed some salts because bowels hadn't moved for two days. Immediately on drinking salts patient became almost maniacal with pain. The doctor gave him  $\frac{1}{4}$  gr morphine with little result, 10 minutes later gave him another  $\frac{1}{4}$  gr, 15 minutes another  $\frac{1}{4}$  gr, but pain was not relieved. Family doctor called me to see this case of supposed intestinal obstruction

On entering the bedroom I noted the patient was doubled up in bed, but would not move an inch to allow an examination. He had such pains all through his abdomen it was impossible to persuade him to turn flat on his back

I asked him about any other pain, but he wasn't inclined to talk. On further inquiry as to pain in his shoulder, he said he had such a burning pain in his shoulder he couldn't let anyone touch it (placing my hand on abdomen—it was flat and board-like)

A diagnosis of perforated duodenal ulcer was made and he was immediately taken to hospital. I found a small perforated ulcer on posterior wall of duodenum, which I closed with Mattress & Lambert sutures

He made an uneventful recovery, but has had some stomach trouble from time to time

*Case of Perforated Gall Bladder*—Mrs C R., age 50, admitted 4/9/23. Well nourished, repeated attacks of gall bladder trouble with jaundice, etc

Twenty-four hours before admission patient started to vomit, had cramps all through abdomen, fever 101, later pain localized in right lower side

Four hours before admission patient suddenly seized with sharp pain in right upper quadrant with severe pain in her right shoulder, which she said was a heavy boring feeling

On examination patient was markedly tender all over abdomen, more marked in right lower quadrant. I made a diagnosis of acute appendicitis while Dr McMullen thought she had a perforation of duodenum or gall bladder

A right rectus incision revealed no gas on opening the peritoneum, but there was a peculiar

<sup>4</sup> Cope. Clinical study of Phrenic Shoulder Pain. Brit Jour Surgery 10 1922—Oct. 1922

# IMPORTANT SYMPTOM OF PERFORATION WITH FREE FLUID IN ABDOMEN\*

F F McGAULEY, M D,

SCHENECTADY, N. Y.

**I**T is customary when called to examine a patient who has a severe intra-abdominal condition to focus all our attention on the abdomen and overlook a very important and fairly constant symptom not in the vicinity of the umbilicus. I refer to pain in the shoulder, not over the scapula, but over the acromio-clavicular joint, usually on the right but occasionally on left side and may even extend across the clavicle to the sternal border.

In reviewing the office records of Drs McMullen, Lenz and myself for past four years, which included 1,100 abdominal operations I found 28 cases of acute perforations. Analyzing these histories and studying their follow-up cards it is interesting to note that 16 or 57 per cent of the cases had pain in shoulder, especially over the outer end of the clavicle.

Practically all of the cases which we have had in the past two years have had history of shoulder pain, because we have asked direct questions at the time. Previous to that time little note was made of this condition, and on re-examination many patients do not remember much about pain in the shoulder, because the abdominal pain was so intense at the time.

Before discussing the typical case records, it might be interesting to study the reason for shoulder pain which is best brought out by a study of the embryology, anatomy and physiology of the diaphragm and phrenic nerve.

**Embryology**—In reviewing the embryology of the diaphragm Dr Mall<sup>1</sup> has stated that in its development the whole diaphragm wanders from the head to the abdomen, passing by, as well as modifying the structures and organs along the way. In the head region of the early embryo lies the anlage of the diaphragm together with those of the heart and liver. In fact the three embryonic body cavities, pericardial, pleural and peritoneal arise from the embryonic head and neck region and descend to their anatomic positions during developments.

The phrenic nerve which arises in the cervical region enters the diaphragmatic anlage and as the organ descends, lengthens to give it innervation.

Keeping this in mind, we can better understand the innervation of the diaphragm by the phrenic nerve.

**Anatomy**—The phrenic nerve has its origin from the 3rd, 4th and 5th cervical nerve roots. It is known to have both motor and sensory fibers.

It supplies sensory branches to both pleural and peritoneal surfaces of diaphragm, except at the border of diaphragm where both surfaces receive innervation from 6-12th intercostals.

**Physiology**—Capps & Coleman<sup>2</sup> have recently studied the pain produced by irritating the under surface of the diaphragm by means of a wire introduced through a cannula in patients having ascites or pneumo-peritoneum.

They conclude that pain induced by stimulation of the diaphragm is never located in the diaphragm itself, but it is referred to some distant part.

As anatomists find the phrenic nerve is chiefly made up of fibers from the fourth cervical nerve, we can understand the greater frequency of pain in the fourth cutaneous segment.

There is every reason to suppose that the different impulses from the diaphragm are carried up the phrenic nerve to the cervical cord where painful stimuli are set up in the corresponding cutaneous segment.

The neck pain from the parietal surface of the diaphragm is a typical referred pain.

The area of pain localization described both clinically and experimentally were for the most part in the distribution of the fourth cervical cutaneous segment (trapezium ridge and acromion region).

In studying the physiology of the phrenic nerve and other nerves supplying the diaphragm, the general laws of the production and distribution of visceral pain as outlined by Head<sup>3</sup> have here direct practical application. Referred pain from the viscera has been summarized in four statements.

(1) It is often remote from the site of irritation.

(2) It follows the lines on the skin of the spinal segmentation rather than the course of the peripheral nerves.

(3) It is usually associated with cutaneous hyperaesthesia and tenderness to pressure.

<sup>2</sup> J. A. Capps & G. H. Coleman—Exp. Observation on Localization of Pain Sense in the Parietal & Diaphragm Peritoneum. Arch. Int. Med. 30:778—Dec. 1922.

<sup>3</sup> Head—Disturbance of Sensation with special reference to pain of Visceral Disease. Brain 16:1—1893.

\*Read before the Medical Society of the County of Schenectady, October 14, 1924.

<sup>1</sup> Mall, F. P. On the development of the Human Diaphragm. Bull.—Johns Hopkins Hospital 12:158—1901.

(4) Often the pain fails to involve the whole segmental area of the skin, but finds expression in one or more points of maximal tenderness and spontaneous pain

Cope of London has attempted to establish a localizing correspondence between the part of diaphragm irritated and the part of shoulder to which pain is referred. However, in most of our cases the pain has been on the right side and usually at the outer border of clavicle

*Clinical Findings*—The medical man is well aware of the referred pain in the abdomen due to chest pathology, but few surgeons note little connection between pain in shoulder and abdominal pathology

However, phrenic nerve pain is not peculiar to free fluid in abdomen but may be due to any condition that irritates the diaphragm. The following is a list of conditions in which shoulder pain is described: pneumonia, pleurisy, pericarditis, pulmonary infarct, actinomycosis of lung, liver abscess, perforated gastric or duodenal ulcers, subphrenic abscess, cholecystitis with peritonitis, perforated gall bladder, perisplenitis, rupture of spleen, acute pancreatitis, appendicitis, ruptured intra-uterine pregnancy, pressure of drainage tube, and supra-renal tumor

In reviewing the cases I will illustrate a few which are typical for the different lesions

*Perforated Duodenal Ulcer*—T. R., age 30, admitted 3/16/23

Always in good health, no indigestion, no previous stomach trouble.

Suddenly seized about 3 hours after dinner with sharp pain in pit of stomach. Was taken home and put to bed. Pain in stomach became worse every minute—took some peppermint water, but no relief

Two hours later I saw him at his home—his mother was putting on hot packs to his right shoulder and he was crying out with terrific pain in stomach and a deep boring pain in right shoulder (acromio-clavicular joint). He said the pain in shoulder just started about an hour previously

On examination patient's temperature was 98°, pulse, 120, respiration, 20, it was impossible to make a physical examination because of intense pain. He dreaded to have anyone touch him, except to put on hot packs to shoulder which he said seemed to help a little

His abdomen was as rigid as a board and very little examination was allowed, a diagnosis of perforated ulcer was made. He was given morphine gr  $\frac{1}{2}$  and taken to the hospital and immediately operated by Dr McMullen, who found

a ruptured duodenal ulcer with abdomen full of peppermint water, etc

The ulcer was closed with Mattress & Lambert sutures and patient made an uneventful convalescence. He has had no further trouble

Mr J. S., age 40

Had stomach trouble for years. Had two previous operations—one for appendicitis with no relief, later for a suspected ulcer. At both operations it was impossible to find an ulcer

Patient went to work in morning, two hours later suddenly had sharp pain in pit of stomach. Taken home and put to bed. Family doctor was called who prescribed some salts because bowels hadn't moved for two days. Immediately on drinking salts patient became almost maniacal with pain. The doctor gave him  $\frac{1}{4}$  gr morphine with little result, 10 minutes later gave him another  $\frac{1}{4}$  gr, 15 minutes another  $\frac{1}{4}$  gr, but pain was not relieved. Family doctor called me to see this case of supposed intestinal obstruction

On entering the bedroom I noted the patient was doubled up in bed, but would not move an inch to allow an examination. He had such pains all through his abdomen it was impossible to persuade him to turn flat on his back.

I asked him about any other pain, but he wasn't inclined to talk. On further inquiry as to pain in his shoulder, he said he had such a burning pain in his shoulder he couldn't let anyone touch it (placing my hand on abdomen—it was flat and board-like)

A diagnosis of perforated duodenal ulcer was made and he was immediately taken to hospital. I found a small perforated ulcer on posterior wall of duodenum, which I closed with Mattress & Lambert sutures

He made an uneventful recovery, but has had some stomach trouble from time to time

*Case of Perforated Gall Bladder*—Mrs C. R., age 50, admitted 4/9/23. Well nourished, repeated attacks of gall bladder trouble with jaundice, etc

Twenty-four hours before admission patient started to vomit, had cramps all through abdomen, fever 101, later pain localized in right lower side

Four hours before admission patient suddenly seized with sharp pain in right upper quadrant with severe pain in her right shoulder, which she said was a heavy boring feeling

On examination patient was markedly tender all over abdomen, more marked in right lower quadrant. I made a diagnosis of acute appendicitis while Dr McMullen thought she had a perforation of duodenum or gall bladder

A right rectus incision revealed no gas on opening the peritoneum, but there was a peculiar

\*Cope. Clinical study of Phrenic Shoulder Pain. Brit Jour Surgery 10 192—Oct 1922

greenish-yellow fluid in peritoneal cavity On examining the appendix there was a large acutely inflamed appendix about three times normal size, which was removed The upper quadrant was explored and a small hole was found in the gall bladder which was full of small stones The gall bladder was also removed

The patient made an uneventful recovery

Mr J M, age 25, ex-service man Walked into the Ellis Hospital complaining of cramps on stomach

He said he had been feeling badly for two days and finally had taken a dose of salts about six hours before admission He had vomited several times

Patient had temperature of 101°, pulse 90, respiration 26 He was put to bed and about two hours later the interne "thoroughly" examined him and made a diagnosis of acute appendicitis A few minutes later the interne was called back to the room because the patient had such pains in stomach The interne ordered  $\frac{1}{4}$  gr morphine and called me to the hospital About a half hour later I saw the patient who was crying out with pain all through his stomach and had such a burning heavy pain in right shoulder just at outer edge of collar bone It was impossible to touch patient except to feel a board-like abdomen A diagnosis of acute ruptured appendix was made and patient was brought immediately to operating room

It was with difficulty the patient was anesthetized A right rectus incision was made—as soon as peritoneum was opened a gush of watery fecal matter came out Several large sponges were used to clean out some of the fluid and the appendix was exposed as quickly as possible At the base of the appendix was a large hole out of which the fecal material was pouring I immediately put a clamp on the base of the appendix and most of the fecal matter was sponged out of the peritoneal cavity The appendix was then removed and several drains inserted The next day patient felt relieved—he had no pain either in abdomen or right shoulder However, he developed pneumonia, probably embolic and expired the following morning

*Ruptured Ectopic*—Mrs J T, age 33, admitted to Ellis Hospital 12/23/23, married 12 years, one child 10 years old, no miscarriages Periods always regular up to last two months Has had slight show for past month

Twenty-four hours before admission, awoke in morning with sudden pain in her left shoulder

—did not vomit but felt nauseated Got up that morning, but did not feel good Said she felt a little weak Went back to bed in the afternoon and complained of pressure pain in her left shoulder—that evening her husband rubbed her shoulder for a rheumatic pain Pain was not severe, but it felt better with a little pressure or when it was rubbed

Dr McMullen was called in consultation the following day, she still had pains in right lower quadrant, but pain in shoulder had disappeared

On physical examination T P R normal

M M good color

Some tenderness over left shoulder

Heart and lungs, O K.

Breasts, normal

Abdomen, full—pendulous abdomen Some question as to free fluid Some pain in right lower quadrant

Pelvis, normal—except for slight softening of cervix

With this diagnostic history and pain in right shoulder irrespective of a positive physical examination, a diagnosis of ruptured ectopic was made.

Operation revealed abdomen full of blood with ruptured ectopic in middle of right tube

*Conclusion*—1 Pain in neck or acromio clavicular joint is a symptom which is constant after rupture of an intra-abdominal viscus provided the fluid which escapes gravitates up to the diaphragm

2 Fluid in abdomen after rupture very rapidly flows up to diaphragm because patient usually assumes a reclining position

3 The pain is described by patient as a "soreness," "rheumatism," terrible burning pain, pressure pain, "seems to choke off their breathing," griping pain, etc

4 The severity of the pain in the shoulder is directly proportionate to the irritating nature of the fluid

5 Noting the pain in shoulder eradicates that question mark which very often accompanies a diagnosis of ectopic, inasmuch as the patient often has a fatty abdomen and it is often difficult to say positively as to free fluid in the peritoneal cavity

6 Pain in shoulder "per se" is not diagnostic, but it is very helpful in making a positive diagnosis on a questionable case

# INTESTINAL TOXAEMIA CONTROL THROUGH BIO-DIETETIC METHODS

By CLARENCE W LIEB, A M, M D,  
NEW YORK CITY

THE role played by one or more of the "daily half dozen" food sugars, namely, dextrose, maltose, levulose, lactose, dextrin and saccharose, in the causation of many alimentary disorders is fast attracting the attention of leading clinicians and laboratory workers

Civilized man eats a far greater variety and quantity of sugars than the uncivilized man. The ratio of metabolic disease in a nation seems to be in direct proportion to the quantity of carbohydrate food it consumes. The Hebrew race is more prone to certain metabolic disturbances than others and excessive carbohydrate consumption appears to be an important casual factor. The Eskimo lived on a practically one hundred per cent meat diet, in other words, a diet free from sugar and starch, up to the period when food of civilized man was incorporated into their dietary. Stefansson affirms that until then constipation, gastro-intestinal upsets and dental caries were unknown. Since adding cereals and sugar to their diet, however, these conditions are very prevalent, constipation and dental caries being the rule now, rather the exception.

Brown<sup>(1)</sup> has emphasized the part played by carbohydrates in the production of chronic headaches. Holt and Foles<sup>(2)</sup> contend that definite digestive disturbances, chiefly intestinal, may be produced when the carbohydrates in the diet are excessive. They likewise believe that dental caries is largely due to the high proportion of carbohydrate in the modern diet. Jean-Charles, Roux and Griffin<sup>(3)</sup> have shown that insufficient starch and sugar digestion permits considerable carbohydrate material to enter the large intestine. They contend that it there constitutes a culture medium giving rise to organic acids and gases which irritate the intestines and produce symptoms.

Wasserman and Ficken<sup>(4)</sup> have demonstrated that the Frankel bacillus, which is non-pathogenic to man and animals, becomes highly pathogenic to an animal when grown in a two per cent glucose solution. They report results with other organisms in which the

toxicity is increased 30-40 per cent by activation with sugars. They conclude that a similar process of activation, rather than a new bacteriological infection, is the basic factor in intestinal toxæmia.

Barger and Dale<sup>(5)</sup>, Koessler<sup>(6)</sup> and others have demonstrated the production of histamin from histadin by bacterial action in the colon. Patty<sup>(7)</sup> has found HCN in the colon in fairly large amounts. Hendriques<sup>(8)</sup> has shown that acetone can be generated in the intestines bacteriologically. Connellan<sup>(9)</sup> in exhaustive experiments has proved the presence of formic acid in human stools and its bacterial production therein. Lieb<sup>(10)</sup> has repeatedly found oxalic acid in the feces of patients suffering from various disease entities. Shaw<sup>(11)</sup> has recently demonstrated the production of formaldehyde by intestinal bacteria. The toxicity of the above poisons has been definitely proven by different workers, particular attention having been given to histamin both from the laboratory and clinical standpoint. Hence the importance of the scientific control of agents responsible for these toxins is obvious. Experiments now in progress point to the fact that there are other toxic amines and poisons elaborated in the colon which are fundamentally important from the clinical and pathologic standpoint.

The different sugars have been used for a long time in the study and identification of bacteria. The gas and acid reactions and rate of growth on the various sugars are differential points of the greatest value, as the following chart demonstrates.

By inoculating the different sugars with feces with our present method it is possible to determine which are the greatest activators of bacterial growth, this with or without acid production. Sugar solutions so inoculated show different gas or acid production from that found when pure cultures of bacteria are used, as is shown in the appended table. We believe that the resulting picture is more practical with collective inoculation than by preliminary growth and inoculation.

Name of Micro-org.	All Gram negative.	Serum	Lactose	Saccharose	Glucose	Maltose	Levulose	Dextrin
Bacil lactaci (Huppe)		0	AG	O	AG	AG	AG	AG
B capsulatus (Pfeiffer)		0	AG	AG	AG	AG	AG	AG
B coli (Escherich)		0	AG	O	AG	AG	AG	AG
B coli, mutabilis (Massini)		0	AG	O				
B dysenteriae (Flexner)		0	O	O	A	A	A	A
B enteritidis (Gartner)		0	O	O	AG	AG	AG	AG
B lactis aerogenes (Escherich)		0	AG	AG	AG	AG	AG	AG
B paratyphosus, A (Schottmuller)		0	O	O	AG	AG	AG	AG
B paratyphosus, B (Schottmuller)		0	O	O	AG	AG	AG	AG
B typhosus (Eberth)		0	O	O	A	A	A	A

Copies from Hewlett (12)  
Abbreviation used in table: A acid G, gas.

Fecal Specimen	Dextrose (Glucose)	Maltose	Saccharose (Sucrose)	Lactose	Dextrin	Levulose	Histamin	Mucous	Reaction of Stool
A	high acid	—	—	—	—	faint acid	+++++	large amt.	acid
B	high acid	faint acid	—	—	faint acid	—	+++++	mod. amt.	faint acid
C	—	high acid	—	—	—	high acid	++	small amt.	very faint alk.
D	—	—	—	—	—	—	+++	small amt.	faint alk.
E	high acid	high acid	—	—	faint acid	high acid	+++++	large amt.	high acid
F	high acid	—	faint acid	faint acid	faint acid	high acid	+++++	large amt.	high acid
G	acid	very faint acid	—	—	—	faint acid	++	small amt.	very faint acid
H	high acid	—	—	—	—	acid	+	mod. amt.	faint acid

Media 5% solution of sugars—C P no protein or peptone. Indicator Brom cresol purple

The effects of continued high acidity, whether due to physiologic or biologic processes, is a factor to which gastro-enterologists have given insufficient attention. High gastric, duodenal and cecal acidities in the light of Hammett's<sup>(10)</sup> recent researches must be seriously considered as a cause of intestinal stasis, particularly of the atonic type. This point has been elucidated in the following quotation from Dr Hammett's letter in reply to a question bearing on duodenal research now in progress:

"Continued high acidity in the duodenum would tend to produce a condition of chronic relaxation of this region of the intestine, that is to say the muscular tone of the duodenal portion of the intestine would be lowered. This follows from my results on the effect of changes in Ph on intestinal motility, which results have been confirmed by workers both in this country, England, Scotland and Germany. This flabbiness of tone or relaxation would assuredly result in intestinal stasis, increased gas formation, distension, laggard passing on of intestinal contents in the particular region affected and, of course, indigestion. The further possible harm that might result would be the action of any toxic agents that might be present upon the sensitive mucosa of that part of the intestine where stasis occurred. Here through prolonged contact amounts of toxic substance which under normal conditions might be harmless (relatively) could be conceived of as exerting a deleterious effect by virtue of the time allowed for reaction."

This may seem at variance with the relatively greater number of cases of colonic spasticities elicited by X-ray studies. Spastic conditions in the colon more frequently give rise to symptoms and thus influence patients more often to seek medical advice. In this

way a greater number of such patients come to be roentgenologically studied. The writer is confident, however, that most colonic pathology starts with a condition of atonicity and that spasticity is a secondary factor, the result of inflammatory activity due to irritant substances in the colon.

In order to get a better perspective on the bio-dietetic problem let us consider the behavior of carbohydrates in the alimentary tract. In the mouth food becomes mixed with saliva, a faintly alkaline fluid containing the enzyme, *ptyalin*. *Ptyalin* hydrolyses starch with formation of soluble starch, dextrin, and finally maltose. The next action is that of the gastric juice when the food reaches the stomach which is hardly sufficient to account for the hydrolysis of sucrose without assuming the presence of invertase. The pancreatic juice has an alkalinity corresponding to the acidity of the gastric juice and the one neutralizes the other. The pancreatic juice contains a powerful amylolytic enzyme which hydrolyses starch with production of maltose and, if the pancreatic juice be neutralized, of glucose. Other disaccharides are unaffected, so that though maltose is present both invertase and lactase are absent. All three enzymes are present in the intestinal juice and absorption of the hexoses takes place mainly in the small intestine. By the time food has arrived at the ileocaecal valve practically all of the carbohydrates have been absorbed.

Fructose, mannose and galactose, if slowly introduced into the circulation are converted into glycogen, probably with intermediate formation of glucose. On the other hand, sucrose, lactose and pentoses are not convertible into glycogen. If the percentage of sugar in the blood rises above 0.2, namely, in hyperglycaemia, then sugar appears in the urine. The



"limit of assimilation of carbohydrates" is the amount of carbohydrates that can be ingested and converted into glycogen in the liver without the content of glucose in the hepatic vein (that is, in the systematic circulation) rising materially above the normal, in short, without hyperglycaemia. There is no well-defined limit for starch. It varies enormously for di- and monosaccharides, being from 100 to 250 g., according to the powers of digestion and the hepatic function of the individual.

Recognition must be given to the fact that the sugars as taken in the food do not exist as such on reaching the colon after digestive metamorphosis. This is shown in the following synopsis and is an important guide in the dieto-therapeutic management of colonic patients. Von Lippmann<sup>(13)</sup>

**Starch.** Constitutes over fifty per cent of the solid matter of cereal grains and a larger proportion of the total solids of potatoes, bananas, etc. In processes of digestion (especially when cooked) starch is changed to maltose and the latter to glucose.

**Glucose** (dextrose). Occurs in large amounts in most fruit and plant juices. Almost all carbohydrates yield glucose when split by digestive ferments. It reaches the large intestine as glucose.

**Saccharose** (sucrose-cane sugar). Occurs commonly in the vegetable kingdom. When digested, it is changed into equal parts of glucose and levulose.

**Levulose** (fructose). Occurs with glucose in fruits, honey and plant juices. Reaches large intestine as levulose.

**Maltose.** Occurs in malted or germinated grains. Large amounts formed by digestion of starch by saliva or pancreatic juice and in turn into glucose.

**Lactose** (milk sugar). Occurs in milk. In the intestine lactose is digested into equal parts of glucose and galactose.

It will be seen that the disaccharides and polysaccharides are all reduced to the simple sugars, glucose, levulose and galactose before absorption.

It is to be noted in the above sugar chart that sucrose has the least activating power of all the sugars. It does not, however, reach the colon as sucrose but as glucose and levulose. Abel<sup>(14)</sup> has found that five ounces of sucrose per day fed to healthy men in a mixed diet showed an average digestibility of 98.97 per cent. In gastro-intestinal individuals the absorbability may not keep pace with digestibility and much invert sugar must necessarily reach the colon. Sherman<sup>(15)</sup> states that very little sugar reaches the colon unchanged. The high consumption of cane sugar in this country (nearly 100 pounds per capita yearly) has

great potentiality for physiologic as well as biologic harm. We know that concentrated sugar solutions cause a distinct abstraction of water from the mucous membrane as is noted when a piece of hard candy is held against the cheek for a short time. Invert sugar does not have as deleterious an effect upon digestion as does sucrose. The repeated irritations of the stomach may lead to serious gastric disturbances. Investigations have shown that with too large an ingestion of sugar (120 grams) the emptying time of the stomach is delayed, resulting in lactic, butyric or alcoholic fermentation.

It is an interesting fact that those fruits which we most use for their cathartic action consist mostly of dextrose-glucose, plus levulose: dates, 78 per cent, figs, 74 per cent, prunes, 73 per cent, raisins, 76 per cent. These fruits also contain cellulose which transports the sugar to the lower bowel. The amount of cellulose, however, contained in a couple of ounces of these fruits cannot explain their cathartic action, nor can the amount of their contained acids, nor that of their contained ash, which is less than two per cent in each of the foods. Their cathartic action is due unquestionably to their bacterial activating power in the bowel by their contained sugar. It is a well-known fact that individuals react differently to such so-called laxative foods—the results varying from nil to marked gaseous diarrhea. This latter is without doubt due to furnishing the colon bacteria with an activating medium.

The cooking of fruits and vegetables has a bearing upon intestinal conditions, as it softens the cellulose by changing the intracellular water into steam, thereby rupturing the starch grains as noted in the popping of corn. In this transformation the cellulose and starch are changed into simpler substances as glucose and other sugars by hydrolytic action. These sugars are thereby made more readily absorbable. Hence, thoroughly cooked fruits or vegetables reach the bowel with a minimum of sugar. One reason why some people can take cooked fruits with impunity and cannot take raw fruits without punishment therefrom is due to the above fact, namely, that in the former the sugar is absorbed and in the latter much of it reaches the lower bowel and activates the bacteria which produces gas and toxins, with resulting symptoms. The fact that raw fruits are more laxative than cooked fruits is thus explained, inasmuch as gases and acids stimulate peristalsis. Foods, which produce their laxative effect by their contained sugars may have potentiality for harm. This bio-chemical factor likewise explains the laxative effect of honey, treacle, and marmalade.

The low cellulose diet has been in use for a long time on the assumption that its value lay fundamentally in its non-irritating and easily assimilable qualities. By pureeing vegetables and straining fruits we remove the cellulose sugar carrier and the cellulose factor in producing peristalsis which hastens the sugar toward the colon before the sugars can be thoroughly extracted in the small bowel. Foods rich in cellulose and taken with sugar or starch undergo, on reaching the lower bowel, fermentation with the production of lactic, acetic, formic and oxalic acids<sup>(17)</sup>

The principle of bacterial-activation control was first used by the writer<sup>(18)</sup> in limiting oxalic acid production in the colon as the following extract indicates

"We have been using a dietary containing the minimum amount of cellulose so that as little sugar as possible is mechanically carried into the lower bowel. We believe that the benefits of the smooth diet in colonic diseases are due in large part to a quantitative reduction of activating sugars reaching the lower bowel. A smooth, low cellulose diet mechanically facilitates starch and sugar digestion and likewise lessens peristaltic activity, thereby prolonging the absorptive period. We believe that colonic passivity or immobilization, produced in so far as that is possible by a low or residueless diet, is just as important in curing colonic pathology as is local rest in other conditions such as an infected lung or a broken leg. Doubtless some of the benefits of a starvation cure as due to intestinal rest and an absence of activating sugars in the colon. Chronic intestinal invalids are notoriously improved for the time by barium meals and enemas. It is very probable that intestinal stasis is a protective mechanism, an effort on Nature's part to produce local rest in the presence of inflammation" (Lieb)

Since the publication of the above paper this dietetic principle has been subjected to much experimentation and elaboration.

It has been demonstrated through laboratory study and trial and error methods that very careful individualization of this dietetic principle is indicated.

The digestive capacity of the different digestive organs and their enzymes must be considered. Neither in the beginning or end of treatment must the change from dietetic control or dietetic release be made too abruptly for there are physiological as well as biological principles at stake. A low residue carbohydrate diet, sufficient to maintain body weight in about ten per cent of patients, produces considerable digestive turmoil. Even though 50 grams of proteid are added to this diet the symptoms do not entirely disappear.

If these patients are placed upon a low residue, thoroughly cooked proteid diet all symptoms disappear and the bio-dietetic problem becomes a simple one.

Sugars taken in liquid form (in beverages) are practically all absorbed before they reach the large bowel and therefore do not have to be considered if within the digestive capacity and not taken with cellulose containing food.

The sugar taken in the form of candy does not enter into the bio-dietetic problem unless eaten in large amounts or with food containing such residue. Agar-agar undoubtedly carries much sugar to the lower bowel. Part of the action of the agar-agar may be due to its power of carrying sugar to the lower bowel and there stimulating peristalsis by gas and acids which have been produced by fermentation.

There are very few dietetic schemes which should be followed intensively for more than two or three weeks. We must guard against avitaminosis, proteid fat, and carbohydrate over dosage. The success of many of the vaunted dietetic schemes lies in their common denominator, a low residue content. Is it not possible that colonic sugar control has been the therapeutic factor?

No therapeutic regimen, dietetic or otherwise, is a rational one without a complete gastro-intestinal survey to eliminate the possibility of mechanical factors or morbid pathology. The problem is an alimentary one, not intestinal alone. Abel<sup>19</sup> has shown that histamin increases gastric acidity. Hyperacidity we know decreases pancreatic function. With decreased pancreatic function we have to deal with an intricate metabolic problem. Poor starch and sugar digestion linked up with the hyperperistalsis so often met with in hyperchlorhydria results in a great increase of activating sugars in the colon with a consequent increase in histamin and other toxins, thus producing a vicious circle.

An interesting observation made repeatedly on gastro-intestinal invalids was the frequent hyperglycemia with rapid amelioration of symptoms when insulin was used in conjunction with saccharo-dietetic control. Naturally it would be hard to draw conclusions from such observations without repeated control experiments. An acceleration in symptomatic cure seemed to take place with insulin therapy even in the presence of a normal blood sugar.

The writer has worked out four dietetic procedures for the selective individualization of each patient.

It would seem on first analysis that the best way to solve the sugar problem as above elaborated should be to omit all foods containing the contra-indicated sugars. But this has been shown to be impractical since the foods which contain the most sugars have in general the least residue and since intestinal immobilization and improved

nutrition are also fundamental factors in treatment, such a scheme is impractical. Therefore, our problem resolves itself to the limitation of colonic sugars through the following methods.

*Diet No 1 Residueless* (practically), containing fresh butter, cod liver oil, sugars, gelatin, calcium, raw vegetables and fruit juices and lactalbumen (as best tryptophan source).

Indicated in severe ulcerative and advanced cases of mucous colitis and to replace the starvation treatment of epilepsy where an intestinal intoxication as an etiological factor is suspected.

*Diet No 2 Low Residue* This diet contains the low cellulose vegetables and fruits, non-fibrous, tender and well cooked fresh animal foods, no milk, but the liberal use of heavy cream, butter and oil. Sugar may be used in tea or coffee.

Indicated in the treatment of the average case of intestinal toxæmia. Hypochlorhydric cases do well on this diet, hyperchlorhydric cases may develop considerable gas due to inhibited carbohydrate digestion, but alkaline therapy or oral pancreatic glandular therapy eliminates this tendency.

*Diet No 3 Low Residue Breakfast and Luncheon* (as in Diet No 2), *High Residue Dinner*. High cellulose vegetables, non-fibrous, well-cooked fresh animal food, diabetic breads, no desserts (practically a diabetic meal).

Indicated during the post-intensive treatment of intestinal toxæmia and in cases complicated with intestinal atony.

*Diet No 4 Intensive High Protein Diet* (sugar free). As near to a 100 per cent meat diet as possible. Animal fats given liberally. Meat should be tender, thoroughly broiled, baked, boiled or stewed.

Indicated in colonic toxæmia in which saccharolytic organisms such as aerogenous capsulatus predominate and where renal function is unimpaired. (Menus published in reprints).

The writer's studies on the value of a sugar-free, proteid diet combined with the results of the interesting dietetic observations made by Stefansson, the noted explorer, during his many years in the far North have amply demonstrated the advantages of a meat diet, properly adapted, in the control of certain types of intestinal toxæmia. But the therapeutic principle underlying a meat dietary appears to be a matter of controlling, qualitatively and quantitatively, the carbohydrate percentages of the colonic fecal content. Doubtless the success of Dr. Salisbury's meat therapy was due to carbohydrate control. On the meat diet as elaborated by the writer a balanced diet can easily be given. Carbohydrates can be given in liquid form in strained fruit juices. Fats can be given during meals in any quantity desired. A very interesting fact was told by Stefansson bearing on this subject to the effect that an exclusive meat diet without fat resulted in great

bodily and digestive suffering which was always quickly corrected by the addition of fat, even though rancid. The innocuousness and undoubted merit of a 100 per cent meat diet and the substitution value of fats for carbohydrates is hereby beautifully shown on a large scale. Stefansson's dietetic observations are worthy of very careful scientific consideration.

It has been claimed that bacterial flora can be changed at will by merely changing the diet from a starch to a proteolytic one and vice versa. Is it not possible that the bacterial picture in such findings is dependent upon the quality and quantity of the various sugars reaching the colon? Certainly the feeding of dextrin and lactose has a definite rationale. But in the opinion of the writer the mere changing of the bacterial flora is not conducive to the best clinical results without the assurance of a thorough colonization of the large bowel with *B. coli*.

Gratifying results have been obtained in the treatment of migraine, petit mal and epilepsy with a 100 per cent meat diet and laboratory experiments are under way to illuminate our clinical observations. Stefansson relates the interesting case of an epileptic whose symptoms entirely disappeared directly he was forced to subsist on nothing but meat while in the far North.

The treatment of the frequent constipation or occasional diarrhea associated with intestinal intoxications requires anatomic, physiologic and biologic knowledge of each case. It is here that the intelligent application of both the art and science of medicine finds its greatest therapeutic opportunity. A complete gastro-intestinal survey of every patient is therefore indicated. The X-ray and the proctoscope give us invaluable information and without these observations neither pill nor diet should ever be prescribed. At the extremities of the colon lie the appendix and the sphincter, each of which may, under pathologic conditions, produce colonic disfunction. Between these two points may be diverticula, kinks, segmental or generalized atony, etc., any of which may have been induced originally by an intestinal toxæmia. It is unreasonable to assume that bio-dietetic methods alone can cure these morbid states, yet it is almost as unreasonable to suppose that these can be cured by radical methods without bio-dietetic control.

Constipation does not necessarily spell intestinal toxæmia. An apparently normal state of health for a varying period of time is possible in many cases of obstinate constipation. It would seem that many individuals have established an immunity against a gradually developing toxæmia or at least that their detoxicating mechanisms are unusually efficient. But if stasis continues too long pathological changes ensue with their attending evils.

No case of intestinal toxæmia can be cured by

catharsis or with intestinal antiseptics per se, whether orally or anally administered. It is about time that this scientifically known fact found general acceptance among all members of the profession. The regular taking of cathartics sooner or later collects its toll of bodily and mental vigor. The physiological and secretory unbalance thus induced, the high cecal acidity engendered, the colonic unrest thereby instituted when colonic immobilization is indicated, the false sense of intestinal security or normalcy which daily catharsis gives—all tend to hasten the day of gastro-intestinal invalidism with all its physical and mental suffering.

We are confident that there are but few cases of intestinal toxæmia and aberrant intestinal motilities which cannot be cured by the proper application of scientific therapy of which bi-dietetic carbohydrate control appears to be a basic factor.

#### BIBLIOGRAPHY

- 1 T R. Brown *Jour A M A*, Oct. 29, 1921, p 1396
- 2 Holt and Foles *Jour A M A*, 1922, 12 p 80
- 3 Jean-Charles Roux and Gouffon *Arch d mal de l'app digest*, etc., Paris, 14 135, Feb., 1924

- 4 von Wasserman and Ficken *Klin Wchschr*, Berlin, June 3, 1922
- 5 Barger and Dale *Monograph*, 1915
- 6 Koessler and Hanke *J of Biol Chem*, vol xxxix, 1919
- 7 Patty *J of Infectious Diseases*, 29-73 July, 1921
- 8 Henriques *Ugeskr f Laeger*, Copenhagen, 85 171, Mar 8, 1923
- 9 Connellan Unpublished experiments
- 10 Lieb *N Y Med Jour and Med Record*, June 6, 1923
- 11 Shaw *Brit M J*, London, p 461, March 15, 1924
- 12 Hewlett *Manual of Bacteriology*, 7th Edition, p 450
- 13 Von Lippman *Chemie der Zuckerarten*, 1904
- 14 Abel and Kubea *J of Phar & Exper Ther*, vol xii, 1919
- 15 Sherman *Food Products*, revised, p 511
- 16 Hammett *Amer Jour of Physiol*, vol LX, No 1, Mar, 1922
- 17 Hiss and Zinsser 5th Edition, Textbook on Bacteriology
18. Lieb *N Y State Jour of Med*, Feb 1, 1924
- 19 Abel U S Dept. of Agriculture, Farmers' Bulletin 535, June, 1913
- 20 Lieb *N Y State Jour of Med*, Mar 7, 1924

NOTE The writer wishes to express his sincere appreciation of the valuable assistance rendered him by J J Connellan in the preparation of this paper

### PSYCHIATRY IN RELATION TO THE PUBLIC SCHOOLS \*

By A. B SIEWERS, M D,

SYRACUSE N Y

**A** FEW years ago the Public School System was composed, roughly speaking, of Teachers and Principals, with a Superintendent. Health of the children attending school did not constitute a part of the Educational Work. The Child's health, however, was realized to be important, and gradually medical activity was introduced. This medical activity was chiefly directed at contagious diseases, and soon became a great power in Community Hygiene, especially as "Preventive Medicine." For some years now the medical work in the schools has been directed toward these factors, in which the results can be clearly seen. That is, attendance records have shown marked improvement under the influence of "Preventive Medicine."

Psychiatry lags behind the field throughout medicine. Psychiatric knowledge does not become part of the general medical knowledge, nearly so quickly as does knowledge in other aspects of medicine. Preventive medicine in the field of Psychiatry has not been advanced in a way at all comparable with that in other fields. Among the reasons for this are possibly

- 1 The inability to show results
- 2 The fact that Psychiatrists are consulted as a last resort in cases of "Nervousness"

Physicians would be severely criticized if they

neglected the surgical aspects of an acute appendicitis, yet they can with impunity neglect the psychiatric aspect of disorders in behavior or backwardness in class rooms. Psychiatry is probably at fault to a large extent in that it functioned so long as a "relegator" of the worst cases to institutions or special classes. Of course today the School System has ungraded classes and classes for backward children but Psychiatry is not contributing enough in a "preventive" way.

There is a noticeable lack of Psychiatric Work in many communities. In Syracuse for example, there is only one member of the Medical Staff of the Department of Education devoting time to Psychiatry. There are no official provisions for anything except the most cursory mental examinations.

There are only three classes in the whole city for atypical children, and the enrollment of the three combined is less than fifty. Two of these classes, one for Boys, and one for Girls, are in an abandoned school building, and the third, for Boys, is in a building likewise abandoned, except for overflow from a nearby school, and a special class in sight saving.

Some of the larger schools have ungraded classes, but this is the exception rather than the rule. Each school has its quota of feeble minded, backward and Psychopathic children, about whom mainly nothing is done.

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester, April 22 1924

The necessity for "Psychiatric" work then can easily be seen, and we are brought face to face with the question, "What can be done?" The provision of additional special classes would probably be admitted as necessary without argument. Probably every school has enough children who do not get along with the regular curriculum to warrant a special course of study. This plan would handle only the backward child who is not a problem from point of view of behavior. The Psychopathic children, however, who are behavior problems, the quasi-delinquent, and the school children who are more or less constantly appearing in the Juvenile Court are "Behavior Problems," and they are the ones who require special study. In this study, the co-operation of Doctors, both in and out of the school system, and the laity, with the Psychiatrist or Mental Clinic conducting the study, is absolutely necessary. This co-operation involves referring all behavior problems to the Clinic as soon as they are recognized. What usually happens is as follows:

Any abnormal behavior on the part of a School Child is at first punished. Later on should the child repeat the offense, the punishment will be deemed inadequate and made more severe. Failure of this added severity to bring about the desired correction might then call forth some effort at determining the real difficulty, but by this time the child is labeled as a "bad one," and might have by this time developed an attitude of suspicion and antagonism which makes the problem all the more difficult.

Psychopathology in the adult is often in the nature of the end result of a long process and the naturalness of the disorder is not so apparent as in the child. The child has to be considered Psychobiologically, that is, from the point of view of the individual as a physical and social unit. We must not divide the child into stomach, heart, brain, etc., without consideration of the personality as a whole. Somatic complaints may be merely a way of expressing a problem of the personality and may be a means by which the patient consciously or unconsciously hopes to achieve a better adjustment.

Tantrums in children, or the substituted phenomena, such as vomiting, headache, convulsive manifestations, anxiety states, obsessive thinking and doing, or the more socially significant delinquencies, such as stealing, lying or running away, all call for a study of the child in relation to the demands of his environment, for often these manifestations are likely to be considered a part of a child's heredity, when as a matter of fact, an attempt to adapt to the environment is the real cause.

*Name*—Donald G——, age 10, is a very difficult school problem, as he teases and quarrels with all the younger children. The result of the

home investigation in January of this year is as follows (*Sources of Information*—Mother, paternal aunt, brother Cedric, school nurse, school teacher, and principal).

*Family History*—*Father*, age 47, chronic alcoholic, irregular work history. Formerly worked in paper mills, now unemployed, trying to find tailor work. His sister says "There is no reason why he should drink, he was well brought up. His father never even smoked, and he was brought up to obey and to do what his mother told him to do." When he is under the influence of liquor he is irritable and ugly, but has never become abusive.

*Mother*, age 40, crippled 7 years ago with infantile paralysis. Is able to get around the house on crutches and do her housework, but can not go up and down stairs, and has been out of the house only twice in a year. She admits she is excitable and irritable. Seems to be fairly well adjusted to her crippled condition and does not indulge in self pity. Gives the impression that she would lack in firmness in handling the child.

*Siblings*, *Gilbert*, age 21, working and living at home. *Sybil*, age 19, telegraph operator. Has left home and is working in Florida—"She wanted to see the world, so she went south with a girl friend."

*Cedric*, age 17, working in Western Union, and planning to be a telegraph operator. Earns \$17 a week. His mother says "He's got just as bad a temper as Donald has and gets just as mad when he can't have his way."

*Donald*, age 10, patient.

*Beverly*, age a year and a half. Cesarean birth. Mother had been crippled for five years. Child appears well.

*Home Condition*—The G——s formerly lived in Fulton, moving to Syracuse about a year ago, because Mr G—— could not get work in Fulton. They live in a poor neighborhood, where the foreigners are of a much better type than the low white population. House of ill repute, etc., are in the near neighborhood, if not in that very block. The family live in a two-story house, rent \$35. The family life is not apparently a happy one. Donald says "My father's horrid when he's drunk. Last night he was so drunk he couldn't stand up. He had spent all his week's pay except \$2, and my mother, she took that from him. My mother cries, but he can't hurt her or my brothers. They just hit him back and my sister does too." "Cedric's the worst to me. He teases me." Mrs G—— bore this out by saying that Cedric had been very bright in school and he always mocks Donald for his difficulties in school.

*Personal History*—Born April 16, 1923. Prolonged labor, no instruments. Mother states that her husband was drinking very heavily at the period of conception—"was drunk most of the time." Developmental history apparently nor-

mal Walked at one year, talked at a year and a half—but he was never as bright as the other children in learning to talk” No history of convulsions Cholera infantum from six to nine months Measles and mumps, no serious after effect

*Habits*—No history of bed wetting No history of masturbation Goes to bed early, sleeps well, no nightmares Good appetite

*Recreation*—Donald does not go with a “gang” He says “there are no nice boys on that street The big fellows all pick on me I wouldn’t go to the Boys’ Club because the big boys there all hit you I went to the Y M C A last summer but the fellows hit me there, and I won’t go back there to swim again No, I don’t play baseball, the fellows won’t let me” On his return from school, Donald wheels the baby out in her cart, as his mother can’t take the child out and there is no back porch for the baby to stay on He runs all his mother’s errands, buys all her supplies and brings her back the correct change “I don’t know how I could get along without Donald, there is no one else to do things for me” Sometimes he stops and plays in the streets instead of coming from school and taking the baby out Donald says that he doesn’t mind taking the baby out—“Crossing the street with the baby carriage is the worst, that’s all I mind”

*School History*—Donald attended the Erie Street School in Fulton until October, 1922 His mother claims he had no difficulty in this school except in the matter of passing the grade “He repeated the 11 and 12, two times I used to think he would never get out of the First Grade, but no one ever told me he misbehaved in any way” When Donald began Putnam School, he was put in 12, and has been advanced each term The principal realizes that he should have been advanced to a class with older boys, but it was impossible to do so, as the child was not capable of doing higher grade work Donald has been a constant conduct problem since his arrival He constantly hits, slaps, teases younger children He is only good when he is running errands He is trusted with money and has never been known to steal He keeps his class constantly in an uproar by annoying the other children, always younger than himself When crossed, he has outbursts of temper, stamping his feet or lying down on the floor, kicking his feet and screaming Mr Wright tells a story where he punished Donald for slapping other children He gave him his hat and coat and told him to go home A few minutes later he looked out of the window and saw Donald lying on the sidewalk crying and kicking his feet in the air He brought him back to his office and kept the child the rest of the day His last episode in school, he threw a marble at a boy, hitting his glass and nearly putting his eye out Mr Wright says he scolded

the other boy for being where he should not have been, but Donald’s only reaction to the episode is that they didn’t let him explain that the other fellow had put him in an ash can This is denied by other children who were witnesses of the fight Mr W—— told Donald to go back to the class, saw him enter the room, stamping his feet and then, seeing a pencil on the floor belonging to a little girl, began to kick it all over the floor Mr Wright then brought him to his office and the child cried and cried and could not be quieted

Donald likes the first teacher whom he had, Miss Dickerson, and feels that she was just and kind to him Miss D—— says she was fond of the child but that he was the most difficult boy she ever had to handle and she was always in terror for fear he would hurt the other children His present teacher is an older woman, who has taught for 37 years, and Mr Wright seems to feel that Donald is too much for her

Any measures which can be introduced to help Psychopathic Children adjust themselves in the community in which they live and in attendance at the school which they should attend, would certainly be infinitely better than placing them in Reform Schools and the like

There are no Special Classes in this school, but there is a class for ungraded boys who need individual attention to get them up to grade Donald was put in this class and the situation was gone over with the mother whose cooperation, to a certain extent, was obtained These simple measures have not produced an angel, but Donald is no longer the “behavior” problem that he was

Troublesome children are present in every school To group such children would certainly create a tempest and would not help The necessity which stands out in the study of the psychopathic child, and likewise, in an attempt to help the child, involves not only a study of the child’s behavior in the classroom, and on the playground, but also a study of the child in the home There must be a connecting link between the environments in which the child lives, the school on one hand, and the home on the other This cannot be done by teachers who have not had special training The idea of a visiting teacher to see the child in his home is a good one, but it cannot be carried out by the teachers who have long been at work under the old system, and have very definite convictions as to the relation of the teacher to the child

A “Child’s Study Department,” such as the Rochester public schools have, is an example of active psychiatric work The principals involved would well be put to use by other communities

This is really an Advisory Department to which principals, teachers, parents and social workers can come for help to better understand children, besides it is a Bureau of Child Standards

The staff consists of Director, psychologist, psychiatrist, neurologist, four psychological examiners, one medical examiner and one home visitor. The problems presented are Backwardness in one or all subjects, superior work in

several or all subjects and irregularity in attendance or behavior.

The recommendations are directed at a correction of physical defects and social and educational readjustment. The value of this work can hardly be overestimated.

## MEDICAL SERVICE PROBLEM

From the Standpoint of a Rural Physician

By LAWRENCE E. SPROUT, M.D.,

WEST LEYDEN, N. Y.

Service to a rural population requires mode of travel, for 80 per cent of the work of the physician in the country is home service. Therefore a map of the section to be served, with location of farms, camps and smaller villages and road conditions in all seasons of the year, gives us an idea of troubles to come.

The problem seems to be for the most part seasonal. With automobiles and improved roads, the hospitals are easily accessible and the doctor can reach his patients with very little inconvenience and have some time for recreation. Winter and Spring is a very different matter. The doctor in these seasons must spend most of his time on the road and this calls for endurance.

To the country people, we, the doctors, are servants of the public and *must* serve. We never tire and should be waiting to go at once for each and every one. Anybody with the title of "Doctor" means the same to them. A school is a school. No attempt is made to learn whether the medical training is good, and he is taken in or moves on as he appeals to the people as a "good fellow."

The work of the country doctor is mostly curative. The Health Officer is supposed to do all that is necessary in the way of preventive medicine. The rural physician has no time for anything except the sick.

### QUALIFICATIONS FOR RURAL SERVICE

The doctor, to do country work, must necessarily be physically fit to stand the long, tiresome trips in Winter and do a large part as chauffeur and hostler. His scientific preparation must also be general—a specialist in every department of medicine. Mostly he works alone with very limited equipment.

Perhaps above all else should come the living conditions in the country. We can now equip a home in the rural community with all the comforts of the city—but this expense must necessarily be met by the community unless the doctor can see a permanent location. The social side must also be considered and will depend upon the doctor's family as well as upon the people of the community, for the term of service will depend upon the attitude of the doctor's family toward the country.

### HOW AND WHERE SHALL WE GIVE SERVICE? AND WHAT SERVICE SHALL WE GIVE?

This problem can and should be met by the doctor that has studied conditions and will work to improve them. A man from the country or one having boyhood knowledge of country life can perhaps get along better and do more toward the education of his rural patients. Many of the problems of rural practice are solved outside of the practice of medicine, or at least without the pill case. The attitude of the patient many miles from the doctor, with roads almost impassable and storm raging, is far different from that of the patient easily accessible to the doctor. The former usually thinks, "Will he try to come if I get worse?" "Could he get here?" The telephone is on the wall, so the doctor gets the call and makes a trip which is perhaps unnecessary.

The Medical Service Problem must be solved in many ways. First of all, by the education of the rural population, which is changing rapidly in some sections. The Department of Education, with examination of school children and remedying defects, will help to take into homes some idea of preventive medicine. The Nurse, County or Community, by her work with children, the Department of Health Clinics (pre-natal, pre-school and dental), Mothers' Clubs, Health Automobile and Radio Health Talks, reach districts that are inaccessible in Winter.

When the rural communities feel the need and will work and invest money and supply a house for the doctor, and also provide in some way a few rooms that may be used by the country people as a hospital, and the people can be induced to use such a place so that the work may be somewhat centralized, then the demand for service can be met and that service will be received at home. These conditions will support a doctor and prevent the work from drifting in Summer to the cities.

The medical profession has a great duty to perform. A bit of introspection is first needed, then co-operation. If the profession could work together as a unit and by a "Gentlemen's agreement" eliminate to some extent the competition which means so little in the country, we could follow the work of the clinics and more profitably and easily remedy defects found.



# EDITORIALS



The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

*Editor-in-Chief*—NATHAN B VAN ETEN, M.D.,  
New York  
*Associate Editor*—ORRIN SAGE WIGHTMAN, M.D.,  
New York  
*Executive Editor*—FRANK OVERTON, M.D. Patchogue

### COMMITTEE ON PUBLICATION

E. ELIOT HARRIS, M.D., *Chairman* New York  
ORRIN SAGE WIGHTMAN, M.D. New York  
EDWARD LIVINGSTON HUNT, M.D. New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

*President*—OWEN E JONES, M.D. Rochester  
*First Vice President*—GEORGE A. LEITNER, M.D. Piermont  
*Second Vice President*—LUZELLE COVILLE, M.D. Ithaca  
*Speaker*—E. ELIOT HARRIS, M.D. New York  
*Vice Speaker*—GEORGE M. FISHER, M.D. Utica  
*Secretary*—EDWARD LIVINGSTON HUNT, M.D. New York  
*Assistant Secretary*—WILBUR WARD, M.D. New York  
*Treasurer*—CHARLES GORDON HEYD, M.D. New York

### CHAIRMAN, STANDING COMMITTEES

*Arrangements*—FREDERICK H FLAHERTY, M.D. Syracuse  
*Public Health and Medical Education*,  
JOSHUA M VAN COTT, M.D., Brooklyn  
*Scientific Work*—ANDREW MACFARLANE, M.D. Albany  
*Medical Economics*—HENRY LYLE WINTER, M.D. Cornwall  
*Legislation*—JAMES N VANDER VEER, M.D. Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex President and the Councilors of the District Branches.

*First District*—EDWARD C. RUSHMORE, M.D. Tuxedo Park  
*Second District*—FRANK H LASHER, M.D. Brooklyn  
*Third District*—ARTHUR J BODELL, M.D. Albany  
*Fourth District*—CHARLES C TREMBLEY, M.D. Saranac Lake  
*Fifth District*—NELSON O BROOKS, M.D. Oneida  
*Sixth District*—GEORGE H FOX, M.D. Binghamton  
*Seventh District*—WILLIAM I. DEAN, M.D. Rochester  
*Eighth District*—HARRY R. TRICK, M.D. Buffalo

### COUNSEL

GEORGE W WHITESIDE, Esq., 27 William St. New York  
Telephone, Broad 1744

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St. New York

### EXECUTIVE OFFICER

JOSEPH S LAWRENCE, M.D. 51 Chapel Street, Albany

### SECTION OFFICERS

*Medicine*  
*Chairman*—ROBERT L. LEVY, M.D. New York  
*Secretary*—L. WHITTINGTON GORHAM, M.D. Albany

*Surgery*  
*Chairman*—MARSHALL CLINTON, M.D. Buffalo  
*Secretary*—EDWARD S VAN DUYN, M.D. Syracuse

*Obstetrics and Gynecology*  
*Chairman*—HAROLD C. BAILEY, M.D. New York  
*Secretary*—NATHAN P SEARS, M.D. Syracuse

*Pediatrics*  
*Chairman*—JOSEPH C. PALMER, M.D. Syracuse  
*Vice-Chairman*—ROGER H. DENNETT, M.D. New York  
*Secretary*—ARTHUR W. BENSON, M.D. Troy

*Eye, Ear, Nose and Throat*  
*Chairman*—ARTHUR G. BENNETT, M.D. Buffalo  
*Secretary*—EUGENE E. HINMAN, M.D. Albany

*Public Health, Hygiene and Sanitation*  
*Chairman*—PAUL B. BROOKS, M.D. Albany  
*Secretary*—ARTHUR D. JACQUES, M.D. Lynbrook

*Neurology and Psychiatry*  
*Chairman*—EUGENE N. BOUDREAU, M.D. Syracuse  
*Secretary*—CLARENCE O. CHENEY, M.D. Utica

## SPOKESMEN FOR THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

Who is authorized to speak in the name of the Medical Society of the State of New York?

The supreme source of power in the Society is the House of Delegates, which corresponds to the House of Commons of England. It is composed of 172 members of whom 150 are elected by the component county medical societies, and 22 are the elected officers of the District Society, the Chairmen of the Standing Committees and the Presidents of the District few minutes. The House of Delegates makes the laws and by-laws of the Society, enacting his feet and formulates the policies of to his office and meets regularly once a year day. His last episode reports of the officers marble at a boy, hitting society and to author-putting his eye out. Mr Wright

ize the activities of the Society during the coming year

The Council of the State Medical Society is the executive and administrative body of the Society. It is composed of the twenty-two members of the House of Delegates who are officers of the State Medical Society. It is empowered to act in the name of the Society when the House of Delegates is not in session. It holds three regular meetings annually and may hold more after legal calls.

The Council has an executive committee of seven members to whom many of the powers of the Council are delegated and who have charge of the administration and business



affairs of the Society while the Council is not in session

There are five standing committees of the State Society, each of which has certain executive duties to perform. Special committees are also frequently appointed by the House of Delegates, the Council, or the Executive Committee, to whom specific activities may be assigned.

It will therefore be seen that there are at least five groups who are authorized to speak in the name of the Medical Society of the State of New York, but their authority varies to a great degree, from almost the unlimited power of the House of Delegates to the modified power of the Executive Committee. There is, however, a system of referendum voting which strengthens the authority of the body ordering the vote.

1 The House of Delegates may order a referendum vote of all the members of the State Society. This vote may truthfully be said to represent the attitude of the Medical Society of the State of New York to a complete degree.

2 The Council may order a referendum vote of the members of the House of Delegates.

3 The Executive Committee may order a referendum vote of the members of the Council.

The referendum vote of the House of Delegates, or of the Council, may also be said to express the attitude of the Medical Society of the State of New York.

The chairmen of the standing committees may properly be credited with the prerogative of speaking for the Medical Society of the State of New York along the lines laid down in the constitution and by-laws, but outside of those specific lines, they cannot act as spokesmen for the State Society unless their reports are approved by the House of Delegates or the Council.

A special committee must have its report approved by the appointing body before its members can claim that they are spokesmen

for the Medical Society of the State of New York.

The most striking application of the principles of spokespersonship is afforded by the Chairman of the Committee on Legislation in his dealing with the Legislature. When he appears before a legislative committee either favoring or opposing a bill, it is necessary that he be in a position to say that he represents the physicians of New York State, and is their spokesman. He ascertains the attitude of physician by correspondence and consultations with the Chairmen of the Legislative committees of the County Medical Societies. These chairmen are in close touch with the members of their County societies and can ascertain their attitudes with a considerable degree of accuracy. The Chairman of the Committee on Legislation therefore has unofficial sanction to act as spokesman for the physicians of New York State without securing the sanction of the Council or the House of Delegates. However, in matters of controversy in which there is a division of opinion, the Council has taken a referendum vote of the House of Delegates, as was done in regard to supporting the Practice of Medicine Bill by a vote which was completed on the fifth of March.

When the Chairman of the Committee on Legislation takes a certain attitude on a bill, he is greatly embarrassed if a member or group of members take an opposing attitude without consulting or informing him. Any physician or county society has a right to express dissent from the opinion of the Chairman, but that opinion should come first to the Chairman of the Committee on Legislation to be presented as a minority report. To express disapproval openly and without due warning gives the legislators the impression that the medical profession is divided and without influence in the community.

It is well that members of the Medical Society of the State of New York consider the responsibility that is upon him who claims to be the spokesman for the medical profession.

F O

---

## ACTIVITIES OF THE JOURNAL

This Journal reflects the activities of the Medical Society of the State of New York, and tries to give the reader up-to-date information regarding every phase of the work of the society.

By far the most important activity since January 1, 1925, has been medical legislation. The Journal has listed something over seventy-five bills which affect physicians, and the practice of medicine, and has been the medium of

communication between the chairman of the Committee on Legislation and the members of the State Medical Society. We feel that this work has been done better than ever before and that the results have justified the effort.

Our only regret is that we have necessarily put less stress than usual on the ordinary activities of the society and have neglected some departments of the Journal. The omission of the page of Prunes has probably given rise to

the greatest number of complaints regarding our short-comings, but we are also reminded that our editorial pages lack variety of subject and breadth of view since we have confined ourselves too closely to legislative matters.

We share the feelings of our critical friends and regret the unbalance resulting from the prolonged legislative activity. But the adjournment of the Legislature is in sight and we will resume the publication of a broader field of medical topics.

We are anxious to resume the Medical Surveys, and our impatience is still further excited by an appreciation which was published in the February issue of the Bulletin of the American Medical Association. After a page of quotation from our survey of Clinton County the article concludes:

"All of the surveys have produced compilations of valuable information that the Medical Society of the State of New York should have, and can use to fine advantage. Any State Medical Society can easily do what is being done in New York State to its own advantage, to the benefit of its county societies and for the public good. Facts in hand are valuable."

The Committee on Publication has authorized us to continue the surveys, and we keenly anticipate the pleasure of making and renewing acquaintances among the physicians throughout the State and assisting them to evaluate their own work in their home communities.

Doubtless our medical friends have noticed a new department which has flourished despite

crowding by legislative matters. We have reported the activities of the Medical Society of the County of New York in its work in Periodical Health Examinations. New York County has undertaken the work along lines differing from those adopted in Kings County. A special feature of the New York plan has been a series of sixteen lectures on various conditions which might be found in making an examination of a patient. The word pre-clinical has been stressed in its application to conditions when they are in a stage which is incipient and curable. We have made abstracts of nine of the lectures and published them in the news columns of the Journal, and expect to publish abstracts of the others.

We are gratified that there is a call for more scientific articles. We had wondered if physicians get all their medical literature out of periodicals devoted to the specialties, but we recall that the great majority of members of the Medical Society of the State of New York are family doctors who get their medical articles principally from such general periodicals as the New York State Journal of Medicine and the Journal of the American Medical Association.

We shall be only too pleased to gratify the desires of our readers for short practical articles on the recognition and care of common diseases. We will probably have more to say along these lines in the future. In the meantime, send your suggestions regarding the articles which you wish to see published.

F O

## CONFERENCE OF CHAIRMEN OF COUNTY LEGISLATIVE COMMITTEES

We are hearing favorable comments on the happy idea of bringing together the chairmen of the County Legislative Committees for a conference regarding the medical bills before the Legislature. A logical program of considerable extent had been prepared by the chairman of the Committee on Legislation, and there was no lost motion during the three hours that the conference lasted. The discussions were as snappy as the printed program, and those in attendance learned the points of view of the others.

A social dinner after the conference gave an opportunity for any member who was impatient or aggrieved to come to an understanding with his opponent.

Such a conference is an ideal way of securing unity of action and interest in the activities of the State Society. We have heard the suggestion made that the chairmen of other Standing Committees might with profit organize similar conferences with representatives of the constituent County Medical Societies.

F O



# LEGAL



By GEORGE W. WHITESIDE, Esq  
Counsel, Medical Society of the State of New York

## THE MISSION OF ORGANIZED MEDICINE TODAY

We have seen in the past twenty-five years horse cars and carriages give way to motor-driven vehicles, old landmarks have been torn down and in their places have been erected massive structures of steel and stone. The skyline of the city now visualizes a change that seems magical and inspiring, aeroplanes and dirigibles are no longer a novelty, and the radio registers the most recent, but probably the sharpest, contrast of the present day with the past.

The contrast in the procedures and practice of medical science during this same period shows as startling and radical a change. A work on surgery that is ten years old is practically useless, as the strides of progress in that science have in so short a time carried the art so far. In diagnosis the trained eye, ear and touch of the skilled physician are supplemented and aided by the X-ray, the laboratory where delicate tests are determined, and improved apparatus that gives precision and accuracy in the measurement of the bodily functions. The psychologist analyzes the changes in abnormal mental conditions by his comprehension of the subtle influences that disturb mental balance and manifest themselves in abnormal physical and mental reactions. The changes about us that so readily register upon our minds are no more startling than those which the science of medicine have undergone in these recent years.

The passage of workmen's compensation laws throughout the country has brought the medical profession into close contact with the industrial world and has produced changes in the practice of industrial medicine that are short of revolutionary. The tendency to mesh the medical profession into the industrial machine and make it a cog in the mechanism, gained sufficient momentum a few years ago to make the passage of compulsory health insurance laws a serious menace to the profession's independence. This effort, however, was but a symptom which sounded the warning of how the industrial world contemplated dealing with the medical profession and of the design to lock-step it in obedience to purely materialistic and industrial needs. The profession was saved from this impending doom not so much by the loud protest of its individuals, as by the power of its organized intelligence. New importance was given by the compulsory health insurance campaign to the necessity and value of organization in medicine, in order that

the profession might take its proper place in the civilization of this present industrial age and not become a part of the army of white-collared wage-earners. That battle has been won, but have the gains of the victory been sufficiently consolidated for a further advance by the profession?

Possession of intelligence alone is not sufficient to cope with the present day problems of this industrial age—for the professors of the schools and colleges throughout the country possess a learning and intelligence quite comparable with that had by any of the learned professions, but their economic status has been one of pity. Their position in the life of this material age is not adequately registered and organized, because such profession does not adequately function in the organization of its intelligence and the expression of its congregated judgment and power.

Numerically the medical profession are practically negligible. Their total voting strength throughout the United States is less than that of a few blocks of tenement dwellers in the City of New York. The structure of ignorance, of blind political partisanship, of selfish greed, will give way to the power of organized intelligence as readily as the giant steel structure can be made to crumble and fall by the application of the acetylene torch.

The industrial world depends upon the physician to keep the workers healthy and to treat scientifically industrial injuries and diseases. Industry must rely upon the maintenance of a high degree of professional integrity, learning, skill and morale in the medical profession to maintain a high standard of industrial production.

The great life insurance companies that have outstanding today fifty-four billion dollars in policies of life insurance have based the writing of every dollar of their promise to pay those billions of dollars upon the opinion, the skill and the integrity of medical men. The millions of dollars paid annually in health and accident insurance are paid only after a medical man has made his examination and given his opinion. The workmen's compensation for industrial accidents, unknown twenty-five years ago, represents today an investment of millions of dollars and the payment of one hundred and seventy-five million dollars in premiums a year. Of these premiums twenty-five million dollars a year are spent for medical service. The whole purpose of this law would be defeated and its

operation ineffective were it not for the contribution made by the medical man in the performance of medical services under its provisions. The banking interests of the country are closely allied with these various industrial and insurance corporations and depend largely for their money upon the millions of dollars that flow into their treasuries. The entire economic system, therefore, has a direct dependence upon the maintenance of a high degree of learning, skill and integrity of the medical profession.

The laws that destroy the profession's morale, by permitting the influx of hordes of ignorant and unqualified to practice a branch of the healing art and exploit a theory of treatment contrary to the science upon which disease today is treated, and laws that destroy the initiative of the medical man in the pursuit of science and in the acquiring of economic independence, strike not

only at the medical profession but through it at the great industrial and business enterprises of this present age.

These are the changes that the last quarter of a century have wrought—quite as amazing as any that we so readily visualize and comprehend about us. Their lesson, it seems, is to emphasize the imperative necessity of firm organization of medical men so that organized intelligence can combat the destructive effects of the industrial tide and guide it into channels of usefulness to mankind and of progress for the race. In this work in the State of New York the Medical Society of the State of New York and its constituent county societies should have the support, not of passive acquiescence, but of active, militant aggressiveness of every medical man of the State, and its leaders should be encouraged and supported in the carrying out of its great mission.

### PROLAPSED UTERUS

The complaint in this action charged that the plaintiff, a woman, consulted the defendant to cure her of the malady from which she then suffered, that the defendant was careless and negligent in his treatment, operation and prescribing for the plaintiff and that as a result of the same the plaintiff was greatly injured in her health and constitution and required to expend moneys for further medical care and attention.

In this action, it appears that on May 6 the plaintiff called at the defendant's office complaining of irregular menstruation and pains in the region of the genital organs. Upon a digital vaginal examination he found that she was suffering from a prolapsed uterus, and advised the performance of a curettage. A general physical examination of the patient was negative. In the endeavor to correct the prolapsed uterus he inserted a hard rubber ring pessary. He continued to treat her daily for a period of ten days. On the second or third day after the insertion of the pessary, upon examination he found that the

same was missing. The patient had not found the pessary. After the first ten days he treated her every other day for a week. During the period that he attended the plaintiff his treatment consisted of the application of douches of lysol solution. He also prescribed an opiate for her nervous condition. The patient was not seen again by the defendant until the following August when she returned complaining of pain in her right leg between the thigh and the knee. Upon examination he diagnosed her condition as neuralgia or sciatica and prescribed salicylic acid. At this time she was seen only once and since then had not been seen by the defendant. Upon the visit in August no vaginal examination was made nor any complaint made by the plaintiff of her previous treatment.

When this action came on for trial it was abandoned by the plaintiff's attorney and the complaint was dismissed for failure of the plaintiff to prosecute.



## LEGISLATION

By JAMES N VANDER VEER, M.D.  
Chairman, Committee on Legislation.

INDEX OF LEGISLATIVE BILLS			B—Bill printed		C—Comment	
Senate Int No	Assembly Int No	Law	Committee to which bill is referred		Page and Date	
			Subject	Codes		
29	527	Penal	Prohibition Enforcement	S Codes	221	Feb 13
115	215	Public Health	THE NARCOTIC BILL	S Public Health	B 80	Jan 23
116	216	Insanity	Institutions for Addicts	S General Laws	C 84	Mar 6
211	307	Public Health	MEDICAL PRACTICE ACT	S Public Health	B 382	Jan 23
228	236	State Charities	Children's Institutions	S General Laws	B 123	Jan 30
263	263	Insanity	Insanity Examiners	S General Laws	C 382	Mar 6
283	399	County	County Nurses	S Internal Affairs	C 329	Mar 27
302	748	Education	Health Service in Schools	S Public Education	B 174	Feb 6
380	570	Workmen's Comp	Choice of Physician	S Labor and Industry	C 382	Mar 6
473		Public Health	Drugless Practitioner Bill	S Public Health	B 175	Feb 6
586	850	Education	Med Exam in Schools	S Public Education	C 441	Mar 13
594	301	Workmen's Comp	Choice of Physician	S Labor and Industry	B 176	Feb 6
647	184	Workmen's Comp	Examination After Injury	S Labor and Industry	C 383	Mar 6
671	868	Penal Law	Physically Handicapped Persons	S Judiciary	B 177	Feb 6
693	950	Public Health	Foreign Medical Degrees	S Public Health	B 232	Feb 13
701		Public Health	Revocation of License	S Public Health	C 441	Mar 13
716	969	Public Health	Rural Hygiene	S Finance	B 272	Feb 20
789		Public Health	Chiropractic Bill (Bouton's)	S Public Health	B 183	Feb 6
943	1167	Public Health	Laboratory Supplies	S Public Health	C 383	Mar 6
944	1423	Public Health	Chiropractic Bill (Fearon's)	S Public Health	B 288	Feb 20
127		Education	Health Service in Schools	S Public Health	C 331	Feb 27
185			Chiropractic Bill (Nicoll's)	S Public Health	B 276	Feb 20
229	422	Education	Mentally Retarded Children	S Public Health	C 384	Mar 6
422		Civil Practice	Professional Secrets	S Public Health	B 332	Feb 27
649		Public Health	Chiropractic (Esmond's)	S Public Health	C 277	Feb 20
678		Public Health	Exam of Food Handlers	S Public Health	B 336	Feb 27
908		Penal Law	Wood Alcohol	S Public Health	C 442	Mar 13
925		Public Health	Reciprocity in Licensures	S Public Health	B 343	Feb 27
987		Penal	Birth Control	S Public Health	C 386	Mar 6
1321		Public Health	Vital Statistics	S Public Health	B 386	Mar 6
1343		Public Health	Chiropractic	S Public Health	C 443	Mar 13
1351		Workmen's Comp	Medical Service	S Public Health	B 86	Jan 23
1377		Penal Law	Antivivisection	S Public Health	C 341	Feb 27
1421		Public Health	Chiroprody and Podiatry	S Public Health	B 87	Jan 23
1429		Public Health	Eyeglasses and Lenses	S Public Health	C 443	Mar 13
1463		Public Health	Chiropractic (Bolton)	S Public Health	B 394	Jan 30
				S Public Health	C 186	Feb 6
				S Public Health	B 278	Feb 20
				S Public Health	C 394	Mar 20
				S Public Health	B 394	Mar 6
				S Public Health	C 395	Mar 6
				S Public Health	B 294	Feb 20
				S Public Health	C 294	Feb 20
				S Public Health	B 343	Feb 27
				S Public Health	C 396	Mar 6
				S Public Health	B 447	Mar 13
				S Public Health	C 448	Mar 13
				S Public Health	B 445	Mar 13
				S Public Health	C 446	Mar 13
				S Public Health	B 450	Mar 20

# SPECIAL ATTENTION

To Chairmen of County Legislative Committees and  
Members of County Medical Societies:

Have you written your letters to, or personally interviewed, your  
legislators on the following legislative bills?

## FAVORING

## AGAINST

Senate Int 115, Conc Assembly Int 215—The Narcotic Bill	Senate Int 283, Conc Assembly Int 399— County Public Health Nurses
Senate Int 116, Conc Assembly Int 216—Re- quiring the licensing of private institutions for the treatment of drug addicts	Senate Int 473—The Drugless Practitioner Bill
Senate Int 211, Conc Assembly Int 307—State Department of Education Bill on Medical Practice	Senate Int 647, Conc Assembly Int 184—Ex- amination after injury
Senate Int 380, Conc Assembly Int 570—In- jured employee to select his physician	Senate Int 789—Senator Bouton's Chiropractic Bill
Senate Int 594, Conc Assembly Int 301—Choice of Medical Attendants	Senate Int 943, Conc Assembly 1167—Labora- tory Supplies
Senate Int 671, Conc Assembly Int 868—Crip- pled Children	Senate Int 944 — Practice of Medicine and licensing chiropractors
Assembly Int 908—Control of wood alcohol	Assembly Int 185—Assemblyman Nicoll's Chiro- practic Bill
Assembly Int 1351—Medical Director of Indus- trial Board	Assembly Int 422—Professional Secrets
	Assembly Int 649—Assemblyman Esmond's Chiropractic Bill
	Assembly Int 987—Birth Control
	Assembly Int 1463—Chiropractic (Bolton)

## BRIEFS ON BILLS

### BRIEF SUBMITTED IN BEHALF OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK TO THE ASSEMBLY COMMITTEE ON LABOR AND INDUSTRIES IN FAVOR OF ASSEMBLY BILL INTRODUCTORY 1351

The Medical Society of the State of New York begs leave to offer its commendation and urge the passage of the above bill, which from consultation with members of the medical profession—not all of whom are members of the Society in this State—seems to meet a situation that has been a cause of acrimonious discussion on all sides relative to the supervision, care and treatment of injured employees of this State under the industrial laws

The Medical Society of the State of New York maintains that the proper ones to advise concerning the supervision, treatment and care of injured employees should rest primarily and in large measure with some organized and recognized group of physicians, and this bill seems to approach that thought the nearest of anything that has yet been offered

In the formative period of the Compensation Laws no well directed effort was made for seeking the advice of such a group, but individual physicians were consulted, many of whose recommendations were biased from the standpoints of personal aggrandizement, from too great favoritism toward injured employees or from a desire to placate employers or insurance companies as individual groups

Following the first draft of the Compensation Law a committee was appointed on which there sat several members suggested by this Society and other groups, and at hearings held throughout the State these medical men collated facts concerning the care and treatment and handling of injured employees

Recommendations were then made to the major committee on the part of the medical representatives, but it is a sorrowful thing to record that these recommendations were in the main ignored

The Medical Society of the State of New York has sought year in and year out to have legislation passed which would provide free choice of medical or surgical attendance for an injured employee, but it has consistently failed in this regard

It recognizes that there are physicians incompetent to treat certain types of injuries which these same physicians have attempted to do, to the detriment of the standing of the medical profession and to the permanent injury of the employee to a greater or lesser degree, as well as in other instances inflicting undue financial burden upon the employer and the insurance companies, but this question would be met undoubtedly by sitting in judgment in the County

Society groups of physicians upon the question, and with the help and advice of a co-operative and real medical director, incompetent physicians would be discovered and their limitations outlined to the satisfaction of all

It is to be hoped that the reading of subsection 5 of Section 81, should this bill be passed, could be so construed as to furnish thought and action to the medical director or his examining physicians that this phase of the problem might be overcome

It is also to be realized that a medical director is more familiar with the charges for medical and surgical attendance or treatment and for nursing and hospital service in the various communities of the State than would a lay person be so acquainted, and his being suggested by this large body of physicians will make him in a measure beholden to the entire group of physicians in the State, to the extent that the discussions as to his competency or management of medical procedure will be brought up from year to year in the large medical meeting so held

If there be any political desire in relation to this position it must emanate, according to this bill, among the doctors themselves, and as a group appearing before this legislature from year to year it is a fair criterion to say that they are non-partisan but are zealous in behalf of maintaining the highest standards in this State for public health and for the good of its citizens

Section 81 seems to have been framed most wisely as to the duties of the medical director, while section 82 would now place squarely upon the group of physicians the responsibility of seeing that cases were actually examined from the standpoint of medical or physical disabilities, and in case of the laxity of any of these examining physicians such as has been complained about so much throughout the medical group in relation to some physicians who now pass upon cases or have passed upon cases, that prompt correction may now be had at the hands of the proposed medical director

This will be, from present judgment, of the utmost benefit in driving out that group of physicians who have not at heart the real purport of their duty, but look upon the question as one of financial gain purely, and in this one move alone the present situation will be infinitely bettered

Section 83 has also been well drawn, but might have contained therein a limiting clause relative to the medical specialist or disinterested medical authority that he be a practitioner licensed in this

# SPECIAL ATTENTION

To Chairmen of County Legislative Committees and  
Members of County Medical Societies:

Have you written your letters to, or personally interviewed, your  
legislators on the following legislative bills?

## FAVORING

## AGAINST

Senate Int 115, Conc Assembly Int 215—The  
Narcotic Bill

Senate Int 283, Conc Assembly Int 399—  
County Public Health Nurses

Senate Int 116, Conc Assembly Int 216—Re-  
quiring the licensing of private institutions for  
the treatment of drug addicts

Senate Int 473—The Drugless Practitioner Bill

Senate Int 211, Conc Assembly Int 307—State  
Department of Education Bill on Medical  
Practice

Senate Int 647, Conc Assembly Int 184—Ex-  
amination after injury

Senate Int 380, Conc Assembly Int 570—In-  
jured employee to select his physician

Senate Int 789—Senator Bouton's Chiropractic  
Bill

Senate Int 594, Conc Assembly Int 301—Choice  
of Medical Attendants

Senate Int 943, Conc Assembly 1167—Labora-  
tory Supplies

Senate Int 671, Conc Assembly Int 868—Crip-  
pled Children

Senate Int 944—Practice of Medicine and  
licensing chiropractors

Assembly Int 908—Control of wood alcohol

Assembly Int 185—Assemblyman Nicoll's Chiro-  
practic Bill

Assembly Int 1351—Medical Director of Indus-  
trial Board

Assembly Int 422—Professional Secrets

Assembly Int 649—Assemblyman Esmond's  
Chiropractic Bill

Assembly Int 987—Birth Control

Assembly Int 1463—Chiropractic (Bolton)



## CONDUCT OF PHARMACIES BY CORPORATIONS

In opposition to Senate Bill Introductory No 632, Print No 660, concurrent *Assembly Introductory No 802*, Print No 824, entitled "To amend the public health law, in relation to the conduct of pharmacies by corporations"

The Medical Society of the State of New York, composed of over ten thousand physicians and representing in a majority degree the sentiment of the Medical Societies of the various Counties, begs leave to enter its objection to the above bill for the following reasons

It is to the practicing physician's interest and also to the public's interest, that pharmacies and drug stores, where pharmaceutical prescriptions are filled, should be of the highest standard and integrity. A physician asking a druggist to fill a prescription, is giving into the hands of that druggist that welfare of his patient, and the sick

person to whom the drug is administered—it can readily be seen—is placing his life against the accuracy and intelligence of the druggist. This being the case, we physicians cannot too strongly urge upon your committee that nothing be done that might jeopardize this relationship which has just been outlined, must exist between the physician and his patient.

Drug stores are permitted to dispense alcohol for medicinal purpose, and the great profit there is in this business has, in many instances, admitted persons to open stores and advertise them as drug stores, although no attempt is made to cater to any business except dispensing alcohol.

This bill would license such prostitution and we trust the committee will oppose it. The law, as it stands at present, covers the situation adequately and nothing would be gained by passing the amendment.

## INJURED EMPLOYEES

In support of Senate Bill Introductory No 380, Print No 385, concurrent *Assembly Introductory No 570*, Print No 573, entitled "To amend the workmen's compensation law, in relation to medical attendance and surgical treatment for an injured employee."

The Medical Society of the State of New York, composed of over ten thousand physicians and representing in a majority degree the sentiment of all of the Medical Societies of the various Counties, begs leave to state that it is in favor of the principle involved in this amendment.

We have always contended that the most satisfactory relationship between physician and patient exists only when the patient has implicit confidence in the physician, and this usually is dependent upon whether he selected the physician himself.

We are sure that an amendment of this character would not only make medical attendance more satisfactory for the physician, but would, likewise, result in a great saving to the employer.

## PHYSICAL EXAMINATIONS AND PRACTICAL TESTS OF CLAIMANTS FOR WORKMEN'S COMPENSATION

Brief in opposition to Senate Bill Introductory No 647, Print No 677, concurrent *Assembly Introductory No 184*, Print No 184, entitled "To amend the workmen's compensation law, in relation to not requiring technical rules of evidence or procedure."

The Medical Society of the State of New York, composed of over ten thousand physicians and representing in a majority degree the sentiment of all of the Medical Societies of the various counties, begs leave to offer its opposition to the enactment of this amendment for this reason.

That it places "physical examinations and practical tests of claimants to determine loss of use and proportionate loss of use of a member" in the hands of persons other than physicians. We

contend that only physicians can interpret the findings of a physical examination or test made upon an injured person. The injury may have been of such nature as to leave a disablement in the patient, with little or no outward evidence of the same. Thus the physician, owing to his knowledge of anatomy and physiology, may be able to discover and estimate, while to a lay person none of those signs and symptoms may be evident, upon which the physician is basing his report. If there is an idea of malingerer, it is quite certain that the physician should make the discovery as quickly as would a layman, with less possibility of making a mistake.

We, therefore, wish to register our opposition to the amendment unless provision is made that the examination shall be made by a physician.

State, thus countering the possibility of medical men entering from another State on invitation and questionably practicing medicine under the present definition when it is to be recognized that the State of New York holds a reputation second to none in its educational and medical requirements

The question of fees has brought forth such a storm that it would seem the wording throughout the bill will react to great good against those unprincipled physicians as occasionally may be seen who would attempt to extort from the State as much as the traffic can be made to bear through pressure from the political or personal side, while at the same time in this same wording, that physician who renders satisfactory care and brings his patient through to speedy recovery now need have no fear that he will be brow-beaten as to his fee for services rendered and in despair offer to settle his bill for a less amount, as reported in some instances

It is also to be hoped from the manner in which this bill is drawn that the fees of the physician will be more promptly paid than have been many cases in the past, while with the giving of greater authority to the medical director, the cases will undoubtedly receive under this new scheme more prompt judgment and quicker decision, thus allowing of appeal sooner if necessary than at present is the case in many instances

In the hope that your Committee will see fit to report this bill out rests a settlement of some and possibly to a large part of the difficulties which confront the medical profession in their discussions whenever they are grouped for conference

Respectfully submitted,

JAMES N VANDER VEER,  
Chairman, Committee on Legislation

### HABIT FORMING DRUGS

In support of Senate Bill Introductory No 115, Print No 115, concurrent *Assembly Introductory No 215*, Print No 215, entitled "To amend the public health law, in relation to habit forming drugs, to provide for the control, possession, sale, prescribing, dispensing, dealing in and distribution of such drugs"

The Medical Society of the State of New York, composed of over ten thousand physicians and representing in a majority degree the sentiment of all of the Medical Societies of the various Counties, begs leave to enter its approval of the above bill

Some members of the committee may recall that this bill is the result of amendments to a bill along the same line that was introduced last year. These amendments have made the bill entirely satisfactory to the medical profession and it, therefore, urges its passage

There is most decidedly a need for such legislation and the Society believes this bill meets the conditions as nearly as it could be expected any enactment should. We, therefore, urge that your committee give its approval to the bill and strive for its enactment

### CONCERNING CADAVERS

In support of Senate Bill Introductory No 851, Print No 897, concurrent *Assembly Introductory No 1027*, Print No 1090, entitled "To amend section three hundred and sixteen of the public health law, in relation to cadavers"

The Medical Society of the State of New York, composed of over ten thousand physicians and representing in a majority degree the sentiment of all of the Medical Societies of the various Counties, begs leave to enter its approval of the above bill and would request that it be reported out favorably by the committee at its earliest opportunity. A brief statement for its approval follows

It is highly essential that medical schools have sufficient material for adequately training their students in anatomy. The bodies left unclaimed at the institutions mentioned in the bill can serve no better purpose than to be distributed among

the medical schools for student dissection, otherwise their disposition would be an expense to the community and they would serve no purpose, while here they can contribute definitely to the advancement of science. Ample provision is made in the bill to prevent, by accident, the disposition of the body of a person who may have friends who would be interested in giving it a decent burial

Accuracy in diagnosis of diseases in the living is largely dependent upon a study of pathological lesions found by post mortem examination of persons dying of such diseases. Therefore, the physicians connected with hospitals should be granted the privilege of making such scientific investigation upon the bodies of all those persons dying, for whom no provision for burial is made

Respectfully submitted,

JAMES N VANDER VEER,  
Chairman Committee on Legislation

## SANITATION IN FACTORIES AND STORES SELLING FOOD

Brief in support of Assembly Bill Introductory No 678, Print No 688, entitled "To amend the public health law, in relation to sanitation in factories, stores and shops engaged in the business of selling food"

The Medical Society of the State of New York, composed of over ten thousand physicians and representing in a majority degree the sentiment of all of the Medical Societies of the various Counties, begs leave to state that it approves of the subject matter of this bill and would like to see a law embodying its principles enacted, but believes that if the above bill should become a law it would be difficult to enforce it, because the physical examination at regular intervals, which it would require of food handlers, will not be understood by the average person and the value appreciated

Employees, not appreciating the importance of such an examination, would not cooperate with the physician by supplying him with the specimens and accurate data necessary for a satisfactory examination and might, on the other hand, think that the procedure was intended to provide employers with data to be used against an employee when desired

A considerable expense would be involved, also, in such periodic examination, which might work a hardship upon the employee or upon the employer, depending upon who was obliged to pay for the services of the examiner

It might be well, in the present bill, to confine the examination to the detection of a few of those diseases whose communicability is well known

## THE CLOSING DAYS OF THE LEGISLATURE

The Legislature has resolved to terminate its business by Friday, March 27th, and, therefore, according to its custom, it will proceed with its business under the Committee on Rules after March 17. The various committees will complete their work and make their final report on March 16. All bills that are not finally disposed of either by being reported out or by having been voted upon unfavorably, will pass to the jurisdiction of the Committee on Rules, and such as remain and go to them may, according to its judgment, be reported out at any time it see fit

Action during these last ten days, therefore, may be very rapid. And, during this period, final action on the bills that have been reported out will be expedited according to the custom of this committee, hence, it is quite essential that the legislators should be informed by their constituents as to the action they desire on any bills that remain unpassed on March 17th. Among these, of course, are our Medical Practice Act and the several chiropractic bills that have been reported out

The Committee on Legislation feels that since there are no longer any members of the State Society who desire to oppose the Karle-Dunmore bill, the probability of its being passed is materially greater this year. Every effort should be made by the physicians, individually and in their Societies, to let their legislators understand that this unity exists and, likewise, that the physicians are firmly combined in opinion against the passage of any of the chiropractic bills, no matter how drastically they may be drawn

Definite, possibly final action can be expected within the next week

No bills were introduced either into the Senate or Assembly during the past week that would affect the practice of medicine. Some of those that were introduced before have been reported out of committee and others have been advanced. Quite a number are still lying with the committee, some of which, without doubt, will never be reported out

### Senate Committee on Rules

(Address Room 335, The Capitol, Albany)

Hon John Knight, Chairman  
Hon Charles J Hewitt  
Hon Warren T Thayer  
Hon James L Whitley  
Hon James J Walker

### Assembly Committee on Rules

(Address Speaker's Room, Assembly Chamber,  
The Capitol, Albany)

Hon Joseph A McGinnies, Speaker  
Hon Simon L Adler  
Hon Eberly Hutchinson  
Hon Edmund B Jenks  
Hon John R Yale  
Hon T Channing Moore  
Hon Nelson W Cheney  
Hon Walter F Clayton  
Hon Maurice Bloch  
Hon Frank J Taylor  
Hon Peter J Hamill

## CENSORS OF THE STATE MEDICAL SOCIETY

Brief in support of *Assembly Bill Introductory No 1348*, Print No 1460, concurrent Senate Introductory No 1176, Print No 1283, entitled "To repeal section three of chapter two hundred and six of the laws of eighteen hundred and eighteen, entitled 'An act to amend an act, entitled 'An act to incorporate medical societies for the purpose of regulating the practice of physic and surgery in this state as amended by chapter six hundred and forty-seven of the laws of eighteen hundred and eighty seven'," relating to the appointment of censors by the state medical society"

The Medical Society of the State of New York, composed of over ten thousand physicians and representing in a majority degree the sentiment

of all of the Medical Societies of the various Counties, begs the committee to report this bill favorably

The object of the bill is to repeal this section of the laws of 1818 which was left in force by the amendment of 1887. What remains is obsolete because it specifies the number of censors that the Medical Society shall elect for its own committee, which is now incorporated in the by-laws of the Society and, therefore, it is unnecessary that it should remain any longer on the statute books

It is simply an attempt on the part of the Medical Society to remove from the laws an obsolete section

## MEDICAL SERVICES IN PUBLIC SCHOOLS

Brief in opposition to *Assembly Bill Introductory No 127*, Print No 1337, entitled "To amend the education law, in relation to medical services in the schools of the state"

The Medical Society of the State of New York, composed of over ten thousand physicians and representing in a majority degree the sentiment of all of the Medical Societies of the various Counties, wishes to offer its opposition to the enactment of this bill. It has several very undesirable features

*First* What it is intended to cover is already taken care of by the Department of Education through its division of school inspection

*Second* It attempts to provide for school children a particular group of physicians, surgeons, dentists, pediatricists and nurses, who shall be paid by the State for the services they render and who shall be asked to examine all children with the idea of treating and correcting physical defects discovered. The proper person to care for a school child is the family physician, he alone is familiar with the conditions under which the child was born and grew to the school age. He, therefore, can give the best service and the child remains for the greater portion of the twenty-four hours in his care, insomuch as when he is taken ill at home it is the family physician who will be called. Medical attention should not be divided thus between two physicians, and especially is this true in case of children. The school physician might find some reason for prescribing or treating a child while in school, the result or effect of which may react in a way not

anticipated, after the child has reached home, in which case, of course, the family physician will be called and he will not be able to prescribe intelligently because he will not know to what the child was subjected in school

The most satisfactory way is that in which the work is done at present, where inspectors are employed by the school authorities to examine children at regular intervals and turn the results of their examinations to the parents, with their suggestions as to what action the parents should take

*Third* It is wrong in principle to employ physicians, surgeons, etc., on full time to give attention to school children, because all of the children will not need attention, while some may need a great deal of care, thus the community at large will be taxed to care for the small group who will need their services. If those who need medical or surgical attention cannot afford to pay for it, there are public clinics where they will receive the best of medical care and attention

On the other hand, if they can afford to pay for the attention they need, it is an imposition on the community to ask them to pay the charges of the care their children receive

Therefore, we urge your committee not to pass this bill unless it be drawn so as to coordinate with the laws already in force under which the Department of Education, through its division of school inspection, is operating, or until such amendments are made which will make it accord with the ideas and principles of the laws already in force

## SANITATION IN FACTORIES AND STORES SELLING FOOD

Brief in support of Assembly Bill Introductory No 678, Print No 688, entitled "To amend the public health law, in relation to sanitation in factories, stores and shops engaged in the business of selling food"

The Medical Society of the State of New York, composed of over ten thousand physicians and representing in a majority degree the sentiment of all of the Medical Societies of the various Counties, begs leave to state that it approves of the subject matter of this bill and would like to see a law embodying its principles enacted, but believes that if the above bill should become a law it would be difficult to enforce it, because the physical examination at regular intervals, which it would require of food handlers, will not be understood by the average person and the value appreciated

Employees, not appreciating the importance of such an examination, would not cooperate with the physician by supplying him with the specimens and accurate data necessary for a satisfactory examination and might, on the other hand, think that the procedure was intended to provide employers with data to be used against an employee when desired

A considerable expense would be involved, also, in such periodic examination, which might work a hardship upon the employee or upon the employer, depending upon who was obliged to pay for the services of the examiner

It might be well, in the present bill, to confine the examination to the detection of a few of those diseases whose communicability is well known

## THE CLOSING DAYS OF THE LEGISLATURE

The Legislature has resolved to terminate its business by Friday, March 27th, and, therefore, according to its custom, it will proceed with its business under the Committee on Rules after March 17 The various committees will complete their work and make their final report on March 16 All bills that are not finally disposed of either by being reported out or by having been voted upon unfavorably, will pass to the jurisdiction of the Committee on Rules, and such as remain and go to them may, according to its judgment, be reported out at any time it see fit

Action during these last ten days, therefore, may be very rapid And, during this period, final action on the bills that have been reported out will be expedited according to the custom of this committee, hence, it is quite essential that the legislators should be informed by their constituents as to the action they desire on any bills that remain unpassed on March 17th Among these, of course, are our Medical Practice Act and the several chiropractic bills that have been reported out.

The Committee on Legislation feels that since there are no longer any members of the State Society who desire to oppose the Karle-Dunmore bill, the probability of its being passed is materially greater this year Every effort should be made by the physicians, individually and in their Societies, to let their legislators understand that this unity exists and, likewise, that the physicians are firmly combined in opinion against the passage of any of the chiropractic bills, no matter how drastically they may be drawn

Definite, possibly final action can be expected within the next week

No bills were introduced either into the Senate or Assembly during the past week that would affect the practice of medicine Some of those that were introduced before have been reported out of committee and others have been advanced Quite a number are still lying with the committee, some of which, without doubt, will never be reported out

### Senate Committee on Rules

(Address Room 335, The Capitol, Albany)

Hon John Knight, Chairman  
Hon Charles J Hewitt  
Hon Warren T Thayer  
Hon James L Whitley  
Hon James J Walker

### Assembly Committee on Rules

(Address Speaker's Room, Assembly Chamber, The Capitol, Albany)

Hon Joseph A McGinnies, Speaker  
Hon Simon L Adler  
Hon Eberly Hutchinson  
Hon Edmund B Jenks  
Hon John R Yale  
Hon T Channing Moore  
Hon Nelson W Cheney  
Hon Walter F Clayton  
Hon Maurice Bloch  
Hon Frank J Taylor  
Hon Peter J Hamill

## CENSORS OF THE STATE MEDICAL SOCIETY

Brief in support of *Assembly Bill Introductory No 1348*, Print No 1460, concurrent Senate Introductory No 1176, Print No 1283, entitled "To repeal section three of chapter two hundred and six of the laws of eighteen hundred and eighteen, entitled 'An act to amend an act, entitled 'An act to incorporate medical societies for the purpose of regulating the practice of physic and surgery in this state as amended by chapter six hundred and forty-seven of the laws of eighteen hundred and eighty seven'," relating to the appointment of censors by the state medical society"

The Medical Society of the State of New York, composed of over ten thousand physicians and representing in a majority degree the sentiment

of all of the Medical Societies of the various Counties, begs the committee to report this bill favorably

The object of the bill is to repeal this section of the laws of 1818 which was left in force by the amendment of 1887. What remains is obsolete because it specifies the number of censors that the Medical Society shall elect for its own committee, which is now incorporated in the by-laws of the Society and, therefore, it is unnecessary that it should remain any longer on the statute books

It is simply an attempt on the part of the Medical Society to remove from the laws an obsolete section

## MEDICAL SERVICES IN PUBLIC SCHOOLS

Brief in opposition to *Assembly Bill Introductory No 127*, Print No 1337, entitled "To amend the education law, in relation to medical services in the schools of the state"

The Medical Society of the State of New York, composed of over ten thousand physicians and representing in a majority degree the sentiment of all of the Medical Societies of the various Counties, wishes to offer its opposition to the enactment of this bill. It has several very undesirable features

*First* What it is intended to cover is already taken care of by the Department of Education through its division of school inspection

*Second* It attempts to provide for school children a particular group of physicians, surgeons, dentists, pediatricists and nurses, who shall be paid by the State for the services they render and who shall be asked to examine all children with the idea of treating and correcting physical defects discovered. The proper person to care for a school child is the family physician, he alone is familiar with the conditions under which the child was born and grew to the school age. He, therefore, can give the best service and the child remains for the greater portion of the twenty-four hours in his care, insomuch as when he is taken ill at home it is the family physician who will be called. Medical attention should not be divided thus between two physicians, and especially is this true in case of children. The school physician might find some reason for prescribing or treating a child while in school, the result or effect of which may react in a way not

anticipated, after the child has reached home, in which case, of course, the family physician will be called and he will not be able to prescribe intelligently because he will not know to what the child was subjected in school

The most satisfactory way is that in which the work is done at present, where inspectors are employed by the school authorities to examine children at regular intervals and turn the results of their examinations to the parents, with their suggestions as to what action the parents should take

*Third* It is wrong in principle to employ physicians, surgeons, etc., on full time to give attention to school children, because all of the children will not need attention, while some may need a great deal of care, thus the community at large will be taxed to care for the small group who will need their services. If those who need medical or surgical attention cannot afford to pay for it, there are public clinics where they will receive the best of medical care and attention

On the other hand, if they can afford to pay for the attention they need, it is an imposition on the community to ask them to pay the charges of the care their children receive

Therefore, we urge your committee not to pass this bill unless it be drawn so as to coordinate with the laws already in force under which the Department of Education, through its division of school inspection, is operating, or until such amendments are made which will make it accord with the ideas and principles of the laws already in force

## SANITATION IN FACTORIES AND STORES SELLING FOOD

Brief in support of Assembly Bill Introductory No 678, Print No 688, entitled "To amend the public health law, in relation to sanitation in factories, stores and shops engaged in the business of selling food"

The Medical Society of the State of New York, composed of over ten thousand physicians and representing in a majority degree the sentiment of all of the Medical Societies of the various Counties, begs leave to state that it approves of the subject matter of this bill and would like to see a law embodying its principles enacted, but believes that if the above bill should become a law it would be difficult to enforce it, because the physical examination at regular intervals, which it would require of food handlers, will not be understood by the average person and the value appreciated

Employees, not appreciating the importance of such an examination, would not cooperate with the physician by supplying him with the specimens and accurate data necessary for a satisfactory examination and might, on the other hand, think that the procedure was intended to provide employers with data to be used against an employee when desired

A considerable expense would be involved, also, in such periodic examination, which might work a hardship upon the employee or upon the employer, depending upon who was obliged to pay for the services of the examiner

It might be well, in the present bill, to confine the examination to the detection of a few of those diseases whose communicability is well known

## THE CLOSING DAYS OF THE LEGISLATURE

The Legislature has resolved to terminate its business by Friday, March 27th, and, therefore, according to its custom, it will proceed with its business under the Committee on Rules after March 17 The various committees will complete their work and make their final report on March 16 All bills that are not finally disposed of either by being reported out or by having been voted upon unfavorably, will pass to the jurisdiction of the Committee on Rules, and such as remain and go to them may, according to its judgment, be reported out at any time it see fit

Action during these last ten days, therefore, may be very rapid And, during this period, final action on the bills that have been reported out will be expedited according to the custom of this committee, hence, it is quite essential that the legislators should be informed by their constituents as to the action they desire on any bills that remain unpassed on March 17th Among these, of course, are our Medical Practice Act and the several chiropractic bills that have been reported out

The Committee on Legislation feels that since there are no longer any members of the State Society who desire to oppose the Karle-Dunmore bill, the probability of its being passed is materially greater this year Every effort should be made by the physicians, individually and in their Societies, to let their legislators understand that this unity exists and, likewise, that the physicians are firmly combined in opinion against the passage of any of the chiropractic bills, no matter how drastically, they may be drawn

Definite, possibly final action can be expected within the next week

No bills were introduced either into the Senate or Assembly during the past week that would affect the practice of medicine Some of those that were introduced before have been reported out of committee and others have been advanced Quite a number are still lying with the committee, some of which, without doubt, will never be reported out.

### Senate Committee on Rules

(Address Room 335, The Capitol, Albany)

Hon John Knight, Chairman  
Hon Charles J Hewitt  
Hon Warren T Thayer  
Hon James L Whitley  
Hon James J Walker

### Assembly Committee on Rules

(Address Speaker's Room, Assembly Chamber, The Capitol, Albany)

Hon Joseph A McGinnies, Speaker  
Hon Simon L Adler  
Hon Eberly Hutchinson  
Hon Edmund B Jenks  
Hon John R Yale  
Hon T Channing Moore  
Hon Nelson W Cheney  
Hon Walter F Clayton  
Hon Maurice Bloch  
Hon Frank J Taylor  
Hon Peter J Hamill

## SUMMARY OF BILLS INTRODUCED IN LEGISLATURE IN SENATE

### Prohibition Enforcement

Senate Int No 29 (conc Assembly Int 527)  
—No action has been taken on the Senate bill

The concurrent Assembly bill was reported on February 24, amended, March 2, third reading, March 10, passed, March 11, to Senate Codes Committee

### The Narcotic Bill

Senate Int No 115 (conc Assembly Int 215)

*Comment* At the hearing before the Senate and Assembly Committees on Public Health held on Wednesday, March 11th, this bill received a great deal of consideration. It was supported particularly by Dr Carleton Simon, Deputy Police Commissioner of New York, and Prof J P Chamberlain of Columbia University, representatives of the drug manufacturers led the opposition.

Several amendments were suggested and accepted. After these have been written in, the bill very likely will be reported out of committee into the Assembly.

### Requiring the Licensing of Private Institutions for the Treatment of Drug Addicts

Senate Int No 116 (conc Assembly Int 216)  
—Still in committee. No progress.

### The State Department of Education Bill Amending the Medical Practice Act

Senate Int No 211 (conc Assembly Int 307)

*Comment* There are ten bills which affect the practice of medicine now before the Legislature at the present time—four of them before the Senate and six before the Assembly.

### In Senate

Senate Int 211—The Karle Bill (Medical Practice)

Senate Int 473—The Gibbs Bill (Drugless Therapy)

Senate Int 944—The Fearon Bill (Chiropractic)

Senate Int 789—The Bouton Bill (Chiropractic)

### In Assembly

Assembly Int 185—The Nicoll Bill (Chiropractic)

Assembly Int 307—The Dunmore Bill (Chiropractic)

Assembly Int 649—The Esmond Bill (Chiropractic)

Assembly Int 1343—The Esmond Bill (Chiropractic)

Assembly Int 1423—The Jenks Bill (Chiropractic)

Assembly Int 1463—The Bolton Bill (Chiropractic)

Two of the above mentioned bills are concurrent bills, namely the Karle-Dunmore Bill, and the Fearon-Jenks Bill.

Since the joint hearing on Wednesday March 4th, the Assembly Committee of Public Health has reported out with slight amendments the Dunmore Bill, the Esmond Bill (Assembly Int 649) and the Jenks Bill (Assembly Int 1423).

The bills have not been considered by the Senate Committee on Public Health, but will very likely receive such consideration the early part of the coming week (beginning March 16th) and it is quite probable that two bills, namely the Karle Bill (Senate Int 211) and the Fearon Bill (Senate Int 944) will be reported out.

Your Committee on Legislation urges you to do your utmost now to see that your legislators support the Karle-Dunmore Bill (Senate Int 211, Assembly Int 307).

Our latest information is that there will no longer be any opposition by physicians in the Society to the Karle-Dunmore Bill, at the same time your legislators should be instructed to oppose the passage of either of the other two bills which will be reported out namely, the Fearon Bill (Senate Int. 944) and the Esmond Bill (Assembly Int 649).

The slight amendments made to the bills are as follows:

First, Art 1 of section 172, where it states that "this article shall not be construed so as to prevent the following (1) the practice of medicine, etc, etc., (2) this subdivision has been broadened so as to include physicians or internes employed in any state hospital or institution in which medical service is provided, and subdivision 7 amended so as to include with chiropractic and dentistry "or optometry."

Second, section 170, subsection d, so as to reintroduce among those causes for revocation of certificates and annulment of registration the violation of any of the provisions of Section 1142 of the Penal Law.

Third, that section which has to do with penalties (Section 173, subsection 6) has been modified by dropping from the sentence which describes the custody of committed persons the words "Sundays and legal holidays included," also the final sentence, viz "The provisions of this article relative to imprisonment for such debts shall be exclusive, and the provisions of the debtor and creditor law and of section seventy-



two of the civil rights law shall have no application, and prosecutions for a crime under this article shall not bar prosecutions for civil penalties"

These amendments were suggested by persons at the hearing and accepted by the Department of Education. The same amendments have been seized as well by Senator Fearon for his bill (Senate Int 944) and by Mr Jenks (Assembly Int. 1423), and by Mr Esmond (Assembly 649)

The Assembly Committee on Public Health has reported out the Jenks bill with the amendments as stated above for the Karle-Dunmore Bill and, in addition, an amendment prohibiting the chiropractor from treating any communicable disease

Mr Esmond had his bill (A Int 649) amended to correspond with the Karle-Dunmore Bill, and in addition under the waiver clause of his bill "C" he reduces the period of practice from 10 to 8 years and requires that in addition those who would claim licenses under this clause shall be graduates of a legally chartered school or college of chiropractic within the United States which at the time of his or her graduation required a course of study including the subjects of anatomy, physiology, pathology, hygiene, analytical chemistry and the theory and practice of chiropractic. He introduced a provision also which is intended to make uniform the examinations of those seeking a license to practice medicine or chiropractic, excepting the subjects of materia medica and chiropractic analysis and the science and practice of chiropractic

#### **Inspection by State Charities Boards of Children's Institutions**

Senate Int No 228 (conc Assembly Int 236)  
—This bill is still in committee. No further comment

#### **Qualifications of Examiners in Lunacy**

Senate Int No 263—Bill still in committee  
No further comment

#### **County Public Health Nurses**

Senate Int No 283 (conc Assembly Int 399)

*Comment* This bill has been amended and reported out of committee as so amended both in Senate and Assembly

The amendment follows

It is stated that the public health nurse shall take direction from a committee of the board of supervisors which committee shall be composed of two supervisors and two physicians, members of the County Medical Society, preferably health officers, and one or two lay persons. That part of the bill which attempted to outline the duties

of the nurse has been stricken out, and it specifies that the school nurse shall be under the direction of the school medical inspector

These amendments are in accord with the wishes of the Society as expressed at the Conference of County Legislative Chairmen

#### **Health Service in Schools**

Senate Int No 302 (conc Assembly Int 748)  
—February 9, Amend and recommit, March 11, Rept amended

*Comment* In our first comment on this bill we objected to the use of the term "health experts". The bill has now been amended by striking out "experts" and substituting "and dentists, dental hygienists" or "assistants"

The bill now meets with the approval of the Society and will not be further opposed

#### **Vaccine Virus**

Senate Int No 351 (conc Assembly Int 536)  
—The Assembly bill has been passed and is now in the Senate Public Health Committee

#### **Injured Employee to Select His Physician**

Senate Int. No 380 (conc Assembly Int 570)  
—Still in committee, no further comment

#### **The Drugless Practitioner Bill—(By Gibbs)**

Senate Int No 473

*Comment* This bill is still in Senate Public Health Committee. *See comment on other cult bills under Sen Int 211*

#### **Inspection of School Children**

Senate Int No 586 (conc. Assembly Int. 850)

*Comment* This bill has passed the Senate and is now in the Assembly Public Education Committee

#### **Free Choice of Physician**

Senate Int No 594 (conc Assembly Int 301)  
—Still in committee, no further comment

#### **Practical Tests of Injured Persons**

Senate Int No 647 (conc Assembly Int 184)  
—Still in committee, no further comment

#### **Physically Handicapped Persons**

Senate Int No 671 (conc Assembly Int 868)  
—Still in committee, no further comment

#### **Abolishing Office of Coroner—Westchester County**

Senate Int. No 673—Bill passed both houses  
Now before Governor

#### **Admission of Foreign Practitioners**

Senate Int No 693 (conc. Assembly Int 950)  
—Still in committee. No further comment

**In Relation to Pharmacies**

Senate Int No 632 (conc Assembly Int 802)

*Comment* This bill was brought up at the hearing before the Public Health Committees on March 11th and considerable opposition developed on the part of pharmacists

**Revocation of License to Practice Medicine**

Senate Int No 701—Still in Committee, no further comment

**Hospital for Crippled Children at West Haverstraw**

Senate Int No 786 (conc Assembly Int 1074)—Still in committee, no further comment

**State Institute for Study of Malignant Disease**

Senate Int No 787 (conc Assembly Int 973)—Still in committee, no further comment

**Rural Hygiene**

Senate Int No 716 (conc Assembly Int 969)—Still in committee This bill will be dropped

**The Bouton Chiropractic Bill**

Senate Int No 789

*Comment* See comment on other cult bills under Senate Int 211

**Dissecting Material**

Senate Int No 851 (conc Assembly Int 1027)

*Comment* No particular opposition has developed to this bill, and it is quite possible that it will be passed

**Laboratory Supplies**

Senate Int No 943 (conc Assembly Int 1167)

*Comment* This bill has been withdrawn by the Department of Health

**A Chiropractic Bill**

(By Mr Fearon)

Senate Int No 944 (conc Assembly Int 1423)

*Comment* See comment on this bill under Senate Int 211

**Foreign Licenses**

Senate Int No 1123 (conc Assembly Int 1478)—This bill is on order of third reading in the Senate.

**Censors of State Medical Society**

Senate Int No 1176 (conc Assembly Int 1348)

*Comment* This bill is progressing was rept on March 12th, third reading on the 13th

No opposition has developed and it will without doubt have an uneventful career and be passed as we desire

**IN ASSEMBLY****Health Service in Schools**

Assembly Int No 127—Still in committee, no further comment

**Practical Tests of Injured Persons**

Assembly Int No 184 (conc Senate Int 647)—See concurrent Senate Int 647

**The Nicoll Chiropractic Bill**

Assembly Int No 185—Still in committee  
*See comment on cult bills under Senate Int 211*

**The Narcotic Bill**

Assembly Int No 215 (conc Senate Int 115)  
See concurrent Senate Int 115 for comment

**Institutions for Addicts**

Assembly Int No 216 (conc. Senate Int 116)  
See Senate Int 116 for comment

**Mentally Retarded Children**

Assembly Int No 229—Still in committee, no further comment

**Children's Institutions**

Assembly Int No 236 (conc Senate Int 228)  
See concurrent Senate Int 228 for comment

**Free Choice of Physician**

Assembly Int No 301 (conc Senate Int 594)  
See concurrent Senate Int 594 for comment

**The State Department of Education Bill Amending the Medical Practice Act**

Assembly Int No 307 (conc Senate Int 211)  
—See concurrent Senate Int No 211 for comment

**County Public Health Nurses**

Assembly Int No 399 (conc Senate Int 283)  
—See concurrent Senate Int. 283 for comment

**Disclosure of Confidential Communications**

Assembly Int No 422—Still in committee, no further comment

**Prohibition Enforcement**

Assembly Int No 527 (conc Senate Int 29)—  
See concurrent Senate Int 29 for comment

**Free Choice of Physician**

Assembly Int No 570 (conc Senate Int 380)  
—See concurrent Senate Int 380 for comment

**Chiropractic Bill**

(By Mr Esmond)

Assembly Int No 649—See comment on this  
bill under Senate Int 211

**Periodic Health Examination of Food Handlers**

Assembly Int No 678—Still in committee, no  
further comment

**Health Service in Schools**

Assembly Int No 748 (conc Senate Int 302)  
—See concurrent Senate Int 302 for comment

**Medical Inspection in Schools**

Assembly Int No 850 (conc Senate Int 586)  
—See concurrent Senate Int. 586 for comment

**Physically Handicapped Persons**

Assembly Int No 868 (conc Senate Int 671)  
—See concurrent Senate Int 671 for comment

**Regulating Sale of Wood or Methanol Alcohol**

Assembly Int No 908—This bill was reported  
out on March 13th

**Reciprocity in Licensure**

Assembly Int No 925—Still in committee, no  
further comment

**Rural Hygiene**

Assembly Int No 969 (conc Senate Int 716)  
—This bill is still in committee It will be  
dropped

**Admission of Foreign Practitioners**

Assembly Int No 950 (conc Senate Int 693)  
—Still in committee

**Dissecting Material**

Assembly Int No 986 (conc Senate Int 681)  
—See concurrent Senate Int 681 for comment

**The Birth Control Bill**

Assembly Int No 987—*Comment* No fur-  
ther comment A hearing has been called for  
Tuesday, March 17th, at which your Com-  
mittee on Legislation will appear in opposition  
to the bill

**Laboratory Supplies**

Assembly Int No 1167 (conc Senate Int 943)  
—See comment on concurrent Senate Int 943

**Another Esmond Chiropractic Bill**

Assembly Int No 1343—See comment on cult  
bills under Senate Int 211

**Medical Treatment of Injured Employees**

Assembly Int No 1351

*Comment* See brief in this JOURNAL on page  
491

This bill was considered at the hearing before  
the Joint Labor and Industries Committees of  
Senate and Assembly on March 11th and further  
comment will be deferred until we learn what  
action is to be taken subsequent to the hearing

**Scientific Experiments on Dogs**

Assembly Int No 1377—Still in committee  
No hearing has been called

**Practice of Chiropody and Podiatry**

Assembly Int No 1421—Still in committee  
This bill will be dropped

**Chiropractic Bill**

(By Jenks)

Assembly Int No 1423 (conc Senate Int 944)  
—See comment on this bill under Senate Int 211

**Sale of Eyeglasses and Lenses**

Assembly Int No 1429—Still in committee,  
no further comment

**Chiropractic Bill**

(By Bolton)

Assembly Int No 1463—Still in Assembly  
Ways and Means Committee

No 1595

Int No 1463

IN ASSEMBLY

March 4, 1925

Introduced by Mr Bolton—(by request)—read once and  
referred to the Committee on Ways and Means

**AN ACT\***

To amend the public health law, creating a board of  
chiropractic examiners and regulating the practice of  
chiropractic and prohibiting the practice of any other  
mode or system under the name of chiropractic.

*The People of the State of New York represented in  
Senate and Assembly, do enact as follows*

Section 1 Chapter forty-nine of the laws of  
nineteen hundred and nine, entitled "An act in  
relation to the public health, constituting chapter  
forty-five of the consolidated laws," is hereby  
amended by inserting therein a new article, to  
follow article eight-a, to be article eight-b, to read  
as follows

\* Matter in italics is new, matter in brackets [ ] is old law  
to be omitted.

## ARTICLE 8-B

§ 189 Creation of a board There is hereby created, a board of chiropractic examiners, to be known as the state board of chiropractic examiners

The board of chiropractic examiners shall consist of three members who shall be appointed by the governor within thirty days after this article takes effect

The appointees shall meet within ten days after their appointment and organize by electing a president, secretary and treasurer, and adopting reasonable rules and regulations for the transaction of business

The appointees shall have the qualifications set forth in section one hundred and eighty-nine-h of this article Subsequent appointees shall be graduates of chiropractic schools or colleges giving a course of at least three years of six months each, in anatomy, physiology, symptomatology, hygiene, sanitation, chiropractic analysis and the principles and practice of chiropractic and requiring actual attendance upon the classes No one may be appointed who practices anything but chiropractic as hereinafter defined

The term of office of the first member shall be one year, the second, two years, the third, three years Appointees after the first shall serve for three years, and until their successors shall have been duly appointed and qualified Vacancies shall be filled by the governor within thirty days

§ 189-a Meetings The board shall hold regular meetings to examine applicants and the transaction of business, commencing on the first Mondays of March, August and November, in each year Special meetings may be called by the president and secretary upon thirty days notice printed in a newspaper of general circulation in the state

§ 189-b Offices The superintendent of public buildings shall, at the request of the board, provide an office where meetings may be held Special meetings may be called anywhere in the state

§ 189-c Eligibility Any person of good moral character, who is a graduate of a chiropractic school or college teaching chiropractic, and giving a course of at least three years of six months each in the subjects numerated in section one hundred and eighty-nine, and requiring actual attendance upon the classes, shall be eligible to examination, provided he possesses preliminary education or experience equivalent to a high school education, and provided further, that he practices nothing but chiropractic, as hereinafter defined

§ 189-d Chiropractic defined Chiropractic is defined to be the science of palpating and adjusting the articulations of the human spinal column by hand only This definition is inclusive and

any and all other methods are hereby declared not to be chiropractic

§ 189-e Practitioners No person shall practice chiropractic without a license, which license shall not entitle him to practice anything else. And, no one may hold himself out as a chiropractor without having a license

§ 189-f Examinations Anyone desiring an examination, shall, at least fifteen days prior to the meeting of the board, make written application to the secretary Such application shall be accompanied by an examination fee of fifteen dollars The application shall state the name, age, sex, and place of residence of the applicant, the name and location of the school or college from which he graduated, the length of time devoted to the study of chiropractic, the date of graduation, together with such other data as the applicant may desire to give In case an applicant fails in the first examination, he shall be entitled to a second one, without further fee Application shall be signed and sworn to by the applicant

The board shall prepare reasonable questions, and fairly mark and grade the answers thereto, all of which shall be done solely for the purpose of determining whether the applicant is reasonably qualified to practice chiropractic All applicants reasonably qualified to practice chiropractic shall be granted a license

§ 189-g Licenses All licenses shall be signed by the president and secretary of the board, and shall be attested by the official seal of the board The licensee shall pay to the secretary of the board before the license is issued a fee of five dollars Every license to practice chiropractic shall, before the licensee begins practice thereunder, be registered in a book kept in the clerk's office of the county where such practice is to be carried on, with name, residence, place and date of birth, and source, number and date of license to practice

Every licensee shall be required to pay to the secretary of board an annual renewal license fee of two dollars

§ 189-h Licenses without examination Any person of good moral character who has been continuously engaged in the practice of chiropractic in the state for two years prior to the passage of this article shall be licensed without examination, upon payment to the secretary of the board of a fee of twenty dollars, if he applies for a license within twenty days after the organization of the board

§ 189-i Reciprocity Any person of good moral character, licensed by a chiropractic board of any other state or territory or holding a certificate from the national board of chiropractic examiners, shall be licensed without examination, upon payment to the secretary of the board of a fee of twenty dollars

§ 189-j Revocation Upon complaint to the

board, after twenty days' notice of time and place of trial has been given to any licensee, if it shall be found that he practices anything other than chiropractic to cure or relieve disease or to remove the cause thereof without having a separate license therefor, or, if it be found that he no longer possesses a good moral character or is addicted to the use of narcotic drugs or in any way is guilty of deception or fraud in the practice of chiropractic, his license shall be revoked

The action of the board shall be reviewable by certiorari proceedings

§ 189-k Finances Within ten days after the close of every meeting of the board, the treasurer of the board shall turn over to the state treasurer, all fees and money received by the board, and take his receipt therefor

The state treasurer shall keep the same in a separate fund, to be used in paying running expenses of the board and a per diem compensation of fifteen dollars to the members thereof for such time as they may actually spend in the discharge of their official duties and traveling expenses

Payments from such fund shall be made by the state treasurer on the warrant of the comptroller and the vouchers of the president of the board

If, at the close of any fiscal year, there remains in the hands of the state treasurer from moneys received from the board, one thousand dollars in excess of all indebtedness of the board, the same shall be turned over to the public school fund

§ 189-l Penalties Any person violating any of the provisions of this article shall be deemed guilty of a misdemeanor and upon conviction thereof shall be punished by a fine not to exceed three hundred dollars or by imprisonment for a term not to exceed three months, or by both such fine and imprisonment.

§ 2 Repeal All acts or parts of acts in conflict with this article, are hereby repealed

§ 3 When act to take effect This act shall take effect immediately

*Comment* See comment on cult bills under Senate Int. 211

#### Hearings

Monday, March 16th

##### Assembly Public Health Committee

Assembly Int No 1429 (Meegan)—Health Law, sale of eyeglasses

Tuesday, March 17th

##### Assembly Codes Committee

Assembly Int No 987 (Boyle)—Penal Law, contraceptive treatment



# State Department of Health



## IODIZED SALT TRADE FLOURISHES IN LOCKPORT

The Division of Communicable Diseases has received a number of interesting communications from Dr Thomas E Spaulding, health officer of Lockport, on the subject of the use of iodized salt in his community. Early in February, Dr Spaulding distributed in the public, private and parochial schools of the city, about 4,200 circulars on goiter prevention through the use of iodized salt instead of ordinary table salt. This was apparently followed by a rushing business in the salt trade. Dr Spaulding states that no less than seven wholesale houses are supplying the local grocers with iodized salt. The usual retail price is 15 cents for a two-pound package.

Dr Spaulding reports that representatives of one firm stated that they had wholesaled 35 cases of 24 packages each to local grocers, and that they had orders for 15 cases, but that the orders were not filled, as available stock was exhausted, although a carload was on the way to the city. He believes that other firms are doing a similar business.

This method of preventing simple goiter is one that is available to any health officer with very little trouble or expense. Further reports on developments in Lockport will be awaited with interest.

The chief difficulty in prevailing on the general public to use the method seems to be the excess-

ive price which is charged for the iodized salt—which contains only .02 per cent of potassium or sodium iodide. The actual retail price for this amount of iodide is less than two-tenths of a cent for each pound of salt. As table salt in convenient packages commonly sells at the rate of five cents a pound, it is difficult to understand why the addition of the iodide should cause an increase of 50 per cent in the price. Possibly increased competition in meeting a larger demand for the iodized salt will result in reducing the excess charge. Even at present prices, however, the use of iodized salt in the home instead of common salt is an insignificant expense, and is far cheaper than other methods of goiter prevention—such as the use of iodide tablets, or the introduction of iodine into the public water supply. It is stated that practically all large salt producers are marketing an iodized salt, and retailers should experience little difficulty in obtaining it through wholesalers and jobbers.

In view of the widespread prevalence of simple goiter in many states, it seems possible that the most practicable way to eliminate the disease would be to compel, by federal enactment, the iodization of all table salt carried in interstate trade. If this were done, the considerable effort now being made by health and educational authorities in combating goiter would be unnecessary.

## NEWBURGH RECOVERS BOY WHO BROKE QUARANTINE

A clipping from the *Middletown Times* of January 20 states that following the escape of a Newburgh boy from his home which was under quarantine for scarlet fever, Dr Thomas J Burke, health officer of Newburgh, discovered that this boy had taken a bus for Middletown.

The facts were reported by him to Dr H J Shelley, local health officer, who found that the child was in a restaurant owned by the boy's uncle. The return of the boy to Newburgh in a private automobile was then ordered.

## "TRENCH" ITCH PROVES TO BE URTICARIA

A story in a Nyack paper a week or so ago gave an account of an outbreak of skin disease at Fishkill Village which affected both children and adults and which was said to have been diagnosed as "Trench Itch" but which was thought by many to be the "Seven Year Itch."

Investigation by one of the district state health officers disclosed the fact that most of these cases were in reality urticaria and that in all cases the families had been breakfasting largely on buck-wheat cakes or had eaten pork recently.

## CONTROLLING SYPHILITIC INCORRIGIBLES

The United States Public Health Service has thought it of enough importance recently to send out a news release calling attention to the fact that the Salt Lake City board of health in co-operation with the state board of health of Utah has been making a systematic effort to quarantine all men and women found under circumstances which give rise to a reasonable suspicion that they have a venereal disease. Under this rule, any situation which will warrant a reasonable inference that the persons are engaged in prostitution or promiscuity provides legal sanction for compelling an examination, and, if an infection is shown, to establish a quarantine and enforce treatment. Both men and women are subject to the working of the measure.

It may not be generally known that New York State has had a very similar "reasonable suspicion" law\* since April 17, 1918. In addition this Department has recommended the following regulation for adoption by municipalities in order that incorrigibles may be better controlled.

"When in the opinion of the health officer it is necessary to safeguard the public, a person affected with syphilis, gonorrhea or chancroid shall be isolated in a hospital, institution or other place designated by the health officer for such period as may be deemed necessary by him."

\* Section 343 of the Public Health Law as added by Chapter 264, Laws of 1918 and amended by Chapter 40, Laws of 1919.

## VACCINATION LATER THAN THREE DAYS AFTER EXPOSURE FAILS TO PROTECT AGAINST SMALLPOX

Through an oversight, a contact to a case of smallpox was recently allowed to go free, although he was not vaccinated until six days after his first exposure. He went to another town and subsequently developed the disease, exposing ten persons.

This is one of many illustrations of the fact that vaccination later than the third day after exposure cannot be depended upon to protect against smallpox, although it may modify the

severity of the attack. Regulation 30, of Chapter II, of the Sanitary Code, provides against this contingency by requiring that persons exposed to smallpox must be quarantined, unless vaccinated within the three-day period. This regulation also stipulates that, when vaccinated, contacts must be kept under observation until the vaccination proves to be successful, or for at least twenty days.

## COMMON UTENSIL SPREADS GONORRHEAL OPHTHALMIA

The innocent contraction of a gonococcus infection is not very frequent, but when cases are reported they are usually infections of the conjunctiva and are of a serious nature. *Venereal Disease Information* for January 1925, reports that two officers in the engineering department of one of our battleships recently developed severe gonococcus infection of the eyes. There was no evidence that either had ever had a venereal disease. A yeoman in the engineer's office was

under treatment for active gonorrhea at the time. The only article used in common was a wash bucket.

The damage to the eyes of the two officers resulted in their being obliged to leave the service, a direct loss to the government not only in personnel, but in money, since many thousands of dollars are expended on the education and training of commissioned officers.



# NEWS NOTES



## REFERENDUM VOTE OF THE HOUSE OF DELEGATES

Referendum vote of the House of Delegates on the Karle-Dunmore Bills canvassed by the tellers appointed by the Council of the Medical Society of the State of New York Polls Closed March 5, 1925

In favor	106	Against	31
E Eliot Harris, Chairman,	Joshua M Van Cott,	George W Whiteside	Tellers

## THE MEDICAL SOCIETY OF THE COUNTY OF QUEENS

A regular meeting of the Medical Society of the County of Queens was held Tuesday, February 24, 1925, 8 30 P M, at the Eagle Place, Jamaica The President, Dr Courten, in the chair

The following physicians were elected to membership Drs Isador Berman, William C Brons, Fred W Backus, Orman Gregersen, Thomas H Grodin, Jordan Lally, Raymond L Sippel, James E Stack

Dr McMahon, Chairman of the Legislative Committee, made the following recommendations as to pending legislation at Albany

1 Opposition to Assembly bill No 422, permitting Physicians and Nurses to disclose Professional Information in certain cases

2 Opposition to State Department of Education Bill, amending the Medical Practice Act, Senate Int No 211 (Conc Int 307)

3 Endorsement of Workmen's Compensation Bill, Senate No 594

These recommendations were approved by vote of the house, the second one being passed by vote of 56 to 4, after prolonged discussion, in which Drs McMahon, Flemming and Barry spoke against the bill, and Drs Steffen, Boettiger and Thomas for it

A resolution instructing the delegates of the society to vote against the bill in the referendum ordered by the Council of the State Society was passed

Dr Flemming reported work done by the committee on membership and on motion the secretary was instructed to send a communication to all hospitals in the borough, requesting that membership on their medical staff be limited to members of the county society

On motion of Dr Chalmers it was voted that the society join with the other societies in the vicinity in an invitation to the American Medical Association to meet in New York City in 1926

Dr J Frank Fraser gave an interesting talk illustrated by lantern slides on the diagnosis and treatment of some common skin diseases

The second paper on "Hemorrhagic Purpura, Treated by Splenectomy and Transfusion" by Robert Emory Brennan, M D, and Carl Boettiger, M D, respectively, Visiting Surgeon and Visiting Physician of St John's Hospital, Long Island City, was read by Dr Boettiger The diagnosis of the condition forming the subject of the paper rests upon the blood picture The similar conditions showing low blood platelet count are bacterial infections, diseases of blood forming organs, as leukaemia, various chemical poisons, and certain nutritive disturbances

Other similar conditions which may be distinguished from hemorrhagic purpura by normal blood platelet count are hemophilia, cholemia, arthritis, Henoch's disease, purpura with arterio sclerosis and congenital vulnerability of capillaries

It is an uncommon disease, characterized by bleeding from mucous membranes and into the skin

The authors reported two cases of the acute type treated by splenectomy, with recovery in one case, the fatal case really being in extremis when operated upon

Conclusion of authors is that splenectomy is life saving in patients suffering from hemorrhagic purpura, when the disease threatens life either by its fulminating character or by chronic bleeding

Transfusion is of no value unless accompanied by splenectomy

JOSEPH S THOMAS, *Secretary*



## OTSEGO COUNTY MEDICAL SOCIETY

The regular meeting of the Otsego County Medical Society was called to order at 4 30 P M, in the Hotel Fenimore, Cooperstown, on March 10, 1925

Dr M H Atkinson was elected to membership

Mr H F Wanvig of New York gave a talk on the Indemnity Insurance approved by the State Society, in which he explained the plan in

full and the advantages which accrue to the members who avail themselves of this insurance.

Dr J C Smith gave an address on the present status of the Medical Practice Act

Dr C W Lanning gave a short history of the early days of the Otsego County Medical Society, founded in 1806

A H BROWNELL, *Secretary*

---

## MEDICAL SOCIETY OF THE COUNTY OF SCHENECTADY

The regular monthly meeting of the Medical Society of the County of Schenectady was held at the Assembly Hall of the Ellis Hospital Tuesday evening, March 10, 1925

The program which consisted of a symposium on expert testimony, was opened by Dr Edward Ellery, Dean of Union University of Schenectady, who commented on expert testimony largely from the chemists' viewpoint. He showed how experts, both of equal ability would often give opposite opinions from examinations of identical specimens with the same methods of chemical analysis. Undoubtedly the testimony of experts is biased in behalf of the litigant by whom they are employed. It would seem, Dr Ellery claimed, that this bias might be overcome by all expert

testimony being employed by the court, and not separate experts by both plaintiff and defendant

The second speaker was Mr Walter Wellman, a prominent attorney of Schenectady. Dr Wellman discussed expert testimony from the courts' viewpoint. Following Mr Wellman, Capt W H Funston, Chief of the Police Bureau, talked on the criminal aspect. He also related some interesting experiences in crime detection occurring during his association with the New York Police Department

The final speaker of the evening was Dr Ellis Kellert, Pathologist of the Ellis Hospital, who took up expert testimony from the pathologist viewpoint

---

## CLINICAL LECTURES OPEN TO GENERAL MEDICAL PROFESSION

The Columbia University Medical School in New York City has just announced that the Clinical Lectures of the third and fourth years will be open hereafter to the general medical profession

These lectures are given at the Medical School, 437 West 59th Street, by Professor John A Fordyce in Dermatology and Syphilology, on

Wednesdays at 3 00, Professor Herbert B Wilcox on Diseases of Children, on Wednesdays at 4 00, Professors Frederick Tilney, Louis Casamajor and others on Neurology on Thursdays at 4 00, Professor Arnold Knapp in Ophthalmology on Wednesdays at 2 00, Professor Thomas W Salmon and others in Psychiatry on Fridays at 5 00

---

## EXAMINATION FOR ENTRANCE INTO THE REGULAR CORPS OF THE U. S PUBLIC HEALTH SERVICE

Examinations of candidates for Regular Corps of the U S Public Health Service will be held at Washington, D C June 1 1925 at Chicago, Ill, June 1, 1925, at New Orleans, La June 1, 1925, at San Francisco, Cal, June 1, 1925

Candidates must be not less than twenty-three nor more than thirty-two years of age, must have been graduated in medicine at some reputable medical college, and have had one year's hospital experience or two years' professional practice

They must pass satisfactorily, oral, written and clinical tests before a board of medical officers and undergo a physical examination

Successful candidates will be recommended for appointment by the President with the advice and consent of the Senate

Requests for further information should be addressed to H S Cumming, Surgeon General, U S Public Health Service, Washington, D C

## THE GORGAS MEMORIAL

That the Gorgas Memorial Institute is accomplishing its initial purpose of uniting laymen and doctors, and instilling into the masses a recognition of the fact that scientific medicine is the only proper authority in health matters, is evident from newspaper reports the country over.

The Gorgas Memorial Institute appears indeed to be enjoying a healthy growth from the Atlantic to the Pacific. The value of periodic health examinations is being stressed in hundreds of newspaper articles, in public talks and in radio addresses.

Scores of editorials have been written and published by leading newspapers. Without exception they have deep sympathy with the ideals of the organization and heartily endorse it.

A special article written for the *Detroit Saturday Night* and appearing in the issue of February 14 is pertinent. It reads in part:

"Quacks and quackery in the field of medicine and general health protection will receive a heavy blow when the Gorgas Memorial Institute, recently founded in honor of the great army medical man who showed the world that yellow fever and other pestilences could be conquered by preventive methods, gets functioning.

"The Institute is not heralding as one of its purposes the counteracting of propaganda such as is spread by circus strong men and health quacks who use every opportunity to attack the medical profession, but just so far as its plans, as announced, are successful, it will help to overcome pernicious teachings and ignorance regarding health."

The article goes on to say—

"The Institute will carry out General Gorgas' ideas of the exercise of preventive measures and the use of scientific medicine to check disease and wipe out pestilence. It is estimated that modern ideas of sanitation, coupled with the principle of periodic examinations, such as General Gorgas

practiced in the United States army during the World War, would mean a saving of \$1,500,000,000 annually. And the decrease in sickness and increase in happiness would be worth as much more.

"On any given day there are 3,000,000 people on the nation's sick list. One million of these are gainfully employed. The daily loss from this one source is staggering."

The County Societies are also proving receptive to the Gorgas idea. They see in the movement a plan which will aid each member individually.

"What benefit will the Gorgas Memorial be to me, personally?" asks the scientific medical man invited to serve on the New York Governing Committee.

This is the answer:

You will be associated in a definite way with the biggest health movement ever inaugurated—a movement endorsed and supported not only by the medical profession but by civic organizations and the general public.

The publicity attendant on this program will bring before the public, in a way never before attempted, the medical man's importance in community development. The organized strength of the most highly regarded profession in the world today, to protect and carry on the ideals which have actuated it for centuries, cannot fail to react beneficially on the individual as well as the group.

The Directors of the Gorgas Memorial Institute of Tropical and Preventive Medicine are basing their success on the efforts of the thousands of friends of General Gorgas who will volunteer to give their time, influence and money to show their appreciation of his contribution to the happiness of many people and of the efforts he made that resulted in saving thousands of lives and millions of dollars. His life's work, if they succeed, will be projected far into the future in the way that he would have desired.

## DOCTORS' FEES IN THE OLDEN TIME

The physicians of New York City did not work for nothing a century and a quarter ago. On the contrary, the gold-headed cane which was the symbol of the honorable station of the physician in society, should have been well within the means of every doctor if he charged and collected the fees according to the following table which was adopted by the Medical Society of New York City in 1798.

### FEE LIST OF 1798

COPY FROM MINUTES OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK.

We, the subscribers, practitioners of physic and surgery in the City of New York, do agree upon the following rate of charges, for our professional services, from and after the first day of July, 1798, agreeably to which rates we do recommend our bills to be presented every six months, or oftener if circumstances permit.

Verbal advice	\$5 00
A letter of advice	10 00
An ordinary visit	1 00
A visit, with a single dose of medicine	1 25
Medicine to be priced as follows	
For powders, each	12
Pills, each dose	12
Boluses, each	25
Electuaries, per ounce	50
Mixtures, per ounce	12
Decoctions, one dollar and 50/100 per lb or per ounce	12
Infusions one dollar and 50/100 per lb or per ounce	12
Lotions, per lb	1 25
Tinctures, per ounce	25
Vol. spirit, per ounce	50
Ointments and cerates, per ounce	25
Blistering plaster, according to their sizes, from \$1.25 to	2 00
Other plasters, 50c. to	2 50
For a single dose of medicine, dispensed without a visit	62

### CONSULTATIONS

The first visit in consultation	\$5 00
Each subsequent visit in consultation	2 00
A night visit	5 00
Visit at a distance from town, per mile	1 00
A visit to Brooklyn	3 00
A visit to Pawles' Hook	5 00
A visit to Staten Island	10 00
The last two charges to be doubled in winter or in stormy and tempestuous weather	
The first visit in epidemic fevers, or in other diseases where there is personal danger incurred	
Each subsequent visit under these circumstances	2 00

### THE CHARGES

For curing a simple or virulent gonorrhea, from ten to	\$20 00
For curing confirmed syphilis, from \$25 to	100 00
For dressing a blister, from 50 to	1 00
For dressing wounds, from \$1 00 to	2 00
For applying cupping glasses	4 00
For bleeding in the arm	1 00
For bleeding in the foot	2 00
For bleeding in jugular vein	2 00
For opening an artery	5 00
For inoculating and attending in the small pox, from \$5 00 to	10 00
Scarifications of the eye	5 00
Punctures in oedematous swellings	2 00
Inserting an issue	2 00
Inserting a seton	5 00
Introducing a catheter the first time	5 00
Introducing a catheter each subsequent time	2 00
Extracting a calculus from the urethra	10 00
Reducing a simple fracture, from \$10 00 to	20 00
Reducing a compound fracture	30 00
Setting dislocations, from \$5 00 to	20 00
For reducing a prolapsus ani	5 00
For reducing a hernia	25 00
For opening an abscess, from \$1 00 to	5 00
For amputating the breast	50 00
For amputating an arm or leg	50 00
For amputating a joint	100 00
For amputating a finger	10 00
For amputating the penis	20 00
For extirpating the eye	100 00
For extirpating the tonsil	25 00
For extirpating the testicle	50 00
For extirpating a polypus	25 00
For extirpating a tumor, from \$10 to	50 00
Perforating the rectum, nostrils, or the urethra	10 00
Paracentesis of the abdomen	10 00
Paracentesis of the thorax	50 00
Operation for an aneurism	100 00
Operation for hair lip	25 00
Operation for hydrocele	25 00
Operation for hernia	125 00
Operation for fistula in ano	50 00
Operation for fistula in perineo	25 00
Operation for phymosis	10 00
Operation for paraphymosis	10 00
Operation for fistula lachrymalis	25 00
Operation for wry neck	25 00
Operation for cataract	125 00
The operation of lithotomy	125 00
The operation of bronchotomy	25 00
The operation of trepanning	100 00
The operation of circumcision	10 00

### MIDWIFERY CHARGES

For a common case, from \$15 00 to	25 00
For tedious or difficult cases, from \$25 to	40 00

RESOLVED, that the Secretary transcribe in the Book of Minutes the medical charges agreed upon in the year one thousand seven hundred and ninety-eight. (1798)

Adjourned.

S BORROWE Secy

## THE GORGAS MEMORIAL

That the Gorgas Memorial Institute is accomplishing its initial purpose of uniting laymen and doctors, and instilling into the masses a recognition of the fact that scientific medicine is the only proper authority in health matters, is evident from newspaper reports the country over.

The Gorgas Memorial Institute appears indeed to be enjoying a healthy growth from the Atlantic to the Pacific. The value of periodic health examinations is being stressed in hundreds of newspaper articles, in public talks and in radio addresses.

Scores of editorials have been written and published by leading newspapers. Without exception they have deep sympathy with the ideals of the organization and heartily endorse it.

A special article written for the *Detroit Saturday Night* and appearing in the issue of February 14 is pertinent. It reads in part:

"Quacks and quackery in the field of medicine and general health protection will receive a heavy blow when the Gorgas Memorial Institute, recently founded in honor of the great army medical man who showed the world that yellow fever and other pestilences could be conquered by preventive methods, gets functioning.

"The Institute is not heralding as one of its purposes the counteracting of propaganda such as is spread by circus strong men and health quacks who use every opportunity to attack the medical profession, but just so far as its plans, as announced, are successful, it will help to overcome pernicious teachings and ignorance regarding health."

The article goes on to say—

"The Institute will carry out General Gorgas' ideas of the exercise of preventive measures and the use of scientific medicine to check disease and wipe out pestilence. It is estimated that modern ideas of sanitation, coupled with the principle of periodic examinations, such as General Gorgas

practiced in the United States army during the World War, would mean a saving of \$1,500,000,000 annually. And the decrease in sickness and increase in happiness would be worth as much more.

"On any given day there are 3,000,000 people on the nation's sick list. One million of these are gainfully employed. The daily loss from this one source is staggering."

The County Societies are also proving receptive to the Gorgas idea. They see in the movement a plan which will aid each member individually.

"What benefit will the Gorgas Memorial be to me, personally?" asks the scientific medical man invited to serve on the New York Governing Committee.

This is the answer:

You will be associated in a definite way with the biggest health movement ever inaugurated—a movement endorsed and supported not only by the medical profession but by civic organizations and the general public.

The publicity attendant on this program will bring before the public, in a way never before attempted, the medical man's importance in community development. The organized strength of the most highly regarded profession in the world today, to protect and carry on the ideals which have actuated it for centuries, cannot fail to react beneficially on the individual as well as the group.

The Directors of the Gorgas Memorial Institute of Tropical and Preventive Medicine are basing their success on the efforts of the thousands of friends of General Gorgas who will volunteer to give their time, influence and money to show their appreciation of his contribution to the happiness of many people and of the efforts he made that resulted in saving thousands of lives and millions of dollars. His life's work, if they succeed, will be projected far into the future in the way that he would have desired.

## DOCTORS' FEES IN THE OLDEN TIME

The physicians of New York City did not work for nothing a century and a quarter ago. On the contrary, the gold-headed cane which was the symbol of the honorable station of the physician in society, should have been well within the means of every doctor if he charged and collected the fees according to the following table which was adopted by the Medical Society of New York City in 1798.

## FEE LIST OF 1798

COPY FROM MINUTES OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK.

We, the subscribers, practitioners of physic and surgery in the City of New York, do agree upon the following rate of charges, for our professional services, from and after the first day of July, 1798, agreeably to which rates we do recommend our bills to be presented every six months, or oftener if circumstances permit.

Verbal advice	\$5 00
A letter of advice	10 00
An ordinary visit	1 00
A visit, with a single dose of medicine	1 25
Medicine to be priced as follows	
For powders, each	12
Pills, each dose	12
Boluses, each	25
Electuaries, per ounce	50
Mixtures, per ounce	12
Decoctions, one dollar and 50/100 per lb or per ounce	12
Infusions one dollar and 50/100 per lb or per ounce	12
Lotions, per lb	1 25
Tinctures, per ounce	25
Vol. spirit, per ounce	50
Ointments and cerates, per ounce	25
Blistering plaster, according to their sizes, from \$1.25 to	2 00
Other plasters, 50c. to	2 50
For a single dose of medicine, dispensed without a visit	62

## CONSULTATIONS

The first visit in consultation	\$5 00
Each subsequent visit in consultation	2 00
A night visit	5 00
Visit at a distance from town, per mile	1 00
A visit to Brooklyn	3 00
A visit to Pawles' Hook	5 00
A visit to Staten Island	10 00
The last two charges to be doubled in winter or in stormy and tempestuous weather	
The first visit in epidemic fevers, or in other diseases where there is personal danger incurred	5 00
Each subsequent visit under these circumstances	2 00

## THE CHARGES

For curing a simple or virulent gonorrhea, from ten to	\$20 00
For curing confirmed syphilis, from \$25 to	100 00
For dressing a blister, from 50 to	1 00
For dressing wounds, from \$1 00 to	2 00
For applying cupping glasses	4 00
For bleeding in the arm	1 00
For bleeding in the foot	2 00
For bleeding in jugular vein	2 00
For opening an artery	5 00
For inoculating and attending in the small pox, from \$5 00 to	10 00
Scarifications of the eye	5 00
Punctures in oedematous swellings	2 00
Inserting an issue	2 00
Inserting a seton	5 00
Introducing a catheter the first time	5 00
Introducing a catheter each subsequent time	2 00
Extracting a calculus from the urethra	10 00
Reducing a simple fracture, from \$10 00 to	20 00
Reducing a compound fracture	30 00
Setting dislocations, from \$5 00 to	20 00
For reducing a prolapsus ani	5 00
For reducing a hernia	25 00
For opening an abscess, from \$1 00 to	5 00
For amputating the breast	50 00
For amputating an arm or leg	50 00
For amputating a joint	100 00
For amputating a finger	10 00
For amputating the penis	20 00
For extirpating the eye	100 00
For extirpating the tonsil	25 00
For extirpating the testicle	50 00
For extirpating a polypus	25 00
For extirpating a tumor, from \$10 to	50 00
Perforating the rectum, nostrils, or the urethra	10 00
Paracentesis of the abdomen	10 00
Paracentesis of the thorax	50 00
Operation for an aneurism	100 00
Operation for hair lip	25 00
Operation for hydrocele	25 00
Operation for hernia	125 00
Operation for fistula in ano	50 00
Operation for fistula in perineo	25 00
Operation for phymosis	10 00
Operation for paraphymosis	10 00
Operation for fistula lachrymalis	25 00
Operation for wry neck	25 00
Operation for cataract	125 00
The operation of lithotomy	125 00
The operation of bronchotomy	25 00
The operation of trepanning	100 00
The operation of circumcision	10 00

## MIDWIFERY CHARGES

For a common case, from \$15 00 to	25 00
For tedious or difficult cases, from \$25 to	40 00

RESOLVED, that the Secretary transcribe in the Book of Minutes the medical charges agreed upon in the year one thousand seven hundred and ninety-eight. (1798)

Adjourned.

S BORROWE, Secy



# THE DAILY PRESS



The question of Medical News is discussed by the *Middletown Herald*, February 25th, in an editorial entitled "Physicians and Censorship." This is a sensible exposition of the viewpoint of the newspaper editor toward news of a medical nature. The editor is opposed to medical censorship, as is shown by the following quotation:

"The statement is being made that organized physicians are supporting a movement to place health and medical news under censorship, arguing that newspapers should have medical editors, because the layman journalist cannot write intelligently upon medical subjects. If this report is true, the position of such physicians as may be supporting the movement is to be deprecated, for this censorship would be nothing short of an abridgement of the freedom of the press."

What physicians want is not *censorship*, but *editorship*. We believe that every newspaper should have a medical editor just as it has a sports editor, and a political editor.

The editor has evidently been rebuffed by physicians, for he says:

"Physicians complain from time to time of ridiculous mistakes made in newspapers in the use of medical terms in news stories on health subjects and so on. If it were possible for a physician to censor all medical news, errors would still creep in, just as errors creep into all printed matter, even medical journals. Any plan to censor newspapers as to what they shall and shall not use, be it in the field of medicine or in other fields, will meet with instant and vigorous opposition from the newspaper profession. If physicians who are called by news gatherers, and hospitals, whence medical news emanates, were more explicit in their answers to questions, much of the inaccuracy could be eliminated. If a physician is called by a reporter, and that doctor gives a gruff and hasty response to a civil question, it is hardly to be expected that a news writer can construct a story as intelligently, from the medical viewpoint, as he could if the doctor were obliging enough to furnish him with accurate information."

But the editor hastens to assure the doctors that he has no personal feeling in the matter.

"Insofar as health news in general is concerned, Middletown, at least, can hardly fall within the scope of criticism for inaccuracies, for both the city health officer and the District State Health Officer are most accommodating in furnishing health items, taking pains to aid the reporter in straight and seeing that the medi-

"Newspapers today are printing intelligently news stories of epidemics which half or even a quarter of a century ago would have been so sensationalized as to have worked to the detriment of the very public the physicians wished to calm. With newspapers ready and willing to assist in spreading the gospel of good health, it appears to be up to the physicians to aid to the utmost, instead of criticizing and ridiculing errors which, many times, are made through lack of information from the medical men themselves."

We have noticed that the *Middletown* newspapers have practised what they preach, and we have frequently quoted them in our *Daily Press* department.

Several up-State newspapers comment on the question whether or not a specific cure for tuberculosis would put tuberculosis workers and associations out of a job. The occasion for the articles was an address made by Dr. Linsly R. Williams, Managing Director of the National Tuberculosis Association, before the State Conference on Tuberculosis held in New York during the third week of February. The *Poughkeepsie Eagle*, February 24th, says:

"A specific cure for tuberculosis will not put tuberculosis workers and associations out of a job. Dr. Linsly R. Williams, managing director of the National Tuberculosis Association, discussed the question at the conference and pointed out that the field of work of associations and workers has already broadened to include many other lines of disease prevention. Dr. Williams warned, however, against broadening the scope of work until the tuberculosis problem was solved."

If a cure for tuberculosis should be found, the next great problem will be to get people to take it. A practically sure cure for diphtheria is known and available, but not only do many persons object to taking it, but there is a growing group of cultists who are trying to combat the use of antitoxin, and the result is that diphtheria deaths are still common.

Tuberculosis is still one of the principal causes of death, and all available sanatoriums and hospitals are filled to their capacity. Nurses and physicians are making strenuous efforts to discover new cases, and yet from one-quarter to one-third of all persons dying of tuberculosis are unknown to the doctors and nurses previous to the last few days of their illness. Another third of deaths are among those who refuse to cooperate with the nurses or to obey their doctors. These cases will always be with us, and there is no prospect that tuberculosis will cease to be

a big factor in public health during this quarter century

The *Glens Falls Times* of February 24th also discusses the question of what will become of tuberculosis workers if a cure is found for the disease. The account says

"Tuberculosis associations and workers, it was reported, will not lose their jobs when a specific tuberculosis cure is found, because their field of work has already broadened to include many other lines of disease prevention, and the time was foreseen when associations financed through the Christmas seal sale will engage in campaigns for the prevention of cancer, heart disease and venereal disease. The warning was given, however, not to broaden the scope of the work until the tuberculosis problem was solved"

In our Daily Press department of January 16th we commented on the publicity given to the campaign for the sale of Christmas seals, and mentioned the lack of any reference to any other purpose than that of the suppression of tuberculosis. We note a growing tendency to suggest other uses for the money besides the suppression of tuberculosis. We also note the indication of a growing fear that many workers might lose their positions if the campaign for the suppression of tuberculosis should succeed to the degree that was predicted by the tuberculosis associations some ten years ago.

The physicians of New York State believe in sticking to one program until it has succeeded in its object. The problem of tuberculosis is now understood to a greater extent than ever before, and physicians are becoming more and more interested in the control of the disease. It would be a calamity to divide the forces which are arrayed against tuberculosis.

It is our opinion that as physicians assume more and more control over tuberculosis, there will be more and more demand for the services of nurses and lay workers in the tuberculosis field.

Publicity of epidemics of communicable diseases is often condemned, but when instances of condemnation are investigated, they usually indicate a failure of the governmental officials to institute control measures early in the outbreak. When publicity is given late, there is a feeling that only half the truth is being told, and that conditions are worse than the officials admit. On the other hand, when full publicity is given early in an outbreak, the people are reassured, and feel that conditions are not half so bad as reported.

We are glad to see several favorable comments on publicity in a smallpox case. The *Olean Herald*, March 2nd, has an editorial entitled "Business Men Converted," in which it quotes from the Health News of the State Department

of Health, an account of a protest of business men against publicity in regard to smallpox, but which was changed to approval when a committee of business men investigated conditions. The Olean editorial concludes

"The aversion of business men to publicity in connection with epidemics of contagious or infectious diseases is natural. They fear that such publicity will restrict business, and being only human, they do not like to contemplate such a contingency. This feeling has been manifested from time to time in most communities. Sometimes the newspapers come in for rather severe criticism for telling the public the facts. Where those who object to publicity err is in overlooking the fact, so clearly established in the instance above cited, that only as the facts are made known can proper remedies be applied. To give the facts is the duty of the public press."

The *New York Sun*, March 11th, contains comments on a study of the subject of colds made by the U S Public Health Service, and quoted from the current *Popular Science Monthly*.

"We no longer can be sure of our ground when we blame the weather for a cold in the head or other nose and throat disorders.

"This lack of relationship between colds and the weather in the United States is demonstrated in the startling similarity between cold occurrence in the rigorous North and that in the warmer South and Pacific Coast. In general, New Orleans and San Francisco suffer with Chicago and Boston—and at very nearly the same time of the year.

"The findings of the investigators may be summarized as follows:

"The common cold is extremely contagious. It does not come from bad weather or wet feet, but from germs that attack those whose physical condition makes them susceptible.

"Each of us, on an average, suffers from 37 colds a year.

"October is the worst time of the year for colds. Another bad month is January. June is the month in which you are least likely to catch cold."

Most articles, both medical and lay, on the subject of colds lay great stress on the body as the *soil* in which the infectious germs grow, and say little about the *seed*, or the germs of infection. The article illustrates the importance of the prevention of the spread of disease germs, or, in other words, the isolation of the person who has an acute cold of whatever nature it may be.

We believe that the time is ripe for Departments of Health to start a campaign to educate the people regarding the necessity of isolation of all cases for the prevention of all the forms of sickness which are called colds.



# BOOKS RECEIVED



Acknowledgment of all books received will be made in this column and this will be deemed by us a full equivalent to those sending them. A selection from these columns will be made for review, as dictated by their merits, or in the interest of our readers.

- MEDICAL CLINICS OF NORTH AMERICA** Volume 8, Number 2, September, 1924 (Chicago Number) Published every other month by the W B Saunders Company, Phila. and London. Per Clinic Year (6 issues) Cloth, \$16 00 net, paper, \$12 00 net.
- IMMUNITY IN NATURAL INFECTIOUS DISEASE.** By F d'HERELLE. Authorized English Edition by GEORGE H SMITH, Ph D Octavo of 399 pages Baltimore, Williams & Wilkins Company, 1924 Cloth, \$5 00
- HYGIENIC FUNDAMENTALS OF FOOD HANDLING.** By CHARLES THOM and ALBERT C HUNTER of the Microbiological Laboratory, Bureau of Chemistry, U S Department of Agriculture. Octavo of 228 pages, illustrated. Baltimore, Williams & Wilkins Company, 1924 Cloth, \$3 00
- DISEASES OF THE HEART** By Dr HENRI VAQUEZ Translated and edited by GEORGE F LAIDLAW, M D Octavo of 743 pages, illustrated Philadelphia and London, W B Saunders Company, 1924 Cloth, \$8 50
- MANUAL OF PSYCHIATRY FOR THE MEDICAL STUDENT AND GENERAL PRACTITIONER.** By PAUL E BOWERS, M S, M D Octavo of 365 pages Philadelphia and London, W B Saunders Company, 1924 Cloth, \$3 50
- PRACTICE OF PEDIATRICS** By CHARLES GILMORE KERLEY M D, and GAYLORD WILLIS GRAVES, M D Third Edition, revised and reset. Octavo of 922 pages with 150 illustrations Philadelphia and London, W B Saunders Company, 1924 Cloth, \$9 00
- ABT'S PEDIATRICS** By 150 Specialists Edited by ISAAC A ABT, M D Volume 5, containing 865 pages with 373 illustrations (Set to be complete in eight octavo volumes) Philadelphia and London, W B Saunders Company, 1924 Cloth, \$10 per volume Sold by subscriptions
- A TEXT-BOOK OF PATHOLOGY** By W G MACCALLUM, M D Third Edition, thoroughly revised Octavo of 1162 pages with 575 original illustrations. Philadelphia and London, W B Saunders Company, 1924 Cloth, \$10 net
- A MANUAL OF OBSTETRICS** By JOHN COOKE HIRST, M D, F.A.C.S. Second Edition, entirely reset. 12mo of 551 pages with 229 illustrations Philadelphia and London, W B Saunders Company, 1924 Cloth, \$4 50 net.
- MEDICAL CLINICS OF NORTH AMERICA** Volume 8, Number 3, November, 1924 (Philadelphia Number) Published every other month by the W B Saunders Company, Phila. and London. Per Clinic Year (6 issues) Cloth, \$16 00 net, paper, \$12 00 net.
- OPERATIVE SURGERY** Covering the Operative Technic involved in the Operations of General and Special Surgery By WARREN STONE BICKHAM, M D, F.A.C.S. Vol 6, completing the set. Octavo 989 pages, 1224 illustrations General Index to Vols 1 to 6 Octavo 189 pages Phila. and London, W B Saunders Co, 1924 Cloth, \$10 per volume Index volume free. Sold by Subscription only
- HIRSCH'S "COMPEND OF GENITO-URINARY DISEASES AND SYPHILIS,"** Including their Surgery and Treatment. 4th Edition Revised 44 illustrations Cloth, \$2 00 By CHARLES S HIRSCH, M D Urologist to the Jewish Hospital, Mt. Sinai Hospital, and Eagleville Hospital for Consumptives, Out patient Dept., Philadelphia. P Blakiston's Son and Co, Philadelphia, 1924
- MEDICAL EDUCATION, A COMPARATIVE STUDY** By ABRAHAM FLEXNER, The Macmillan Company, 1925 Price, \$2 50
- PROCEEDINGS OF THE INTERNATIONAL CONFERENCE ON HEALTH PROBLEMS IN TROPICAL AMERICA.** Held at Kingston, Jamaica, B W I, July 22 to August 1, 1924 By Invitation of the Medical Department United Fruit Company Published by United Fruit Company, Boston, Mass., 1924
- HANDBOOK OF OPERATIVE SURGERY** By SIR WILLIAM IELAND DE C WHEELER, (Mod) B A., M D (Dub Univ), F.R.C.S.I., F.A.C.S. (Hon.) Surgeon to Mercer's Hospital and the National Children's Hospital, Dublin Fourth Edition, William Wood & Company, New York, 1925 Price, \$5 50
- THE PRACTICAL MEDICINE SERIES,** comprising eight volumes on the year's progress in medicine and surgery Vol IV, Pediatrics, edited by ISAAC A ABT, with the collaboration of JOHANNA HEUMANN, M D Series 1924 The Year Book Publishers, Chicago, Ill Price, \$2.00
- HANDBOOK OF BACTERIOLOGY** For Students and Practitioners of Medicine By JOSEPH W BIGGER, M D (Dublin), F.R.C.P.I., D P H., William Wood & Company, New York, 1925 Price, \$5 00
- DIABETIC DIET** A Handbook for Diabetics By A DORIS MCHENRY, B A., and MARJORIE M COOPER, B A Harper & Brothers, New York
- SELECTED MEDICAL PAPERS,** containing eighteen articles reprinted from the writings of Dr ALFRED WORCESTER, one article from the writings of Dr EDWARD R. CURLER, and four sketches by Mr RUSSELL T HYDE. The Four Seas Company, Boston 1925 Net, \$3 00
- AN INTRODUCTION TO PRACTICAL BACTERIOLOGY, AS APPLIED TO MEDICINE AND PUBLIC HEALTH** A Guide to Bacteriological Laboratory work for Students and Practitioners of Medicine. By T J MACHIE, M D, and J E. MCCARTNEY, M D William Wood & Company, New York. Price, \$3 50
- DISEASES OF THE RECTUM AND PELVIC COLON** By MARTIN L. BODKIN, M D, F.A.C.S., New York. Illustrated. Second Edition Revised and Enlarged E B Treat & Company, New York, 1925 Price, \$6.00
- THE TECHNIC OF LOCAL ANESTHESIA** By ARTHUR E. HERTZLER, A.M., M.D., Ph.D., LL.D. F.A.C.S. Third Edition. With 140 Illustrations The C. V Mosby Company, St. Louis, 1925 Price, \$5.50
- ON THE BREAST** By DUNCAN C. L. FITZWILLIAMS C.M.G., M.D., Ch.M., F.R.C.S., Ed and Eng C V Mosby Company, St. Louis, 1924 Price, \$10 00



# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL. 25, No 11

NEW YORK, N Y

MARCH 27, 1925

## DISEASES AND FATE OF TWINS \*

By ISAAC A ABT, M D,

CHICAGO, ILL.

IT is with the modern biological, rather than with an anthropological study of twins that the present paper is concerned Grassl<sup>1</sup> expresses the opinion that multiple pregnancies are neither atavistic nor the result of variation, but simply indicate an excess of the natural or usual fertility He attempts to confirm this opinion by his experience obtained by collecting hazel nuts for a period of thirty years When the season is favorable and the crop is unusually good, double ones occur with greater frequency than in those years when the productivity of the bushes is small He found the same true of dandelions In those seasons when dandelions are abundant, double flowers are of common occurrence.

It has also been maintained that climate, race, and the age of mother or father influence the birth of twins Bruder<sup>2</sup> found that twins from one ovum are usually born of women under twenty-five years of age, twins from two ova of women over twenty-five Primipara are more likely to have one ovum than two ovum twins In every age of development one ovum twins are weaker than those from two ova because obviously one placenta cannot sufficiently nourish two fetuses

Two kinds of twins are distinguished those that originate from a single ovum, and those that originate from two separate and distinct eggs Two ova escaping from an ovary at the same time may be fertilized and ultimately develop into two distinct fetuses in the uterus If the ova locate in close proximity, the two placentas fuse, but their circulatory mechanism does not If the two ova locate at a considerable distance from one another two distinct placentas are formed Where the twins originate from one ovum—so-called homologous or monochorionic or identical twins—it is assumed that two polar bodies must be extruded

The placenta in uni-oval twins is always sin-

gle. There are usually two cords, though occasionally there is only one which bifurcates near the body of the fetuses One egg twins are relatively rare Ahlfeld<sup>3</sup> found in 1,157 twin pregnancies only 15.55 per cent that were uni-oval While proof is lacking, nevertheless there are those who think that fecundity and a tendency to bear twins or triplets are inherited

It is also maintained that there are racial differences in the frequency of twin births For example, twin births occur more frequently in the Slavic, Hungarian, Finnic, and Germanic races It is said that twin pregnancies are rare among Latin races, and that they occur less commonly in Japan than in Europe In 1,339,975 births in the United States in 1917 there were 1 in 931 twins Statistics gathered from all parts of the world seem to indicate that on the average sixty-three per cent are of the same sex, thirty-seven per cent of the opposite sex

A Orgler<sup>4</sup> recorded some observations on twins from his examination of twenty-six pairs The weight was the same in only five pairs The difference in weight was more marked when the twins were of different sex They usually increased in weight at the same rate, though frequently one continued to be heavier than the other for a considerable time, unless one or the other fell ill He also observed that if both twins fell ill, one of them usually lost more markedly in weight than the other, and when they regained health, both increased in weight at the same rate, though the original disproportion continued for some time

In a number of cases the heavier child is more resistant and becomes less severely ill when attacked than the lighter one In a number of cases this does not hold Frequently there is a difference in the length of the children at birth While many of them seem to increase at the same rate, in a certain number the increase in length occurs at different rates, so that the one shorter at birth may reach the height of the longer one or even overtake him

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester April 23 1924

The average weight of twins is approximately equal to the weight of a single newborn. The average weight of uni-sexual twins was 3,960 grams, though the female pair weighed 840 grams less than the male. The average weight of the male pairs was 4,380 grams, of female pairs 3,540 grams, and the average weight of one twin was 1,980 grams, though there was a difference in the weight of the sexes. Thus, boys weighed on the average 2,190 grams, girls 1,770 grams.

Concerning the height of newborn twins, it may be noted according to the statistics of N. Miller<sup>5</sup> that the average length was 43 cm and that the girls averaged 3 cm less than the boys. The average height of boys was 45.5 cm, that of girls 41.5 cm. Newborn twins, especially those of the same sex, may be approximately of the same height and weight.

On the other hand, there may be great disparity in their weights, varying from 200 to 800 grams and, in extreme cases, even 1,000 grams. Differences in height are also noted. Sometimes one infant is 2.5 cm longer than his mate.

Differences in the development may be accounted for at times on a purely mechanical basis. In some instances the nutrition of the two fetuses is unequal. In one case the umbilical cord may be short and straight, in the other one, long and winding. It is evident that in the former the blood supply would be greater and the nutrition would be better. At other times, one placenta is located favorably on the uterine wall, and the other one is attached in an unfavorable position. The greater the respiratory surface of the placenta, the better the fetus develops. In other words, the larger the placenta the more closely it is approximated to the uterine decidua, and the more favorable are the conditions of the fetus.

Newman<sup>6</sup> states in his "Physiology of Twinning" that there is a popular impression that in human twins one is usually stronger and more vigorous than the other. Practical experience tends to bear out this impression. Even in identical twins, there is usually a more vigorous twin who is the dominant member of the combination. One twin tends to gain a physiological ascendancy over the other to the slight or very great detriment of the latter. Spaeth<sup>7</sup> found no evidence that the twins of either type had any definite physiological effect upon each other, though he grants as an evidence of inter-influence the condition of *situs inversus viscerum*. Newman<sup>6</sup> points out the disadvantages of twinning by saying that when two or more fetuses come to occupy the space usually filled by one, the twins, whether of the one egg or two egg type, crowd each other and compete for the common food supply. In the case of two egg twins, the competition is for placental surface.

The period of uterine gestation is at best a

hazardous one. In addition to those hazards that are met by single embryos and by two egg twins, there are certain very serious special dangers that fall upon one egg twins by reason of their close genetic relationship. One egg twin varies according to the period when the placenta is developed, and consequently one may receive more nutriment than the other. Moreover, on account of the difference in the blood supply to the two fetuses, one is more favored than the other, a condition which may even lead to the death of the less favored. Because of these variations in food supply and as a result of one fetus crowding upon the other, there is not only a disproportion in size and weight of the two infants, but malformation and conditions of arrested development may be noted in the weaker twin. Thus, one of the pair may be strong and healthy at birth, the other weak and delicate physically and defective mentally.

In my practice I have such an instance. The weaker one was extremely difficult to nourish, was very much retarded physically, and has remained defective mentally, while the other child developed rapidly and normally. The twins are now fifteen years old, the one a tall, bright, well-developed girl, while her sister is infantile in size and has attained no mental development. I recently saw a pair of male twins, three years old. One was bright, well grown, and his development was perfectly normal. The other weighed only twenty pounds at three years, teeth developed late, and his static development was markedly delayed. He was mentally much retarded and unable to talk. The normal twin's birth weight was six pounds, the other's three pounds. Instances of this kind must be very frequent.

Dentition may occur at different periods in the two infants, and this does not always depend on the severity of the rickets. In one pair that seemed free from rickets, the first dentition occurred at the seventh month, while the other infant developed his first teeth two months later. At ten months the first infant had eight teeth, while the other had only two. The difference between the eruption of teeth in the two babies may be as long as four months.

Francis Galton<sup>8</sup> made a study of twins from the biologic and genetic aspects, and hoped to be able to differentiate between the effects of tendencies received at birth and of those that were imposed by the special circumstances of their afterlives. He sent questionnaires to persons who were either twins or near relatives of them. He received eighty replies, thirty-five of which entered into instructive details. In a few of these not a single point of difference could be specified. The color of the hair and the eyes was almost always identical. In many instances the twins were of the same height, weight, and strength. In others there was a notable dif-

terence in these factors, though the resemblance was in other respects close

The manner and personal address of the thirty-five pairs were similar. The speaking voices of twins were usually the same, even where they sang in different keys. The handwriting was usually dissimilar, no matter how much the twins resembled each other. There is, however, one exception to this in Galton's series, where the handwriting was so similar that the two brothers could not distinguish their own lecture notes. In a number of Galton's collected cases, the twins suffered from some special ailment or had some exceptional peculiarity. Thus, several pairs showed peculiarities in their fingers, consisting of a slight congenital flexure of one of the joints of the little fingers. Another pair of twins had crooked little fingers. There were frequently close resemblance and correspondence in the falling of the hair. Several died of the same diseases. Very frequently both fell ill at the same time, not necessarily with contagious diseases. Thus, one parent writes to Galton "If anything ails one of them, identical symptoms nearly always appear in the other." Galton also points to the extreme resemblance and similarity in the ideas and associations of twins. They are inclined to make the same remarks on the same occasions, begin to sing the same songs at the same moment. One would commence a sentence and the other would finish it.

Galton found from his inquiry that while there were many points of resemblance in taste and ideas, there were certain differences which may be represented by the following groups of qualities. The one was vigorous, fearless, energetic, the other was gentle, clinging, timid. Or the one was more ardent, the other more calm and placid. Or again, the one was more independent, original, and self-contained, the other more hasty, generous, and vivacious. The difference was that of intensity rather than energy. It did not involve their fundamental characters. Ill health might depress the more vivacious. Galton says the difference was in the keynote, not in the melody. In the "Comedy of Errors" Shakespeare makes Dromio say, "Methinks you are my glass, and not my brother."

Twins may be dissimilar at birth and tend to become more alike on account of the close relationship in their lives.

Twins may present sharply contrasted characteristics in their physical, as well as in their mental, constitutions. The dissimilarity of twins is illustrated by the story of Esau and Jacob who, as it is recorded, differed even at birth. "The boys grew and Esau was a cunning hunter, dwelling in the fields, and Jacob was a plain man, dwelling in the tents." As they grew older, Esau became a hairy man and Jacob had a smooth skin. The dissimilarity at birth con-

tinues more or less throughout life, no matter how close the association or how similar the training.

Even joined twins may show striking dissimilarity. This is illustrated in the famous Hungarian joined twins, Judith and Helen. Judith was homely, nervous, hypochondriacal. Helen was pretty, healthy, with a happy disposition. Judith suffered frequently from neuralgia and convulsions, while Helen remained healthy except for an attack of pleurisy. Menstruation occurred at different periods.

The Siamese twins also showed dissimilarity in characteristics. They married at the age of thirty-two and between them had twenty-two children. Cheng was weaker and of an equable temperament, Eng was stronger, though inclined to be melancholy. The brothers often quarrelled. This occurred most often if one of them imbibed too freely. Finally Cheng developed hemiplegia which was followed by pneumonia of which he died. Eng witnessed the tragedy of his brother and asked to be released. The operation was performed at his request, and his death occurred two hours after the death of his brother.

Gesell<sup>9</sup> reports twins who showed superior intellect. They both sat up at six months, walked and talked at eleven months, learned French at three years, and were in the seventh grade at the age of nine. They resembled one another, both physically and mentally. In fact, there was no noteworthy distinction between the two. Their physique, countenance, demeanor, conversation were completely similar.

Homologous twins usually show marked similarity physically, as well as mentally. They resemble each other in weight, body structure, voice and gait. They may learn to speak and walk at the same time. Not rarely they show the same anomalies and faults of development. They may become sick at the same time and die almost at the same time.

Ganther and Rominger<sup>10</sup> studied the finger prints of five pairs of one ovum twins and forty-two pairs of two ovum twins. They found that in the five pairs of one ovum twins there was marked similarity in the finger prints, and in the system of lines of the hands. In the two ovum twins there is a certain similarity of structure, but never the striking correspondence of the system of lines. They conclude from their studies that a striking similarity of the structure of the lines of the hands indicates that the twins are uni-ovular. H. Wilder,<sup>11</sup> in *Science*, 1909, also concluded that finger and sole prints which are identical or nearly so, indicate single ovum twins.

Ahlfeld<sup>3</sup> collected seven cases of similar malformations in homologous twins. Others have observed patients in which both had pseudo-hermaphroditism. D'Outrepoint reports a case in which both twins had spina bifida. According to Siebold and Velpeau<sup>12</sup> both twins had six fin-

gers Lehmann<sup>12</sup> writes of twins with cerebral hernia and hypospadias

Miller<sup>5</sup> describes 247 pairs of twins of the same sex which he studied at the Moscow Findelhaus. He assumed that thirty were homologous. Twenty-three showed similar or analogous malformations. In five pairs the twins had hypertrophied umbilicus. Four had dolicocephalic skulls and four others congenital phimosis. Two had congenital depressions of the sternum. Two other pairs had marked shortness of the frenulum of the tongue.

Some of the twins showed anomalies occurring in both during the early days of life as a result of acquired disease. Thus, two boys had simple pemphigus. Two other male twins both developed mastitis on the left side, followed by erysipelas. They both recovered practically at the same time.

Brophy<sup>13</sup> quotes a paper by Albert D. Davis, of Omaha, on twins having congenital cleft lip and palate. In six twins one of each pair had cleft palate. Shearer<sup>14</sup> reported three cases of cleft palate in twins in one of which both girls had cleft palates. One had a cleft lip on the right side, the other on the left.

Among the rare conditions may be mentioned a case of congenital megacolon in one of twins. H. Goldstein and M. Schenck<sup>15</sup> contributed a description of an unusual case of dwarfism in twins. These were seven years old. The smaller one showed on examination that half of the body was uniformly smaller than the other side. The smaller child was mentally backward. Harrison<sup>16</sup> reported in the Virginia Medical Monthly, 1919, one of twins with congenital absence of the right femur.

The temperature of twins sometimes varies at birth. One infant may show two to three-tenths of a degree higher temperature than the other. As a general rule, well-developed twins have a slightly higher temperature than those who are weakly.

**Prematurity.** Twin pregnancy is a relatively frequent cause of premature birth. Ylppö's<sup>17</sup> series of prematurity showed that out of 688 cases, 19.2 per cent, or 128 cases, were twin babies.

The prematurely born, whether singly or in pairs, are predisposed to a variety of disorders. The susceptibility of prematures to rickets is a common observation. Huenekens<sup>18</sup> found that of seventy cases of premature twins, fifty-eight developed definite signs of rickets. He observed that the condition appeared sometimes before the fourth month of life. Craniotabes, an early symptom, may be present in the sixth week of life.

Other rachitic manifestations occur in premature twins as well as in prematures of single birth. Among the early symptoms may be mentioned rachitic rosary and rickets of the long cylindrical bones. In premature infants there is a deficiency of the calcium content as well as

of other mineral substances. By the third or fourth month, there is a lowered phosphorus and calcium content, and rickets and its sequelæ result.

Premature or underweight newborn twins frequently manifest the spasmophilic diathesis and tetany. Evidence of spasmophilia may be found in these infants even if they are born at full term.

An instance is cited where, in a pair of twins, the one developed laryngismus stridulus, facial phenomenon, and electrical over-excitability, giving all the symptoms of spasmophilia, while the other remained free from this disorder. It has also been observed that craniotabes may be present in one infant and absent in the other.

Langstein<sup>19</sup> reports a case of twins in whom convulsions always appeared when artificial food was used as a substitute or complement for breast feeding. It should be noted, however, that the twins did not develop the tetany at the same time. One pair developed spasmophilia within seven to twelve days after the administration of artificial food, the other eighteen to twenty days thereafter.

A pair of twin girls, nine weeks old, came into my service on the 19th of July, 1922. The first one had convulsions lasting three days. The other twin had convulsions which lasted a week. They both had marked craniotabes, Harrison's groove, slight rosary, and protuberant abdomen. The Chvostek sign, as well as carpopedal spasm, were present in both. Both were breast fed. Thus, it is evident that these nine weeks old infants had almost similar attacks of tetany with florid rickets.

In twins not prematurely born, rickets and spasmophilia in both children is a frequent occurrence and is commonly observed. Orgler<sup>4</sup> records in his series a case of rachitic twins where the degree of intensity was different. The one was severely affected, the other only moderately. He also recorded a case in which one child had developed scurvy, the other had not. Alfred Hess<sup>20</sup> says that twins have a special tendency to develop rickets, and this is partly due to a sub-normal quota of anti-rachitic constituents stored in their tissues and also to the variable susceptibility of infants to rickets.

**Anemia.** The anemias of prematures may be of a high degree and may be prolonged into the second and third year, though this condition may occur in children born at term.

A pathological anemia occurring in twins may affect one or both. The hemoglobin is usually low and the reduction may be observed during the first days of life. Occasionally one or both parents show marked debility or anemia. Charles Herrman<sup>21</sup> states that twins and single infants born prematurely come into the world with an imperfectly developed blood forming system and, if some injurious external agent affects the in-

tants, this latent inferiority soon manifests itself. He says that some of these infants show their anemia from birth, some not until later. Von Jaksch's pseudo-leukemic anemia may occur in one or both twins. Finkelstein<sup>22</sup> reports twins who developed a clinical type of pseudo-leukemic anemia after infections.

Chlorotic anemia has been described from Finkelstein's clinic by Kunkel as occurring in prematures and twins. Kunkel's investigations considered the blood changes in premature and feeble children. Among this group were seven pairs of twins, sixty prematures, seven feeble children. He found that most of them suffered from a chlorotic type of anemia characterized by oligosideremia and slight diminution of the cellular elements of the blood. Spleen and lymph nodes are not enlarged. This form of anemia occurs very early in life. This is particularly true of the prematures. Kunkel gives several instances where the twins were much below normal in weight and the anemia continued until one infant was four months old. At that time his hemoglobin was 43 per cent. When the children were taken out of doors, the condition improved, though at the sixth month the hemoglobin content had reached only 60 percent. Occasionally only one of the infants becomes anemic, though as a rule both are affected, but there may be a difference in degree. Senator reported a case of splenic leukemia which developed in twin sisters of eighteen months. Both died about the same time.

**Mental Affections.** Mongolian idiocy may occur in one or both twins, though in the majority of the cases only one of the pair is affected. Halbertsma<sup>23</sup> quotes sixteen instances where one of the twins was a mongol and two where both were mongols. His table is appended (Insert I).

The mental affections of twins do not differ

in form or in frequency from those of other individuals. A limited number of psychic disturbances have been reported which do not differ from those encountered in children of single birth.

Epilepsy of both children with mental deficiency is reported. A few cases of dementia precox have been recorded. Hydrocephalus occurred in a pair of twins. One was delivered by craniotomy, the other was born spontaneously. There was no syphilis or alcoholism in the parents. The father was by occupation a painter, but did not suffer from lead poisoning. The second infant died on the twelfth day.

Soukhanoff<sup>24</sup> made an analysis of thirty-three cases of insanity in twins in 1900. In some there were congenital mental defects, in one dementia precox, in one general paralysis. In most cases the twins uni-ovular, alike in appearance and mental character, and the form of insanity in each pair was the same.

Schütz and Ostermayer<sup>25</sup> state that the cause of psychosis lies in a high grade similarity in the structure of the brain, so that the psychic functions show a parallelism both physiologically and pathologically. Ostermayer collected fifteen cases from the literature. Duncan Campbell<sup>26</sup> found twenty-nine cases of insanity in twins. Among those described are maniac depressive insanity, melancholia, paranoia, dementia precox, imbecility, and idiocy. In several of the cases which he reported the twins were living in different cities, but the disease occurred at the same time and apparently in the same manner. Elmgier<sup>27</sup> believes that the psychoses in twins must be regarded in the same way as are psychoses in siblings. Mental deterioration is not peculiar to twins but merely indicates that they are of the same constitution and predisposed to

#### CASES OF MONGOLISM IN ONE OF TWINS

No	Author	Sex of Twins	Type of Twin
1	Fraser ( <i>J Ment Sc</i> , 1877)	The mongol was one of twins	Unknown
2	Hultgren ( <i>Nord med Ark</i> , 1915)	Mongol boy, normal girl	Two egg
3	Neumann ( <i>Berl klin Woch</i> , 1899)	Mongol boy, normal girl	Two egg
4	Cassel ( <i>Berl klin Woch</i> , Vol LIV, p 159, 1917)	Mongol boy, normal girl	Two egg
5	Cassel ( <i>ibid</i> )	Mongol boy, normal girl	Two egg
6	Shuttleworth ( <i>Brit M J</i> Vol. II, p 661, 1909)	Mongol girl, normal boy	Two egg
7	Comby ( <i>Arch d med d enf</i> , 1917, Vol. XX, p 505)	Mongol girl, normal boy	Two egg
8	Weigall (quoted by Comby)		Two egg
9	Swanberg-Haynes ( <i>Arch Neurol and Psych</i> , Vol I p 717, 1919)		Unknown
10	McClean ( <i>J A M A</i> , 1922)	Mongol boy, normal girl	Two egg
11	Halbertsma	Mongol boy, normal girl	Two egg
12	Halbertsma	Mongol girl, normal girl	Two egg
13	Halbertsma	Mongol boy, normal girl	Two egg
14	Halbertsma	Mongol boy, normal girl	Two egg
15	Halbertsma	Mongol boy, ?	Two egg
16	Clay ( <i>Arch of Pediat</i> Nov 1922)	Mongol boy, normal boy	Unknown

#### CASES OF MONGOLISM IN BOTH TWINS

No	Author	Sex of Twins	Type of Twin
1	Hjorth (quoted by Shuttleworth)	Same sex	One egg (?)
2	De Bruin ( <i>Nederlandsch Tijdschr v Geneesk</i> 1902)	Two mongol boys	One egg (?)

gers Lehmann<sup>12</sup> writes of twins with cerebral hernia and hypospadias

Miller<sup>5</sup> describes 247 pairs of twins of the same sex which he studied at the Moscow Findelhaus. He assumed that thirty were homologous. Twenty-three showed similar or analogous malformations. In five pairs the twins had hypertrophic umbilicus. Four had dolicocephalic skulls and four others congenital phimosis. Two had congenital depressions of the sternum. Two other pairs had marked shortness of the frenulum of the tongue.

Some of the twins showed anomalies occurring in both during the early days of life as a result of acquired disease. Thus, two boys had simple pemphigus. Two other male twins both developed mastitis on the left side, followed by erysipelas. They both recovered practically at the same time.

Brophy<sup>13</sup> quotes a paper by Albert D. Davis, of Omaha, on twins having congenital cleft lip and palate. In six twins one of each pair had cleft palate. Shearer<sup>14</sup> reported three cases of cleft palate in twins in one of which both girls had cleft palates. One had a cleft lip on the right side, the other on the left.

Among the rare conditions may be mentioned a case of congenital megacolon in one of twins H. Goldstein and M. Schenck<sup>15</sup> contributed a description of an unusual case of dwarfism in twins. These were seven years old. The smaller one showed on examination that half of the body was uniformly smaller than the other side. The smaller child was mentally backward. Harrison<sup>16</sup> reported in the Virginia Medical Monthly, 1919, one of twins with congenital absence of the right femur.

The temperature of twins sometimes varies at birth. One infant may show two to three-tenths of a degree higher temperature than the other. As a general rule, well-developed twins have a slightly higher temperature than those who are weakly.

**Prematurity.** Twin pregnancy is a relatively frequent cause of premature birth. Ylppö's<sup>17</sup> series of prematurity showed that out of 688 cases, 19.2 per cent, or 128 cases, were twin babies.

The prematurely born, whether singly or in pairs, are predisposed to a variety of disorders. The susceptibility of prematures to rickets is a common observation. Huenekens<sup>18</sup> found that of seventy cases of premature twins, fifty-eight developed definite signs of rickets. He observed that the condition appeared sometimes before the fourth month of life. Craniotabes, an early symptom, may be present in the sixth week of life.

Other rachitic manifestations occur in premature twins as well as in prematures of single birth. Among the early symptoms may be mentioned rachitic rosary and rickets of the long cylindrical bones. In premature infants there is a deficiency of the calcium content as well as

of other mineral substances. By the third or fourth month, there is a lowered phosphorus and calcium content, and rickets and its sequelae result.

Premature or underweight newborn twins frequently manifest the spasmophilic diathesis and tetany. Evidence of spasmophilia may be found in these infants even if they are born at full term.

An instance is cited where, in a pair of twins, the one developed laryngismus stridulus, facial phenomenon, and electrical over-excitability, giving all the symptoms of spasmophilia, while the other remained free from this disorder. It has also been observed that craniotabes may be present in one infant and absent in the other.

Langstein<sup>19</sup> reports a case of twins in whom convulsions always appeared when artificial food was used as a substitute or complement for breast feeding. It should be noted, however, that the twins did not develop the tetany at the same time. One pair developed spasmophilia within seven to twelve days after the administration of artificial food, the other eighteen to twenty days thereafter.

A pair of twin girls, nine weeks old, came into my service on the 19th of July, 1922. The first one had convulsions lasting three days. The other twin had convulsions which lasted a week. They both had marked craniotabes, Harrison's groove, slight rosary, and protuberant abdomen. The Chvostek sign, as well as carpopedal spasm, were present in both. Both were breast fed. Thus, it is evident that these nine weeks old infants had almost similar attacks of tetany with florid rickets.

In twins not prematurely born, rickets and spasmophilia in both children is a frequent occurrence and is commonly observed. Orgler<sup>4</sup> records in his series a case of rachitic twins where the degree of intensity was different. The one was severely affected, the other only moderately. He also recorded a case in which one child had developed scurvy, the other had not. Alfred Hess<sup>20</sup> says that twins have a special tendency to develop rickets, and this is partly due to a sub-normal quota of anti-rachitic constituents stored in their tissues and also to the variable susceptibility of infants to rickets.

**Anemia.** The anemias of prematures may be of a high degree and may be prolonged into the second and third year, though this condition may occur in children born at term.

A pathological anemia occurring in twins may affect one or both. The hemoglobin is usually low and the reduction may be observed during the first days of life. Occasionally one or both parents show marked debility or anemia. Charles Herrman<sup>21</sup> states that twins and single infants born prematurely come into the world with an imperfectly developed blood forming system and, if some injurious external agent affects the in-

pemphigus, eczema and the so-called exudative diathesis are not infrequently recorded, but differ in no way from the same affections when they occur in other children. There is recorded a case of eczema in one twin, while the other was free from the affection, at least during the time when they were both examined. Kretschmer<sup>26</sup> reports twin girls, fourteen years of age, who entered the hospital at the same time, both of whom showed renal tuberculosis. Worcester<sup>27</sup> reported phthisis occurring at the same time in both children.

**Mortality.** Twins in general are characterized by low vitality. The death rate is much greater than in single newborns. In the first weeks after birth the mortality is forty per cent. It is generally stated that twins have thirteen times less chance to live than ordinary newborn babies. In the report of Miller's<sup>5</sup> cases at the Moscow infant Asylum 3,883 pairs of twins were observed among 277,902 children. 62.9 per cent of these died during the first weeks of life. In half of the cases, both twins died on the same day. In the remainder, the one lived one or two days longer. Septicemia and syphilis were frequent causes of death. The greatest mortality of those infants who survived the first few weeks of life seems to concentrate in the first and second year. After the fifth year of life, the mortality of twins and non-twins is about the same.

It has been estimated that out of a hundred pairs of twins born there are eighty pairs who survive. In fifteen pairs, only one child survives, in five pairs both children die. According to Hecker,<sup>28</sup> fifteen per cent die during the first eight days. It has also been said that twin girls seem to have greater viability than twin boys.

Since Galton's memorable studies no investigation has been conducted on the pathological aspect of twins. The *British Medical Journal* of 1912 contained a very interesting and suggestive editorial on twinship and fame. The editorial was suggested by the remarks of Doctor Kaiser, of Dresden, who stated that he knew of no famous man who had a twin brother. A similar query had been raised by Doctor Simpson in the *Edinburgh Medical Journal* of 1862. Simpson was not aware of a single instance in which a twin had distinguished himself intellectually. The editorial writer takes issue with these two gentlemen and goes on to show that there were several twin brothers who had won more or less fame. In attempting to collect information on this subject, it was found that no records of morbidity or mortality in twins were available.

It is to be regretted that there are not more data at hand concerning the development, physical and mental of twins during their later lives. To make such data available, it would be important for obstetricians to record in every instance whether the twins originated from one or two eggs, which information should also be

supplied to the families. Parents, physicians, teachers should be able to furnish significant information. Twins themselves or their friends might in some instances contribute important biographical sketches, and life insurance companies and bureaus of vital statistics should furnish details about the causes of death. Information of this kind would be of great interest, if not of practical value, to a great number of people. Knowledge of such facts would constitute a noteworthy contribution to medical science.

## BIBLIOGRAPHY

- 1 Grassl. Die Mehrlingsgeburten insbesondere in Bayern. *Friedreich's Blätter f. Gerichtl. Medizin*, 1908, Vol. LIX, pp 280-366.
- 2 Bruder, R. *Beitrag zur Lehre von den Zwillingen*, Gießen, 1903.
- 3 Ahlfeld. Quoted in Lubarsch and Ostertag. *Ergebnisse der allgemeinen Pathologie des Menschen u. der Tiere*, Vol. XV, 2, pp 85 ff.
- 4 Orgler, A. *Beobachtungen an Zwillingen*, 1910, Vol. IX, pp 170-180, 1914. Vol. XII, pp 490-501, *Monatsschr. f. Kinderk.*, 1923, Vol. XXV, pp 500-508.
- 5 Miller, N. *Über homologe Zwillinge. Jahrbuch f. Kinderheilkunde*, 1893, Vol. XXXVI, pp 333-343.
- 6 Newman, H. H. *The Physiology of Twinning*. University of Chicago Press, Chicago, 1923.
- 7 Spaeth, J. *Zeitschrift d. Gesell. d. Aerzte zu Wien* 1860, Nos 15 and 16.
- 8 Galton, F. *Inquiries into Human Faculty and Its Development*. London, 1883, p 216.
- 9 Galton, F. *The History of Twins as a Criterion of the Relative Powers of Nature to Nurture. Popular Science Monthly*, Vol. VIII, pp 345-357.
- 10 Gesell, A. *Antenatal and Physical Correspondence in Twins. Scientific Monthly*, 1922, Vol. XIV, pp 305-331, 415-428.
- 11 Ganther, R., and Rominger, E. *Über die Bedeutung des Handleistenbildes für die Zwillingsforschung. Ztschr. f. Kinderheilkunde*, 1923, Vol. XXXVI, pp 212-220.
- 12 Wilder, H. *Physical Identity in Duplicate Twins. Science*, 1908, Vol. XXVII, pp 451-452.
- 13 Lehmann. Quoted in Wilder.
- 14 Brophy, T. W. *Cleft Lip and Palate*. Blakiston, Philadelphia, 1923.
- 15 Shearer. Quoted by Brophy.
- 16 Goldstein, H., and Schenck, M. *An Unusual Case of Dwarfism in Twins. N. Y. Med. Jour.*, 1920, Vol. III, pp 98-100.
- 17 Harrison, V. *Uniovular Twin with Congenital Absence of the Right Femur. Virginia Med. Monthly*, 1919, Vol. XLVI, pp 54 ff.
- 18 Ylppö. Quoted in Hess, J. H. *Premature and Congenitally Diseased Infants*, Philadelphia, 1922.
- 19 Huenekens, E. J. *Lancet*, 1917, Vol. XXXVII, pp 804.
- 20 Langstein, L. *Kasuistischer Beitrag zur Kenntnis der rachitischen u. spasmophilen Veranlagung. Kassowitz Festschrift*, 1912, pp 181-187.
- 21 Hess, A. In *Abt's System of Pediatrics*, Vol. II.
- 22 Herrman, C. *The Anemias of Infancy. Arch. of P. diat.*, June, 1923.
- 23 Finkelstein, H. *Lehrbuch d. Säuglingskrankheiten*. Berlin, 1921.
- 24 Halbertsma, T. *Mongolism in One of Twins. Amer. Jour. Dis. Child.*, May, 1923.
- 25 Soukhanoff, S. *Ann. Med. Psychol.*, 1900, Vol. XII Ser. 1, p 214.
- 26 Schütz and Ostermayer. Quoted by Lubarsch and Ostertag.
- 27 Campbell, D. *Zwillingsirreseum u. induziertes Irreseum. Inaug. Diss.*, Leipzig, 1902.

the same hereditary disorders. Migraine has been observed in both twins.

J. H. Hess<sup>28</sup> reports Friedreich's ataxia in twin brothers, age ten years. This condition followed an acute infectious disease when they were eight years. The affection had been progressive in both boys, the one showing less involvement than the other. Family history was negative. The disorders from which these boys suffered consisted of a mask-like face, tremor of the tongue, scoliosis, poor muscular development, awkward, staggering gait, slow, scanning speech, defective memory. The Romberg and Babinski signs were positive. One year later the defective gait was more pronounced. Horizontal nystagmus was present. The arches of the feet were very high. The author makes some reservation about the diagnosis, and considers the possibility of a post-infectious encephalitis, as well as that of a multiple sclerosis.

**Infections.** According to Orgler's observations, the behavior of twins towards infectious and nutritional disturbances was not always the same in both. One twin became ill with bronchitis, while the other developed whooping cough. The first recovered in two weeks, while the latter remained ill for two months.

They often reacted differently to infectious diseases. One twin died of generalized military tuberculosis, while his mate developed tubercles and a strongly positive Pirquet reaction and the disease ran a more protracted course. In those instances where one twin developed rickets or exudative diathesis, the other had it also, though the intensity of the manifestations was frequently variable, the disease being intense in one child, mild in the other.

There is also recorded a case of single ovum twins who seemed to be similar physically and mentally, but who showed some difference in their resistance to infection. Whether this difference in resistance is peculiar to one ovum twins cannot be definitely stated. It may be assumed that there has been an unequal division of the germ plasma in the uniovular variety which might account for the variable behavior to infection.

Three sets of double ovum twins, observed by Orgler, showed uniform behavior to infection. However, in the case of twins of opposite sex who were admitted to the hospital at the age of five weeks and remained there for a considerable length of time, the boy, at the age of six months, developed measles, while the girl remained free from the disease, notwithstanding the fact that they occupied adjoining cribs.

Ballantyne<sup>29</sup> in his "Antenatal Pathology" records a case where both twins acquired variola from their mother. In another case, one was affected while the other escaped. In a third, both fetuses exhibited the eruption. One presented many pustules, while the other had only a few.

During infancy and early childhood twins, like other siblings, develop almost simultaneously intestinal upsets, grippal infections, measles, mumps, chicken pox, scarlet fever, and other infections.

**Syphilis.** Where one or both parents are syphilitic, the twins, as a rule, suffer the same fate as does the fetus in a single pregnancy. There are cases recorded, however, where one of the twins presents evidence of manifest lues while the other seems to remain immune. Grete Singer<sup>30</sup> reports twins, a girl and a boy, one of whom was clinically and serologically luetic, the other normal. The non-infected infant showed negative Wassermann reactions during a period of two years. Finger<sup>31</sup> reports cases of dissimilar severity of syphilis in twins, i. e., one was more severely affected than the other. There are numerous corroborative reports in the literature, in which one case was syphilitic, the other healthy. Rosinski<sup>32</sup> reported syphilis in twins. The boys showed severe symptoms of hereditary lues. The girl, who was observed for twenty-four years, remained entirely free from the disease. No satisfactory explanation can be found for this inequality in the distribution of the disease. Why one child should be infected and the other remain free is difficult to conceive. It has been suggested, however, that the difference in the severity of the disease is due to different modes of infection. It is thought that this is more probable than that there is a difference of immunity in the two fetuses.

**Miscellaneous Diseases.** In Ballantyne's<sup>29</sup> "Antenatal Pathology and Hygiene" a case of Stocker is quoted. A woman had eleven children, including one set of triplets and two sets of twins. The twins under consideration were female, one of whom was a giant infant. She menstruated at three years of age, and when eight had the appearance of a girl of twelve, measuring 139 cm in height and having well-developed genitals and mammae. The other girl developed normally.

Sclerema neonatorum may occur in one or both twins. Northrup<sup>33</sup> reports sclerema in one such. Carminati<sup>34</sup> states that the disease is especially common. Ichthyosis may be a familial disease, attacking several children of the same family. Ballantyne reports a woman who gave birth to twins, one of whom suffered from ichthyosis. There are a few cases recorded in Tarnier Budin's<sup>35</sup> textbook of midwifery in which one of the twins suffered from general dropsy. One fetus was affected with general dropsy. There were two distinct amniotic sacs. The membrane of the edematous fetus were infiltrated with serum. In every case the dropsical fetus was still born, while the other twin was viable and unaffected by this disorder. Galton<sup>8</sup> reports a case in which both grown-up twins developed Bright's disease at the same time. Cases of



Basler Frauenhospitals für d. Zeit v 1896-1910, Basel, 1913

Thomas, N W Twins in the Yoruba Country, London, 1921, Vol XXI, p 140

Prinzling, F Die örtlichen Verschiedenheiten der Zwillingshäufigkeit u. deren Ursachen, Ztschr f Geburtshk. u Gynäk., 1907, Vol. LX, pp 420-436.

Strassmann, P Die Mehrfache Schwangerschaft,

in F v Winkel's *Handbuch d Geburtshilfe*, 1904, Vol I, p 741

Bertillon La gemellite selon l'âge de la mère et le rang chronologique de l'accouchement.

Weinberg, W Beiträge zur Physiologie u. Pathologie der Mehrlingsgeburten beim Menschen. *Arch f d ges Phys*, 1901, Vol. LXXXVIII, p 392

## FOOT STRAIN \*

By SAMUEL W BOORSTEIN, M D, F A C S,

NEW YORK CITY

IN selecting a topic for this gathering none appealed to me so much as "Foot Strain," since almost every civilized person, and especially the city dweller, is subject to this affliction. Hence, this is a more or less vital topic to everyone. The medical men of your organization have to know more about foot disturbance than formerly, as their patients demand more information. Even if they do not attempt to treat them themselves, they must be able to answer the questions they are so often pried with.

You dentists and pharmacists, having to stand on your feet a great deal, ought certainly to be interested in this topic. The Northern Dental Society considered this topic sufficiently important to invite me to read before them a paper which was afterwards published in their journal under the title "The Efficiency of the Dentist as Affected by Weak Feet."

The members of the legal profession feel the effect of foot strain and transmit it to their work.

Not only you, yourselves, but almost every member of your family, including the children, suffer from such afflictions.

This affection is so widespread that during the recent war many men had to be rejected from the army on account of their weak feet. This number was so great that at the second draft they had to be accepted, and afterwards constituted one of the greatest problems for the orthopedic surgeons. Special squads were instituted, but the problem was never solved.

Medical literature on the topic is voluminous. The shoe stores with their expert advertisers have spread both proper and improper information in attempts to interest the public in their particular shoe. It is no exaggeration to say that 60 to 70 per cent of the urban population is suffering from some foot trouble, and about 60 per cent of those consulting the orthopedic surgeon are afflicted with "Foot Strain," and not with rheumatism as they themselves imagine.\* So much

has been written about shoes and plates as to cause a great confusion and leave one at a loss as to which procedure to follow. I will here attempt to bring some order out of this chaos, by giving you a more definite idea about normal and abnormal feet, foot strain, and shoe wear.

### ANATOMICAL CONSIDERATION

I will take just a few minutes to give a short resume of the anatomy and function of the foot.

Mechanically, the foot is an elastic arched structure, bearing the body weight, and it articulates with the bones of the leg at about the posterior third of the foot. The functions of the foot are (1) weight bearing, and (2) propulsion. It must be remembered that in standing as well as walking or running, the entire weight of the body is transmitted to the ground by way of the astragalus, which is the only foot bone in contact with the leg bones.

*The Arches*—The foot has two arches, the longitudinal, and the transverse or anterior arch. The longitudinal arch or instep forms a half dome, and when the two feet are placed close to each other they form a dome, not circular, but elliptical in shape. The dome formed by the two feet rests on the ground all around the edge from the heel of one foot round the outer border of the foot along the toes and back along the outer border of the other foot to the heel. Considering one foot by itself, the weight of the body rests upon a half dome touching the ground on its outer border. It is stable if the body weight is so balanced that it rests on its outer edge, but if the body weight falls too near the inner side of the half dome there is a tendency for it to capsize inward.

The two arches should be considered as an integral part of one structure and an affection of the longitudinal arch is associated with a disturbance of the transverse arch.

*Improper Posture*—One means of making the leverage function difficult is the custom of turning the feet outward. In this position the strain falls too much upon the inner border of the foot.

In proper walk the feet should be held practically parallel to one another, so that the line of weight passing downward through the center of

\*Read before the Westchester Professional Men's Club November 12 1924

†To be exact I like to quote my statistics. (1) Fordham Clinic for a period of ten years—26% of the new admissions consulted for foot strain. (2) In private practice for the same period—30%. (3) Bellevue Clinic in the last year—48%. (4) Union Health Center for the last three years—85%. The reason why the per cent is so low in Fordham Hospital is because there are many children admitted.

- 27 Elmiger Beiträge zum Irresein bei Zwillingen *Psychiatr neurol Wochenschr* 1910, Nos 8 and 9
- 28 Hess, J H Friedrich's Ataxia in Twin Boys *Mod Clin N Am* 1922, Vol VI, 1749-1755
- 29 Ballantyne, J H. *Intenatal Pathology and Hygiene*, Wood & Co, New York, 1902
- 30 Singer, Grete Bericht über einen luetischen u einen nicht luetischen Zwilling *Arch f Kinderhk*, 1919, Vol LXVII, p 362
- 31 Finger *Handbuch d Geschlechtskrankheiten*, 1916
- 32 Rosinsky Quoted by Finger
- 33 Northrup, W P Sclerema Neonatorum *Arch of Pediat*, 1890, Vol VII, p 1
- 34 Carminati, Sullo indurimento cellulare nei neonati, 1822 *Annali Univer di Med*, Vol XXVIII, 1823
- 35 Budin and Tarnier Quoted by J W Ballantyne Diseases and Deformities of the Fetus Edinburgh, 1892, Vol I, p 104
- 36 Kretschmer, H L Renal Tuberculosis in Twins *Annals Surg*, 1921, Vol LXXIII, pp 65-71
- 37 Worcester, W L. *Amer Jour Insan*, 1890-1891, Vol XLVII, p 535
- 38 Hecker Quoted in Meyer's Konversationslexikon
- 39 Senator Quoted by Finkelstein
- Lauritzen, Ugeskr f Läger, 4, R, Vol XXVI, 6 S, 77
- Macnaughton, W A The Longevity of Twins *Caled Med Jour*, 1914, Vol X, pp 127-129
- Westergaard, H Die Sterblichkeit der Zwillinge. *Ugeskr f Lager*, 1892, HR. XXVI, p 3 *Abt in Jahrb f Kinderhk*, 1893, Vol XXXV, p 355
- Winckel *Handbuch der Geburtshilfe*, Wiesbaden, 1904
- Kidd, L J The Prolificity of Opposite Twins *Lancet*, 1916, Vol II, 776
- Hartog, E Ungewöhnliche Entwicklungsdifferenzen v Zwillingen *Münch med Wochenschr*, 1907, Vol LIV, p 1787
- Taylor, J L Diseases of Twins *Lancet*, 1907, Vol CLXXIII, p 1496
- Harrison, S G Living Child and Dead Fetus *Brit Med Jour*, Vol I, p 252
- Bruce, R Living Child and Dead Fetus *Brit Med Jour*, 1911, Vol I, p 1313
- Riviere, M, and Drouin, M Double hydrocephale dans une grossesse gémellaire. *Gaz hebdo des sciences med*, 1910, Vol 342-344
- Ziehen, T, in Bruns, Kramer and Ziehen *Handbuch f Nervenkrankheiten im Kindesalter*, 1912, p 824
- Popper, J Congenital Megacolon *N Y Med Jour*, 1920, Vol CXII, pp 1030-1031
- Mulward, F V Non-Development of the Lower Extremities in Twins *Brit Jour Dis Child*, 1908, Vol V, pp 479-481
- Burkard, H Tumors in Twins *Deutsche Ztschr f Chir*, 1922, Vol CLXIX, p 166
- V Reuss *Krankheiten des Neugeborenen*, Berlin, 1914, p 129
- Clay, H T Mongolian Idiocy Occurring in One of Twins *Arch of Pediat*, Nov 1922, p 726
- Jett, R L Nutrition of Twins and Triplets *Ohio Med Jour*, 1910, Vol VI, p 597
- Gallo, C Syphilis and Twin Pregnancy *Pediatrics* 1923, Vol XXXI, p 599 *Ab Jour A M A*, Nov 2, 1923
- Thoenes, F Lues Congenita and Zwillingsschwangerschaft *Deutsche Med Wochenschr*, 1922, Vols II, XLVIII, pp 1386-1387
- Cockayne, E A Disease in Homogeneous Twins *Brit Jour Dis Child*, 1911, Vol VIII, pp 487-491
- Frantz, M H Dementia Praecox in Twins *Jour Nerv und Ment Dis*, 1919, Vol L, pp 325-530
- Imbecillité gemellaire. *Arch de neurol*, 1909, Vols I-II, pp 8-12
- Toledo, R M Notes on Two Cases of Epilepsy in Twins *Jour Ment Sci*, 1919, Vol LXV, p 262
- Wakley, Th Influence of Inheritance on the Tendency to Have Twins *Lancet*, 1895, Vol II, p 1289
- Cory, R Influence of Inheritance on the Tendency to Have Twins *Lancet*, 1895, Vol II, p 1105
- Macphail, D Influence of Inheritance on Tendency to Have Twins *Lancet*, 1895, Vol II, p 1429
- Fisher, R A New Data on the Genesis of Twins. *Lugens Review*, 1922, Vol XIV, pp 115-117
- Danforth, C H Is Twinning Hereditary? *Jour Hered*, 1916, Vol VII, pp 195-202
- Dayenport, C H The Origin of Twins Editorial, *Sci Am Monthly*, 1920-1921, Vol II, p 364
- V Grabe, E Über Zwillingsgewürten als Degenerationszeichen *Arch v Psych u Nerven*, 1921-1922, Vols LXIV-LXV, pp 79-86
- Smith, P Psychoses Occurring in Twins *New York Med Jour*, 1912, Vol XCVI, pp 1268-1272
- Newman, H H Developmental Hazards of Human Twins Univ of Chicago Press, 1913
- Zwillinge. Meyer's Konversationslexikon
- Twins Eulenburg's Realenzyklopädie
- Twinship and Fame. Editorial *Brit Med Jour*, 1912, Vol II, p 655
- Twins and Their Burdens Editorial *Scribner's*, 1919, Vol LXVI, p 590
- Evans, P H Mortality by Order of Birth *Trans of the Actuarial Soc of Am*, 1918, Vols XIX, I, p 59
- Samaja, N Pituitary Anomalies in Twins *Chirurpi degli Organi di Movimento*, Bologna, Dec. 1921, Vol V, p 1090 *Ab Jour A M A*, 1922, 18, Vol I, p 765
- Zeleny, C Relative Numbers of Twins and Triplets *Science*, 1921, Vol LIII, p 262
- Rohr, F Einenge Zwillinge. *Ztschr f Kinderhk*, 1920, Vol XXVI, pp 304-306
- McLean, P Mongolian Idiocy in One of Twins *Jour A M A*, Jan 7, 1922
- Wimberger, H Einenge Zwillinge. *Ztschr f Kinderhk*, 1921, Vol XXXI, pp 216-225
- Moser, J M Case of Rickets in One of Breastfed Twins *Wash Med Annals*, 1917, Vol XV, pp 175-177
- Halbertsma, T Comparative Therapeutics in Twins *Jour A M A*, 1922, Vols LXXVIII, I, p 118
- Anemia in Twins *Nederlandsch. tijd v geneeskunden*, Oct. 8, 1921, Vol II p 1837
- Plauchu and Devin Les premature jumeaux. *Lyon Medical*, 1911, Vol CXVI, pp 67-72
- Thorndike, E L The Resemblance of Young Twins in Handwriting *Am Naturalist*, 1915, Vol XLIX, pp 377-379
- Jaschke, Th Physiologie, Pflege u. Ernährung des Neugeborenen, Wiesbaden, 1917, p 381
- Schiff, F Über das serologische Verhalten eines Paares einenger Zwillinge *Berlin klin Wochenschr* 1914, Vol LI, pp 1405-1407
- Kowalski Entwicklungsdifferenzen bei Zwillingen *Monatschr f Geburtshk u Gynäk*, 1913, Vol CXXXVII, pp 389-381
- Weiss, J Das Kind, Berlin, 1923
- Groszmann, M P E Twins and the Problem of Heredity *New York Med Jour*, 1922, Vol CXV, pp 284-287
- Oliver, J Hereditary Tendency Toward Twin-Bearing and the Influences Aiding in the Determination of Sex. *Lancet*, 1911, Vol CLXXXI, pp 496-497
- Martin Zwillingsschwangerschaft mit einer luetischen Frucht. *Berl klin Wochenschr*, 1908, Vol XLV, p 1821
- Apert, E Les jumeaux, etude biologique et pathologique *Rec de med vet*, 1920, Vol XLVI, pp 158-168
- Rabinowitsch Chatzkel Über Zwillingsgewürten des

tributing factor to foot strain and clawed toes \*  
(We will discuss shoes in more detail later on )

### DIRECT CAUSES

1 Change of occupation requiring longer hours than the patient was previously accustomed to, especially prevalent in cases where a change from inactive to active life takes place. This is very commonly seen among the young girls who take up nursing following their college training. The sudden change from sedentary occupations to standing on the tile floors in the hospitals causes severe foot strain so that during their probationary period they are often forced to consult the orthopedic surgeon. In some hospitals the orthopedic surgeons have instituted the custom of examining the feet of the nurse candidate. Those found having weak feet are dissuaded from taking up nursing. Others who are on the border line are watched during the probationary period and have corrective exercises ordered regularly. If their feet become worse they are not accepted for nursing.

I have been connected for more than ten years with Fordham Hospital and have had a chance to watch the change of occupation from a different view point. Fordham Hospital has no training school for nurses, but gets its nurses through affiliations with other hospitals. Naturally it gets the force from small hospitals that lack the facilities offered by larger institutions. Every time a new batch of nurses comes, at least 25 per cent of them are referred to me as patients within the first month. They invariably suffer from foot strain due to the change to tile floors and more strenuous work.

2 Overuse of the feet in standing and walking. This is especially true in the case of men engaged in sedentary occupations throughout the week and who indulge in long walks on Saturday and Sunday. The foot should be gradually accustomed to exercises. The same condition is seen in naturally athletic young men and women, who, due to their occupation, have acquired sedentary habits, but who play indoor tennis or basket ball on hardwood or cement floors once or twice a week in soft soled shoes.

3 General weakness following an illness or after child birth. To emphasize the causes of flat feet, I recapitulate some of my previous statements. The disability of weak feet is due to a disproportion between the strength of the foot and the weight and strain to which it is subjected. The most constant predisposing cause is the direct injury caused by improper shoes, occupation requiring long hours or standing or

walking, excessive weight and diminution of muscular and ligamentous strength. The direct causes are sudden change of occupation or overuse of the feet on days of rest.

### SYMPTOMS

In general one must remember that a normally high arch beginning to suffer strain, is vastly more painful and more troublesome than an arch in reality much lower but normal for that individual. A high arch is slightly less enduring than any other form of foot—hence one not acquainted with these conditions will neglect to treat the high arch till the ailment is advanced. Abducted and everted foot, and the foot with a notably short tendo-achillis are probably more liable to painful strain under unfavorable conditions than are the other types.

1 Initial symptoms of foot strain usually noticed are that the feet become hot and uncomfortable, burn after use, and perspire more than before.

2 *Weakness and Strains*—The earliest symptom, if patient can recollect, is usually a sensation of weakness, of fatigue and strain about the inner side of the foot and ankle. Sometimes after long standing a dull ache in the calf of the leg, or pain at the knee, hip or the lumbar region (symptoms more common in women than men). Sometimes these symptoms are traced to a certain overexertion, such as a long walk, and thus the victim ascribes the origin of the ailment to such an occurrence. Later on, the patient becomes aware of the fact that he is accommodating his habits to his feet, he rides when he once walked, he sits when he once stood, he no longer runs up or down stairs or jumps off the street car. His feet have lost their spring. The feet stiffen on sitting, and are most uncomfortable on getting up in the morning and at the close of the days work.

3 *Pain*—In the beginning there is discomfort only after standing or walking. Actual pain is felt only when the foot is in use and stops under temporary rest, thus the patient suffers more when he begins to walk after having rested awhile or after rising in the morning. (It is this remittance of symptoms, together with the fact that the discomfort is usually more marked in damp weather that leads so often to the mistaken diagnosis of rheumatism.) In severe cases the pain is continuous.

Pain in the leg, knee, hip or back is frequently complained of. The pain occurring in such a remote region is, due to static disturbances in the flat foot. The pain occurring not directly in the foot, is the stumbling block of the physician. The patient cannot be convinced that the pain in the hip is due to the weak feet and not to rheumatism, sciatica or lumbago, as he had previously been told. Pain is usually found below

\* In some cases where the heel cord is contracted as the result of years of bad shoeing the orthopedist is occasionally compelled to permit a medium sized heel as a low heel will make the patient quite uncomfortable because at every step a special strain is put on the calf muscle, and when the muscle is short and reaches its limit of extensibility the necessary strain in finishing the step must come on the sole of the foot.

the knee and ankle joints, is continued over the second toe

*Art of Walking*—At first one bears the weight momentarily on the heel, then upon its outer border, the heel is then raised and the weight is put on the toes, which have to spread and assist in maintaining equilibrium. The body is then lifted over the tips of the toes. The big toe gives the final push which sends the body further forward.

The movements of the foot are dorsal flexion (bending towards the body) and plantar flexion (bending away from the body), eversion (turning outward), and inversion (turning inward).

*Range of Motion*—Dorsal flexion is ten to twenty degrees less than a right angle. Plantar flexion is fifty to sixty degrees more than right angle. With the knee extended and passive dorsal flexion attempted, the limit of 20 degrees will be found to exist in the minority of cases, and in very many, perhaps the majority of cases, the foot will not go appreciably above a right angle unless it is allowed to evert and abduct.

The muscles which keep up the arch can be developed only by proper use. Weakening of the foot muscles is one of the penalties of civilization, especially since the introduction of railroads, street cars and automobiles. The savages who are barefooted do not suffer from foot strain. Some of them are born with flat feet, but this is normal for them and in motion the foot is kept in a different position.

From the above short remarks on the anatomy it is evident that the weight of the body comes down in the line of gravity through the astragalus to an elastic, weight bearing arch, and is distributed through it to the ground, that the line of gravity comes somewhat to the inside of the center of support and comes upon an arch weaker in its inner component than in its outer.

#### NOMENCLATURE AND DEFINITIONS

The term foot strain has been chosen instead of the commonly abused term flat foot, as the latter is based on the assumption that every case of foot strain is caused by a broken down arch which requires support. And further, it is popularly believed that this condition can be corrected by highly advertised shoes or by the use of plates self exalted in the advertising columns.

The term "foot strain" covers all disabilities of the foot. It may occur in the foot with the high arch as well as in the one where the arch has been flattened.

The term "flat foot" should be reserved for those cases only, where the longitudinal arch of the foot either touches the ground, or where it is so much lowered that it almost touches.

There are other terms used for this condition "weak foot" (Whitman), "pronated foot." The lay people use the term "fallen arches," "broken arches," and "prominent ankles." We will omit all these terms.

#### ETIOLOGY OR CAUSES

Both rich and poor are affected with foot strain. Both sexes seem to be equally attacked. Children are also subject to this ailment.

#### I CAUSES PREDISPOSING TO FOOT STRAIN

1 An occupation which requires continuous standing, hence the ailment is frequently found among waiters, cooks, policemen, letter carriers, cutters, barbers, salesmen, druggists, dentists and nurses. The condition is worse in cases where the work requires standing or walking on concrete or tile floors. The latter is so well-known a source of trouble that in most hospitals it has led to a general reduction of the shift from twelve to eight hours of duty, resulting in an enormous diminution in the amount of trouble encountered.

2 Real organic diseases, as rickets, infantile paralysis, arthritis, and spastic paraplegia.

3 Excessive weight—either through increase of body weight or from habitual lifting or carrying heavy loads, as in the case of men engaged in such work.

4 Diminution in muscular and ligamentous support resulting from ill health or convalescence from illness, especially after a child birth, or rapid growth. This is also found in cases of direct injury to the leg.

5 Lowered resistance which is the result of nervous fatigue and the lack, not the increase of healthy physical exercises.

6 The most common predisposing cause is the wearing of improper shoes. The object of the shoe is to cover and protect the foot and it must therefore, correspond exactly to the shape of the foot. In civilized countries the foot, on the contrary, is encased from early childhood in a more or less unyielding leather shoe. This is invariably narrowed and somewhat pointed in its front part, so that the great toe is displaced outward and cannot grip the ground as it should. As there isn't sufficient room at the toes, the shoe causes crumpling and distortion of the toes and prevents the forward part of the foot from spreading as it should at each step. The sole of the shoe is also more or less unyielding, as a rule stiffened in the shank\* so that the foot is laced down to a stiff sole. This tends to pull down the dorsum of the foot at each step. The heel of the shoe used by the fair sex is very high. This throws the entire weight to the front part of the foot which is unfitted for the burden of the entire body. This is the more ill advised, since the forepart of the shoe is narrow and has no room for even the normal toe. In addition the high heel is frequently the cause of tight heel cord (tendo-achillis) which is too often a con-

\* Some shoe stores point with misplaced pride to the fact that their shoes have stiff shanks.

sidered only preventive and not curative. It will never cure a weak foot.

2 Rest is always necessary for the feet, hence one who has an occupation that compels him to stand on his feet a great deal should rest at intervals (say ten minutes every hour). This will give a fair chance to the tired muscles to rest. In cases of a temporary disproportion as in pregnancy, or after an exhausting disease, it is desirable to rest quite frequently. If the acute foot strain is very tender it may be advisable to confine the patient to bed for 48 hours and order frequent application of hot compresses or foot baths.

3 A weak foot should not be overworked.

4 *Proper Attitude*—One must avoid long continued standing in one position. One should train himself to walk properly, i.e., keeping the feet parallel or even slightly turned in.

5 The proportion of the weight of the body to the foot power should be taken into account, hence it is advisable to avoid overweight and under weight.

One must study carefully the conditions which produced the strain with a view of relieving it.

### *B Treatment of Foot Strain (especially in the flexible foot) I General Principles*

1 Remove or remedy the underlying cause.

2 Correct the abnormal thrust of the line of gravity on the foot so that the weight of the body falls on the foot in a proper relationship.

3 The main aim should be the restoration of function and not merely correcting the deformity.

## II DIRECT TREATMENTS

### 1 *Acute Painful Foot*

*Rest*—Painful, irritable and strained feet, especially, are best treated under rest. If the condition is very bad, staying in bed may be necessary, which is really perfect freedom from all weight bearing. If this cannot be done and if the feet are not too stiff, a good rest can be obtained by strapping the feet with adhesive plaster straps in such a manner as to raise and rest the muscles and ligaments on the under surface of the foot, especially at its inner side. Occasionally felt pads are placed under the strapping.

*Purpose*—The object of strapping the strained foot is to hold it in such a position that those ligaments which are strained and which have been giving trouble on this account are held relaxed, if the foot is at the same time kept at rest, as in recumbency, it is possible to maintain this relaxation by the adhesive strapping. If the foot is used to bear the body weight, this can scarcely be done in the strict sense of the word, it is possible, however, even with the use of the foot, to relieve the ligaments of the stress of weight-bearing to such a degree by means of this strapping that the patient is not only kept free from pain, but the irritation and tenderness at the insertions of the ligaments diminish appreciably. What

is essential to the correct application of this dressing is that one have an understanding of the mechanics of the condition for which it is applied and that each strip of adhesive plaster be applied under tension enough and in such position that it has a real mechanical effect. Thus in the usual case of strained foot, those ligaments are to be relaxed which are strained when the foot acts in its position of functional weakness, since this is abduction and eversion (turned out), the foot must be strapped in such a way that it is held in adduction and inversion (turned in). Furthermore, it is important that the foot be strapped more firmly than is apparently necessary in order to allow for the slipping on the skin which always takes place, and particularly when the foot is used in walking or standing.

Hot foot baths should be used every night. I am accustomed to use epsom salt in the hot water.

When tenderness has passed, exercises should be given to develop power of adduction and inversion of the foot.

### 2 FLEXIBLE FLAT FOOT

The foot is strapped for a while. Then use of supports is indispensable. Such supports are intended for temporary use only. The feet should be strengthened by correct standing, walking, by exercises until the further use of supports becomes unnecessary.

When one advocates plates he encounters great difficulties. The supports that are ordinarily used for flat feet and are sold in the shoe stores do not fulfil the requirements. They are usually ill-fitting and often of such length and shape as to splint the foot and thus to restrict its normal motion. As a rule they are sold by persons wholly ignorant of the first principles of plate requirements. In addition they are often so soft as to bend under use. Ill-fitting plates do a great deal of harm by confusing the soft parts. Almost every person consulting an orthopedic surgeon comes well supplied with plates. The form of the plates really to be recommended, is hard to describe. There are many plates invented by orthopedic surgeons which give excellent results if properly fitted to the proper foot at the proper time. You can, therefore, understand that not every foot can use the same form of plate and, of course, not every orthopedic surgeon recommends the same plate. There are some plates so excellently devised as not only to support the arch, but also to overcorrect the foot, at the same time not preventing the normal motions and thus not to cause atrophy and interfere with the increase of muscular strength.

A great deal has been written against rigid arch supports. One objection is that the wearer becomes dependent upon them, and a second objection is that the continued use may cause atrophy or thinning of the muscles. The prejudice

the internal malleolus and along the ridge of the astragalo-calcaneal joint, and running down on to the inner side of the os-calcis, and in certain cases at the tip of the external malleolus and on the outer side of the os-calcis

4 *Tenderness*—Is usually present in parts of ligamentous strain. It is common under the scaphoid, centre of the heel, behind the internal malleolus, at the outer border of the foot and in the great toe. It is more common in children. The tenderness of the scaphoid is constant.

5 *Muscular Spasm*—Due to irritability and teno synovitis of the muscles, especially of peronei and tibials, also due to irritability of the ligaments caused by the failure of the fatigued and overstrained muscles to reinforce them as they should normally do. This spasm restricts markedly the range of motion of the ankle joint. The tendo-achillis is often considerably contracted.

6 *Stiffness*—Due to congestion and swelling of the foot. It involves mainly the midtarsal joint. The foot becomes so stiff that patient cannot accommodate himself to inequalities of the surface, hence he dreads to cross a rough pavement, for every misstep causes discomfort. At this stage, the patient finds that after sitting or rising in the morning he is unable to walk, but staggers or limps for several minutes (this being explained by local sensitiveness and muscular spasm increased by the use of the limb).

7 *Gait*—Is slouchy, the feet are apparently pushed one by the other or, to use a common expression, the feet are clumsy. The normal raising of the heel is avoided through fear of stress being thrust upon the tarso-metatarsal ligaments. The whole of the foot remains in contact with the floor as the body moves forward.

8 *Condition of Skin*—The foot is usually cold and bathed in perspiration caused by impaired circulation. The return of blood is slow when pressed out of the skin. Local or general swelling appears. The feet feel tight in the shoe. In long continued cases of foot strain a fluctuating swelling, not necessarily painful, develops just in front of and below the external malleolus.

9 *Deformity of the Foot*—The internal malleolus is more prominent than normally and is thought by the patient to have enlarged. The foot is everted (turned out). In many cases, the head of the astragulus and the scaphoid tubercle form a marked bony prominence at the middle of the inner border of the foot.

10. *Pressure symptoms* as callosities under the second and third metatarsal heads, around the heel and inner border of the foot. Tender heel due to periostitis of os-calcis is often present and becomes especially painful when one has to put weight on the flat sole of the shoe. Corns and callosities are marked.

11. Rigid feet are often the result of long continued foot strain. These are persistently held in eversion and deformed position. They are due to marked muscular spasm and secondary bony changes.

*Resumé of Symptoms of Foot Strain*—(1) Indisposition to use the feet as much as formerly, (2) Tiring quickly when walking, (3) Feeling of stiffness while attempting to walk after a rest, (4) Pain when walking or after standing for a while, later continuous pain, (5) Deformed foot (frequently).

#### DIAGNOSIS

The diagnosis of foot strain is not always an easy matter. The first thing to be determined is whether the symptoms are really due to the foot abnormality and not to some other cause. Secondly, what type of foot strain it is, so as to determine what treatments to institute.

#### PROGNOSIS

The prognosis falls under two heads (1) The relief of pain (especially in cases of acute foot strain) and (2) the correction of the existing deformity.

1. As far as relief of pain is concerned, the prognosis is best in people before middle age. If the symptoms are of comparatively recent occurrence due to overuse, bad shoeing, or temporary ill health, the prognosis is better. It is not so good in neurasthenics and overworked women who are obliged to stand on their feet for a long time. In people who are overweight the prognosis is also not so good, unless the weight is reduced.

2. *For the Correction of Deformity*—In normal children the prognosis as to the correction of the deformity is favorable. If they undergo rapid growth or are oversize the progress is somewhat slow.

The results of treatments are as a rule satisfactory. A spontaneous cure is not to be expected. In cases with little permanent distortion, but great muscular weakness, benefit and cure can be expected from careful treatment. In cases of average severity, relief can almost always be given by very simple measures. Severe deformity can be corrected by operative means.

#### TREATMENT

##### *A. Prevention*

1. Proper shoes should be worn by everybody, especially by those who have to stand on their feet a great deal or who have to walk extensively. People who begin to assume an occupation calling for a greater number of hours on their feet, as policemen, firemen, ward tenders, nurses and dentists should especially wear properly fitting shoes at work (perhaps still allowing fashion to dictate the evening shoe). A shoe should be con-

reserving the term "flat foot" for cases where the arch has really dropped

2 The predisposing causes are Occupation requiring continuous standing, excessive weight, diminution in muscular and ligamentous support, and generally lowered resistance

3 The most common predisposing cause is improper shoes

4 Direct causes Change of occupation, over-use of the feet in standing and walking, and general weakness following an illness

5 The height of the arch is no criterion of the symptoms complained of A high arch may give more trouble than a low arch

6 The disability and deformity of the weak feet may be only temporary and caused by a disproportion between the strength of the feet and the weight and strain to which it is subjected

7 The symptoms of foot strain are (1)

Indisposition to use the feet as much as formerly (2) Tiring quickly when walking (3) Feeling of stiffness while attempting to walk after a rest (4) Pain when walking or after standing for awhile, later on continuous pain (5) Deformed feet (frequently)

8 People with occupations requiring standing, should be especially careful about the care of the feet, including the choice of the shoe

9 The acute foot strain should be relieved by rest, adhesive plaster strappings and hot applications

10 The flaccid (flexible) flat feet are treated by strappings, exercises, then specially constructed plates intended for temporary use only

11 Rigid flat feet should be first converted into flexible flat feet and then treated as such

12 Arch supports, if necessary, should be carefully made for each case separately, after a careful study of the individual patient

## ACUTE LEUKEMIA AND MONONUCLEOSIS \*

By NELSON G RUSSELL, M.D.,

BUFFALO, N Y

THE problem of acute leukemia and one possibly allied condition seems a big one for a short paper of this kind These conditions confront the practitioner very often and one finds from experience that there are too many errors in diagnosis and prognosis to convince him that the problem is anywhere near a solution or the clinical picture as clearly understood as might be

Recent papers by Sprunt and Evans, Blaedon and Haughton, and many others, have indirectly revived interest in the diagnosis of acute leukemia, and Longcope's article in the *American Journal of the Medical Sciences*, December, 1922, has covered the ground very thoroughly in regard to infectious mononucleosis

Our interest in this subject is purely the practical one and the following cases are selected in an effort to give what seems to be one of every group in which they naturally fall, according to the simplest classification—acute myelogenous, acute lymphatic and infectious mononucleosis

*Myeloid Type*—The symptoms of the acute myeloid type, as given, are fever, malaise, temperature which resembles typhoid, recurring chills in some, striking anemia and varying degrees of enlargement of spleen Stomatitis, pharyngitis, frequently showing organisms of Vincent's Angina The nodes are swollen in some cases, though in my experience this is very variable The hemorrhage from the gums and

stomatitis may be very severe and is often accompanied by necrosis

The degree of exhaustion is very great and pulse quite rapid The blood picture is quite definite shortly after the onset in most cases, showing an increase in leucocytes with hemoglobin and red cells decreasing evenly The white count is not enormously increased, though the average is about thirty thousand My cases showed from 1,000 to 80,000 The differential count shows a great number of mononuclear cells which are in size between large or small lymphocytes These cells have a large nucleus and take the stain for peroxidase granules Frank myelocytes may be rare This stain which shows granules in myelocytes and premyelocytes if not too young has changed over to the myeloid group some of the cases formerly classified as lymphatic

*Lymphatic Type*—Acute lymphatic leukemia presents similar symptoms The onset is often abrupt, occasional chills, severe prostration, anemia, sore throat, often with Vincent's organisms and difficulty in swallowing Hemorrhages almost invariably occur in some form Enlarged glands are at all degrees from very slight enlargement to those of considerable size, spleen is usually palpable but not very large Liver is often large later

The blood shows marked anemia with red cells and hemoglobin dropping at the same rate The white cells are much increased, with a normal or diminished absolute number of poly-

\*Read at the Annual Meeting of the Medical Society of the State of New York at Rochester April 24 1924

has also been aggravated by the variety of ill-fitting plates sold at the shoe stores

To answer these objections, I can say that I feel no more hesitation in putting a proper plate on a lame foot which requires rest than I do about putting a sling on a lame shoulder. In both instances they serve the purpose of relieving muscular strain temporarily. But I regard these plates in the same light as a crutch or a cane in the treatment of any joint unable to bear the strain of use. It is, therefore to be discarded when the normal strength has returned and the irritability has disappeared.

It is of course better to use the plate that will cause less atrophy, is easier to fit and holds the foot in the proper position.

When there are enough reasons to suspect improvement, the plate should be gradually discarded. Usually the patient can hope to discard the plates after one or two years. If the foot has been damaged a great deal, they may have to be worn permanently.

### 3 TREATMENT OF RIGID FEET

Rigid flat feet without muscular spasm are often not painful at all. If accompanied by spasm, however, it is quite disabling. They cannot be treated by strapping or a stiff plate. The rigidity and muscular spasm must first be relieved in order to correct the foot. Anesthesia is quite frequently required to attain this. The foot is overcorrected and put in an extremely inverted position and then placed in a plaster cast extending to the knee. The plaster is left on for six to eight weeks, then a foot plate (arch support) can be used. In severe cases of long standing, operative measures to correct the rigid flat feet must frequently be employed. The tendo-achillis may have to be cut if it is markedly contracted. In cases of peroneal spasm an open operation to remove about three-quarters of an inch must be resorted to.

## III STRENGTHENING THE MUSCLES

### (EXERCISES)

The following exercises will suffice for all except special cases.

1 Stand with the feet parallel and rise on the outer borders without twisting the legs or bending the knees. (In this exercise the movement takes place entirely below the astragalus, it calls the adductors of the foot only into play.)

2 With the feet parallel, rise on the outer borders and walk in this position. (This has the same action as Exercise 1, provided the legs are not twisted outward, if one toes in or twists the legs outward, the rotators of the hip are called into play.)

3 Sitting on a chair, with the feet crossed, and resting on the outer edge alternately partially rise and sit.

4 Standing with one foot in front of the other, the front foot turned in and the rear foot resting behind the front leg on its outer edge, lower yourself a number of times by bending the knee, without changing the position of the feet.

5 Standing with the toes closely touching and heels apart, bend your knees as far as possible, without raising the heels from the floor, and then spread the knees, keeping the soles of the feet flat. This exercise is especially useful in cases where the tendo-achillis is contracted.

6 Using several sizes of marbles, pick them up from the floor with your toes and place them in a small basin. At first only small marbles can thus be seized, but gradually larger sizes may be used. The number of marbles picked up will also be increased during the practice. (This exercise is to be used where the anterior arch is depressed.)

### METATARSALGIA

This name has been given to an affection marked by attacks of pain, sharp or burning in character, often of paroxysmal occurrence, and which are usually located in the fourth metatarsophalangeal joint, and occasionally in the second or third. This condition is generally attributed to flattening of the transverse arch of the foot through which the heads of the metatarsal bones fall into abnormal relations to one another, when pressed together by the shoe, mechanical irritation results.

*Treatments*—For temporary relief, and especially when pain is acute, resort may be had with advantage to felt pads applied transversely just back of the metatarsal heads retained by adhesive plaster. Later on, we prescribe a flat foot plate with a prolongation for the anterior arch.

### SHOES

In all cases it is necessary to provide a proper shoe, as the wearing of improper shoes has been shown to be responsible for so many cases of acute foot strain.

The requirements of a proper shoe are

1 It must have sufficient space for the independent movements of the toes, hence it must have plenty of room at the front part of the toes.

2 The heel should be broad and low.

3 The shape of the sole should correspond to the shape of the foot, hence there should be a right and left shoe and the inner border should be straight to follow the line of the big toe.

4 In mild cases of foot strain especially in the case of children, the inner border of the sole and heel of the shoe should be one quarter of an inch higher in order to throw the weight to the outer side of the foot.

### SUMMARY

1 The term "foot strain" should be used as the general term in cases of static foot disability,



reserving the term "flat foot" for cases where the arch has really dropped

2 The predisposing causes are Occupation requiring continuous standing, excessive weight, diminution in muscular and ligamentous support, and generally lowered resistance

3 The most common predisposing cause is improper shoes

4 Direct causes Change of occupation, overuse of the feet in standing and walking, and general weakness following an illness

5 The height of the arch is no criterion of the symptoms complained of A high arch may give more trouble than a low arch

6 The disability and deformity of the weak feet may be only temporary and caused by a disproportion between the strength of the feet and the weight and strain to which it is subjected

7 The symptoms of foot strain are (1)

Indisposition to use the feet as much as formerly (2) Tiring quickly when walking (3) Feeling of stiffness while attempting to walk after a rest (4) Pain when walking or after standing for awhile, later on continuous pain (5) Deformed feet (frequently)

8 People with occupations requiring standing, should be especially careful about the care of the feet, including the choice of the shoe

9 The acute foot strain should be relieved by rest, adhesive plaster strappings and hot applications

10 The flaccid (flexible) flat feet are treated by strappings, exercises, then specially constructed plates intended for temporary use only

11 Rigid flat feet should be first converted into flexible flat feet and then treated as such

12 Arch supports, if necessary, should be carefully made for each case separately, after a careful study of the individual patient

## ACUTE LEUKEMIA AND MONONUCLEOSIS \*

By NELSON G RUSSELL, M.D.,

BUFFALO, N Y

THE problem of acute leukemia and one possibly allied condition seems a big one for a short paper of this kind These conditions confront the practitioner very often and one finds from experience that there are too many errors in diagnosis and prognosis to convince him that the problem is anywhere near a solution or the clinical picture as clearly understood as might be

Recent papers by Sprunt and Evans, Blaedon and Haughton, and many others, have indirectly revived interest in the diagnosis of acute leukemia, and Longcope's article in the *American Journal of the Medical Sciences*, December, 1922, has covered the ground very thoroughly in regard to infectious mononucleosis

Our interest in this subject is purely the practical one and the following cases are selected in an effort to give what seems to be one of every group in which they naturally fall, according to the simplest classification—acute myelogenous, acute lymphatic and infectious mononucleosis

*Myeloid Type*—The symptoms of the acute myeloid type, as given, are fever, malaise, temperature which resembles typhoid, recurring chills in some, striking anemia and varying degrees of enlargement of spleen Stomatitis, pharyngitis, frequently showing organisms of Vincent's Angina The nodes are swollen in some cases, though in my experience this is very variable The hemorrhage from the gums and

stomatitis may be very severe and is often accompanied by necrosis

The degree of exhaustion is very great and pulse quite rapid The blood picture is quite definite shortly after the onset in most cases, showing an increase in leucocytes with hemoglobin and red cells decreasing evenly The white count is not enormously increased, though the average is about thirty thousand My cases showed from 1,000 to 80,000 The differential count shows a great number of mononuclear cells which are in size between large or small lymphocytes These cells have a large nucleus and take the stain for peroxidase granules Frank myelocytes may be rare This stain which shows granules in myelocytes and premyelocytes if not too young has changed over to the myeloid group some of the cases formerly classified as lymphatic.

*Lymphatic Type*—Acute lymphatic leukemia presents similar symptoms The onset is often abrupt, occasional chills, severe prostration, anemia, sore throat, often with Vincent's organisms and difficulty in swallowing Hemorrhages almost invariably occur in some form Enlarged glands are at all degrees from very slight enlargement to those of considerable size, spleen is usually palpable but not very large Liver is often large later

The blood shows marked anemia with red cells and hemoglobin dropping at the same rate The white cells are much increased, with a normal or diminished absolute number of polynu-

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester, April 24 1924

clear cells. The lymphocytes predominate, amounting to 90 to 98 per cent of the total.

The few cases I have seen of this disease showed most of the lymphocytes were true to form and did not show the great relative increase of the large cells given in the textbooks as indicating the acute lymphatic type.

*Acute Mononucleosis*—The symptoms of acute mononucleosis are as follows, quoting from the article of Dr. Warfield T. Longcope, published in the *American Journal of the Medical Sciences*, December, 1922:

"The onset is rather gradual, with malaise, headache and irregular fever, occasionally accompanied by chills. In many instances at the onset there is a pharyngitis, an actual tonsillitis, a tracheitis or a cough. Sometimes the lymphoid tissue of the pharynx becomes much swollen. Very frequently the patients complain of sweating. In a few instances there has been abdominal pain with nausea and vomiting. Rarely the first sign of the disease noticed by the patient has been an enlargement of the cervical lymph nodes. More frequently the cervical lymph nodes became enlarged and tender during the first week of the disease. They may reach 1 or 2 cm. in diameter and are quite firm. In some instances the enlargement is confined to the cervical nodes but frequently the axillary, inguinal, even the epitrochlear and possibly the bronchial, lymph nodes are involved and become swollen, firm and tender. In some cases during the first or second weeks the spleen is enlarged, becomes readily palpable and is tender. By the seventh day the mononucleosis is well marked and from this time until the tenth to the eighteenth day the leukocytes increase in numbers and the mononucleosis advances. The fever, which is often mild and rarely goes above 102 or 103, continues irregularly until the tenth to the twentieth day and then gradually subsides. With the fall in temperature the symptoms subside, the lymph nodes recede, the spleen diminishes in size, the leukocytes fall and the mononucleosis gradually disappears. Convalescence is rapid and uneventful.

The prognosis is unfortunately the only thing which can be given the patient, hence an effort should be made to establish a correct diagnosis.

The leukemias have a very clear group of symptoms which suggest a very severe infection, though the cause is still unknown, while acute mononucleosis has similar symptoms without the hemorrhage, marked anemia, or severe prostration.

The diagnosis by the blood smear is extremely difficult to establish without following the case and distinguishing the bone marrow cells by use of the oxadase stain. As many of the abnormal lymphocytes resemble young myelocytes to any but an experienced observer, it is difficult to dis-

tinguish an acute myelogenous leukemia from a mononucleosis.

The differential diagnosis is clear to a certain extent, though in our experience tuberculosis, typhoid fever symptoms and malignant endocarditis have been clung to for a considerable time.

The blood picture of a leukemia is not at all definite, though I have not seen one that did not show a disturbed relation or occasional abnormal leucocyte when searched for. Longcope suggests that glandular fever may be the manifestation of the condition called mononucleosis. Since reading this I have seen four cases which seemed to fit under that heading, but found normal blood reactions in all—just a slight leucocytosis.

#### CASE REPORTS

Miss F. N., age 39—History of scarlet fever, and diphtheria when a child. Has had trouble with throat, hoarseness particularly. Some abdominal distress. Diagnosis of gall stones and chronic appendicitis. There was some evidence of tubercular infiltration, upper right. In 1920, appendix was removed.

During the following year had one attack of gall stone colic. Hoarseness at times. In September tonsils were removed. After ten days a membrane appeared on throat which showed organism of Vincent's angina. In about one week complaint of pain on left side upper abdomen with large spleen extending to two inches below free margin of ribs. This gradually enlarged almost to the crest. Temperature gradually rose to 100 and remained between 102 and 104, with pulse gradually increasing from 110. There were some hemorrhagic spots. Blood culture was negative.

Blood on October 11, was: Hb 60, white cells 5,000, red cells 3,160,000, polys 51 per cent, monos 31 per cent, L monos 9 per cent, trans 5 per cent, eosino 4 per cent. Reds irregular in size, polychromatophilia, one normoblast in 100, several cells resembling Turk irritation forms.

On October 26: Hb 50, whites 6,000, polys 29 per cent, monos 26 per cent, L monos 14 per cent, trans 28 per cent, Baso 3 per cent, reds irregular in size, fewer polychromatophilic cells, no blasts, one resembling Turk irritation.

The patient died six weeks from tonsillectomy and about four and one-half weeks from the beginning of fever and membrane on throat.

The pathologists' report showed: *Spleen*—General and considerable atrophy of the follicles, and myeloid metaplasia of the pulp elements, the latter consisting of numerous partially and completely differentiated myelocytes, and a considerable number of mostly typical megakaryocytes. No nucleated red blood corpuscles. It seems that the enlargement of the spleen is due chiefly to the increase in the pulp as a result of the presence of these myelogenous elements.

*Liver*—Diffuse intracapillary and subendothelial infiltration with myelogenous elements, as in the splenic pulp, but with only very few bone marrow giant cells, and here and there similar infiltration in the interalveolar connective tissue, the whole picture constituted a characteristic picture of myelogenous leukemia, especially as distinguished from the lymphatic variety

This is a case which might easily escape detection on blood examination alone, though the abnormal cells suggested the possibility of leukemia, the second differential count being more suggestive

G B, age 26, clerk—Entered hospital April 14, 1924. Complaint—Rash on body, headache, frontal throbbing in character, weakness, poor appetite, bleeding gums. Onset For previous ten days patient felt sore and tired. Six days before coming to hospital she became sick and vomited and had a bad headache, was in bed next two days, worked on the 11th, but went home in afternoon

On admission to hospital positive findings were history of weakness for eleven days, bleeding gums, purpura eruption bright to dark red, on extremities, neck and upper chest

*Physical Examination*—Bleeding gums, purpura spots, spleen enlarged two fingers breadth below margin. Blood pressure 72/122. Hb 50, leukocytes 25,600, polys 3 per cent, s lymph 4 per cent, Ll 93 per cent. Cells were nearly all large and medium lymphocytes. Oxidase reaction negative. Platelets very scarce. Blood chemistry: Uric acid, 6.6, urea nitrogen, 16.8, creatinin 17, sugar, 106. Coagulation time, 20 minutes. Bleeding time, 20 minutes. Fragility test: Complete, 30 per cent, partial, 37 per cent. The patient grew rapidly worse and on the 18th, vomited a large amount of blood, fluid and clots. She died on the 19th—two weeks after first symptom

Positive autopsy findings were hemorrhagic areas on skin all over body. Blood in gums, in uterus, peritoneum, stomach bowel, pericardium and ovaries

Bronchial and periaortic lymph nodes slightly enlarged and appeared pyoid on section. Spleen

three times normal size, pale, capsule wrinkled, pulp confluent. Bone marrow red and pyoid in appearance

M R, schoolboy, age 15—Gave a history of whooping cough, measles, chickenpox, tonsillectomy at 7, frequent attacks of nausea, tenderness in appendix region

On October 24, 1922, complained of sore throat, weakness and slightly enlarged glands in neck. Temperature slightly elevated. Culture showed staphylococcus and streptococci. Smear showed some Vincent's organisms

During this time the boy ran a temperature of 99 to 103, gradually returning to normal in about three weeks. There was considerable depression and some general aching. The nodes in the neck, axilla and groin were enlarged, some in neck to size of small walnut, one month later these were normal. The spleen was palpable for a few days, a blood count about a year before showed a normal differential. The treatment in the case was small doses of neo-salvarsan every second day for four doses

These cases were selected because they may serve to illustrate some of the difficulties which the practitioner encounters

The first one shows a picture of an infection occurring, the convalescence from a simple tonsillectomy and which never gave a count above six thousand white cells and only twice showed pathological cells in very small numbers. The symptoms, fever, anemia, sore throat and hemorrhage, taken as a whole, gave a good picture of leukemia, but the blood count did not confirm this though fairly frequent counts were made. It had been more persistent in our search of the slides, possibly more pathological cells might have been found. The pathologist, Dr. Roman, made an unqualified diagnosis of acute myelogenous leukemia

The second was a clean cut case of acute lymphatic leukemia running its entire course in fifteen days. There was little if anything lacking to complete the clinical picture. The blood specimens were classical, showing a great increase in lymphocytes. Many of the pathological forms were present, but none showed oxidase granules

Date	Wt	Refs	Whites	Polys	SL	Lf	Trans	Eos	Bas.
10/22			25,500	15.5	77	3.5			
10/25	50	442000	26,800	24	67	3.5	5.5	0	0
10/26†			26,800	19.5	42	3.2	5		
10/28			33,600	17	68.5	11.5	3	1	0.5
10/30			17,000	12	57	27	4		
10/31			13,000	10	64	22	3.5	5	
11/3			14,000	20	73	6	5	5	
11/13			10,600	35	59	2	2	2	
11/23				32	53	14	1		
12/30			10,400	58	36	2	3	1	
4/5/23	Sl inf		14,800	59.5	38	1	1	5	
4/20				44	51	2	1	2	
12/4				62	32	5	1		
2/11/24				73	25	1	0	1	

† Abnormal cells during October 1922. Some pathological mononuclears.

The post-mortem findings, however, showed marked changes in the bone marrow and relatively slight changes in the general lymphatic system. Fortunately the treatment has so little effect that its discrepancy between the clinical and pathological findings makes little difference.

The third case seems to me a fair sample of acute infectious mononucleosis, which appears perfectly simple, though the diagnosis was not made until the course was very apparent.

The symptomatology of the acute leukemia and acute mononucleosis seems almost identical to a certain point when the more severe signs, as hemorrhages and grave anemia, appear. These seem to be two distinct groups. One going to a

fatal termination, and the other, in nearly all cases, to complete recovery with a normal blood response to ordinary infections.

Nothing can be said about treatment of acute leukemia for the usual procedures have failed to give any relief, and in a few cases we have thought that the disease progressed more rapidly after X-ray and radium treatment. Transfusion has also been used without effect.

Acute mononucleosis seems to run a self limited course. Our few cases recovered while taking arsenic in some form. This was used partly from habit and partly because the Vincent's organisms were present and these apparently yield to arsenic.

## SERUM THERAPY OF PNEUMONIA IN NEW YORK STATE \*

By AUGUSTUS WADSWORTH, M D,

ALBANY N Y

I APPRECIATE greatly this opportunity of presenting to you the work that has been done in New York State in the development of the serum therapy of pneumonia, together with the results that have been obtained in the treatment of cases. The work was started in 1915 when centers for the determination of type and the distribution or administration of anti-pneumococcus type I serum were established to serve as large a proportion of the population as it was possible to reach in such a large state. Since then, the distribution and use of the serum has become more general and is now no longer limited to these centers, as many of the local laboratories are equipped and qualified for the work. From the beginning, the serum, tested by the methods and according to the standards still in force, has been of the highest potency.

The published reports of eighteen groups of cases of type I pneumonia treated with anti-pneumococcus serum—eleven from Army camps and seven from civil hospitals—have been reviewed in another paper. The reduction in mortality is not convincing of the value of serum treatment, but it is only necessary here to note essential facts in order to understand how impossible it is to arrive at any definite conclusion, either favorable or unfavorable in that respect. A number of conditions affect the significance of statistical reports—the great variation in the mortality of pneumonia, the almost insuperable difficulty of securing satisfactory control series or untreated cases for comparison, uncertainty with regard to the potency of some of the early serums before standardization was instituted by the federal authorities—and more than anything else especially in the civil population, the selec-

tion of serious cases for treatment, or delay in treatment until the prognosis becomes obviously unfavorable. In addition, there are fundamental conditions underlying the development and course of pneumonic infection of the lung which determine to a large extent the limitations of serum therapy in pneumonia.

Reports from the Rockefeller Institute Hospital, where conditions for serum treatment and the results obtained from it are more favorable than elsewhere, give a total of 195 serum-treated cases, with 18 deaths, a mortality of 9.2 per cent. In this hospital there is no question of the selection of cases, delay in treatment or of the potency of the serum used.

As previous reports, with the exception of the one from the Rockefeller Hospital, did not give definite information in this regard, we decided to go over carefully the cases in New York State which were all treated with serum of known high potency, produced by uniform methods in our laboratory. The records of these cases illustrate strikingly the importance of securing complete and reliable data if correct inferences are to be drawn from statistical reports.

A miscellaneous group of 151 cases is compiled from records kept in the central laboratory at Albany of scattered cases occurring throughout New York State, and reported by local physicians.

Although complete data on all the thirty-three fatal cases which were treated with the serum are not available, sufficient information is recorded in many of them to indicate the extent to which delayed or inadequate treatment affected the statistics of this group. These factors are so evident that the control series of 218 untreated cases with a mortality of 18.81 per cent, approxi-

\*Read at the Annual Meeting of the Medical Society of the State of New York at New York City May 23, 1925.

mately the average mortality in pneumonia, cannot be considered a representative series for comparison. The mortality of the more serious cases of pneumonia may reach 40 or 50 per cent. But this general fact cannot be regarded as constituting a satisfactory basis of comparison. More striking possibly to those who have had an opportunity of observing the effect of treatment at the bedside, is the marked improvement in the cases, often with sharp amelioration of the symptoms and the febrile reaction, following the administration of the serum. These signs, however, cannot be distinguished from those evident in the spontaneous recovery by crisis. Thus, even with complete data it is impossible to secure convincing evidence of the beneficial action of the serum.

Undoubtedly better conditions of treatment prevailed in the series of cases treated in one district, the City of Rochester. Dr. Joseph Roby reports 126 cases treated with serum, which had a mortality of 13.6 per cent, as contrasted with 19 per cent of the parallel series of 126 cases in which serum was not given. Nevertheless, the selection of serious infections and delay in treatment were evident in this series and noted especially by Dr. Roby, who administered the serum in many, if not all, the cases.

The reports on cases in the Army camps treated with serums from the same source approach the other extreme. At Fort Bliss, Nichols reports sixty-three type I serum-treated cases, with a mortality of 8 per cent. At Camp Wheeler, there were seventy-two cases with only two deaths, a mortality of 2.8 per cent—yet the mortality in these outbreaks exceeded 20 per cent, whereas the average mortality of pneumonia in the Army, according to the Surgeon General's report, was 10.7 per cent. From various camps, Sutton collected thirty-three cases which were treated with serum and in which no deaths took place. These cases probably constituted the usual incidence of pneumonia in the Army and were not associated with any particular outbreak. Thus, in these three groups, 168 cases were treated, with a mortality of 4.68 per cent.

Reports on the use of this particular serum

of known and uniform potency are seemingly at variance with one another. They possibly represent extremes and can only be attributed to the conditions under which the cases were treated. The fact that young, healthy adults were selected by the draft boards was doubtless an important factor in determining the low mortality in the Army hospitals in both treated and untreated groups of cases, but in the outbreaks of pneumonia in the camps the mortality was equal to or exceeded that ordinarily recorded in civilian hospitals, and it was largely these cases which were treated with serum. It is evident that delay in treatment affects the results of serum therapy to such an extent that it is useless to give the serum late in the course of the very serious infections.

The study of the fatal cases, however, demonstrated the limitations of serum therapy. On this account, I wish to emphasize the importance of complete records and reports on the use of the serum which is distributed to the physicians of the state by the laboratory. Apart from the accidents of anaphylaxis due to faulty methods of administration there is no evidence that the serum is harmful. This fact, however, does not justify excessive dosage or treatment prolonged beyond reason. The serum should be given slowly to determine the tolerance of the individual after careful desensitization. The dose should be at least fifty cubic centimeters, preferably one hundred. It should be repeated at eight or twelve-hour intervals. Four or five doses suffice in nearly all cases. The exceptionally prolonged or the complicated cases require special study to determine the wisdom of continuing the treatment.

In conclusion, I may state that although it is impossible to foretell the results of serum therapy in individual cases, and although there are cases in which the serum will not bring about recovery, it is evident that anti-pneumococcus type I serum of known high potency, if administered promptly in adequate dosage by physicians experienced in giving serum treatment, will be shown to be of definite practical value.

The post-mortem findings, however, showed marked changes in the bone marrow and relatively slight changes in the general lymphatic system. Fortunately the treatment has so little effect that its discrepancy between the clinical and pathological findings makes little difference.

The third case seems to me a fair sample of acute infectious mononucleosis, which appears perfectly simple, though the diagnosis was not made until the course was very apparent.

The symptomatology of the acute leukemia and acute mononucleosis seems almost identical to a certain point when the more severe signs, as hemorrhages and grave anemia, appear. These seem to be two distinct groups. One going to a

fatal termination, and the other, in nearly all cases, to complete recovery with a normal blood response to ordinary infections.

Nothing can be said about treatment of acute leukemia for the usual procedures have failed to give any relief, and in a few cases we have thought that the disease progressed more rapidly after X-ray and radium treatment. Transfusion has also been used without effect.

Acute mononucleosis seems to run a self limited course. Our few cases recovered while taking arsenic in some form. This was used partly from habit and partly because the Vincent's organisms were present and these apparently yield to arsenic.

## SERUM THERAPY OF PNEUMONIA IN NEW YORK STATE \*

By AUGUSTUS WADSWORTH, M.D.,

ALBANY N. Y.

I APPRECIATE greatly this opportunity of presenting to you the work that has been done in New York State in the development of the serum therapy of pneumonia, together with the results that have been obtained in the treatment of cases. The work was started in 1915 when centers for the determination of type and the distribution or administration of anti-pneumococcus type I serum were established to serve as large a proportion of the population as it was possible to reach in such a large state. Since then, the distribution and use of the serum has become more general and is now no longer limited to these centers, as many of the local laboratories are equipped and qualified for the work. From the beginning, the serum, tested by the methods and according to the standards still in force, has been of the highest potency.

The published reports of eighteen groups of cases of type I pneumonia treated with anti-pneumococcus serum—eleven from Army camps and seven from civil hospitals—have been reviewed in another paper. The reduction in mortality is not convincing of the value of serum treatment, but it is only necessary here to note essential facts in order to understand how impossible it is to arrive at any definite conclusion, either favorable or unfavorable in that respect. A number of conditions affect the significance of statistical reports—the great variation in the mortality of pneumonia, the almost insuperable difficulty of securing satisfactory control series of untreated cases for comparison, uncertainty with regard to the potency of some of the early serums before standardization was instituted by the federal authorities—and more than anything else, especially in the civil population, the selec-

tion of serious cases for treatment, or delay in treatment until the prognosis becomes obviously unfavorable. In addition, there are fundamental conditions underlying the development and course of pneumonic infection of the lung which determine to a large extent the limitations of serum therapy in pneumonia.

Reports from the Rockefeller Institute Hospital, where conditions for serum treatment and the results obtained from it are more favorable than elsewhere, give a total of 195 serum-treated cases, with 18 deaths, a mortality of 9.2 per cent. In this hospital there is no question of the selection of cases, delay in treatment or of the potency of the serum used.

As previous reports, with the exception of the one from the Rockefeller Hospital, did not give definite information in this regard, we decided to go over carefully the cases in New York State which were all treated with serum of known high potency, produced by uniform methods in our laboratory. The records of these cases illustrate strikingly the importance of securing complete and reliable data if correct inferences are to be drawn from statistical reports.

A miscellaneous group of 151 cases is compiled from records kept in the central laboratory at Albany of scattered cases occurring throughout New York State, and reported by local physicians.

Although complete data on all the thirty-three fatal cases which were treated with the serum are not available, sufficient information is recorded in many of them to indicate the extent to which delayed or inadequate treatment affected the statistics of this group. These factors are so evident that the control series of 218 untreated cases with a mortality of 18.81 per cent, approxi-

\* Read at the Annual Meeting of the Medical Society of the State of New York at New York City, May 25, 1925.

mately the average mortality in pneumonia, cannot be considered a representative series for comparison. The mortality of the more serious cases of pneumonia may reach 40 or 50 per cent. But this general fact cannot be regarded as constituting a satisfactory basis of comparison. More striking possibly to those who have had an opportunity of observing the effect of treatment at the bedside, is the marked improvement in the cases, often with sharp amelioration of the symptoms and the febrile reaction, following the administration of the serum. These signs, however, cannot be distinguished from those evident in the spontaneous recovery by crisis. Thus, even with complete data it is impossible to secure convincing evidence of the beneficial action of the serum.

Undoubtedly better conditions of treatment prevailed in the series of cases treated in one district, the City of Rochester. Dr. Joseph Roby reports 126 cases treated with serum, which had a mortality of 13.6 per cent, as contrasted with 19 per cent of the parallel series of 126 cases in which serum was not given. Nevertheless, the selection of serious infections and delay in treatment were evident in this series and noted especially by Dr. Roby, who administered the serum in many, if not all, the cases.

The reports on cases in the Army camps treated with serums from the same source approach the other extreme. At Fort Bliss, Nichols reports sixty-three type I serum-treated cases, with a mortality of 8 per cent. At Camp Wheeler, there were seventy-two cases with only two deaths, a mortality of 2.8 per cent—yet the mortality in these outbreaks exceeded 20 per cent, whereas the average mortality of pneumonia in the Army, according to the Surgeon General's report, was 10.7 per cent. From various camps, Sutton collected thirty-three cases which were treated with serum and in which no deaths took place. These cases probably constituted the usual incidence of pneumonia in the Army and were not associated with any particular outbreak. Thus, in these three groups, 168 cases were treated, with a mortality of 4.68 per cent.

Reports on the use of this particular serum

of known and uniform potency are seemingly at variance with one another. They possibly represent extremes and can only be attributed to the conditions under which the cases were treated. The fact that young, healthy adults were selected by the draft boards was doubtless an important factor in determining the low mortality in the Army hospitals in both treated and untreated groups of cases, but in the outbreaks of pneumonia in the camps the mortality was equal to or exceeded that ordinarily recorded in civilian hospitals, and it was largely these cases which were treated with serum. It is evident that delay in treatment affects the results of serum therapy to such an extent that it is useless to give the serum late in the course of the very serious infections.

The study of the fatal cases, however, demonstrated the limitations of serum therapy. On this account, I wish to emphasize the importance of complete records and reports on the use of the serum which is distributed to the physicians of the state by the laboratory. Apart from the accidents or anaphylaxis due to faulty methods of administration there is no evidence that the serum is harmful. This fact, however, does not justify excessive dosage or treatment prolonged beyond reason. The serum should be given slowly to determine the tolerance of the individual after careful desensitization. The dose should be at least fifty cubic centimeters, preferably one hundred. It should be repeated at eight or twelve-hour intervals. Four or five doses suffice in nearly all cases. The exceptionally prolonged or the complicated cases require special study to determine the wisdom of continuing the treatment.

In conclusion, I may state that although it is impossible to foretell the results of serum therapy in individual cases, and although there are cases in which the serum will not bring about recovery, it is evident that anti-pneumococcus type I serum of known high potency, if administered promptly in adequate dosage by physicians experienced in giving serum treatment, will be shown to be of definite practical value.

# EDITORIALS

The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

*Editor-in-Chief*—NATHAN B VAN ETEN, M D,  
*Associate Editor*—ORRIN SAGE WIGHTMAN, M D,  
*Executive Editor*—FRANK OVERTON, M D

### COMMITTEE ON PUBLICATION

E. ELIOT HARRIS, M.D., *Chairman* New York  
ORRIN SAGE WIGHTMAN, M.D. New York  
EDWARD LIVINGSTON HUNT, M D New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

*President*—OWEN E JONES, M D Rochester  
*First Vice President*—GEORGE A. LEITNER, M D Piermont  
*Second Vice President*—LUZERNE COVILLE, M D Ithaca  
*Speaker*—E. ELIOT HARRIS, M D New York  
*Vice-Speaker*—GEORGE M. FISHER, M D Utica  
*Secretary*—EDWARD LIVINGSTON HUNT, M D New York  
*Assistant Secretary*—WILBUR WARD, M D New York  
*Treasurer*—CHARLES GORDON HEYD, M D New York

### CHAIRMAN, STANDING COMMITTEES

*Arrangements*—FREDERICK H. FLAHERTY, M D Syracuse  
*Public Health and Medical Education*,  
JOSHUA M. VAN COTT, M D, Brooklyn  
*Scientific Work*—ANDREW MACFARLANE, M D Albany  
*Medical Economics*—HENRY LYLE WINTER, M D Cornwall  
*Legislation*—JAMES N VANDER VEER, M D Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex President and the Councilors of the District Branches

*First District*—EDWARD C. RUSHMORE, M D Tuxedo Park  
*Second District*—FRANK H. LASHER, M D Brooklyn  
*Third District*—ARTHUR J. BEDELL, M D Albany  
*Fourth District*—CHARLES C. TREMBLEY, M D Saranac Lake  
*Fifth District*—NELSON O. BROOKS, M D Oneida  
*Sixth District*—GEORGE H. FOX, M D Binghamton  
*Seventh District*—WILLIAM I. DEAN, M D Rochester  
*Eighth District*—HARRY R. TRICK, M D Buffalo

### COUNSEL

GEORGE W. WHITESIDE, Esq., 27 William St. New York  
Telephone, Broad 1744

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St. New York

### EXECUTIVE OFFICER

JOSEPH S. LAWRENCE, M.D. 51 Chapel Street, Albany

### SECTION OFFICERS

#### Medicine

*Chairman*—ROBERT L. LEVY, M.D. New York  
*Secretary*—L. WHITTINGTON GORHAM, M.D. Albany

#### Surgery

*Chairman*—MARSHALL CLINTON, M.D. Buffalo  
*Secretary*—EDWARD S. VAN DUYN, M.D. Syracuse

#### Obstetrics and Gynecology

*Chairman*—HAROLD C. BAILEY, M.D. New York  
*Secretary*—NATHAN P. SEARS, M.D. Syracuse

#### Pediatrics

*Chairman*—JOSEPH C. PALMER, M.D. Syracuse  
*Vice Chairman*—ROGER H. DENNETT, M.D. New York  
*Secretary*—ARTHUR W. BENSON, M.D. Troy

#### Eye, Ear, Nose and Throat

*Chairman*—ARTHUR G. BENNETT, M.D. Buffalo  
*Secretary*—EUGENE E. HINMAN, M.D. Albany

#### Public Health, Hygiene and Sanitation

*Chairman*—PAUL B. BROOKS, M.D. Albany  
*Secretary*—ARTHUR D. JACQUES, M.D. Lynbrook

#### Neurology and Psychiatry

*Chairman*—EUGENE N. BOUDEKAU, M.D. Syracuse  
*Secretary*—CLARENCE O. CHENEY, M.D. Utica

For a list of the officers of the county medical societies, see this issue, advertising page vii

## STANDARDS OF THE PRACTICE OF MEDICINE

When a physician publishes a plea for higher standards of medical practice, chiropractors and other cultists are likely to quote the medical author to prove that physicians generally are an incompetent lot and do not know their business. Since nearly every patient that goes to a cultist has been treated by physicians without relief, the published confessions of the physicians tend to confirm the evidence of experience that doctors do not always cure the conditions for which they are consulted. The obvious conclusion is—since the doctors fail, let some one else try.

It is not such a bad thing for the medical profession that quacks and cultists are watching the doctors' failures and are advertising them to a

public that is always ready to accept any new healing theory as the latest and best scientific discovery in therapy. The quack gives the impression that his diagnosis is absolutely correct and that his prescription is surely efficacious—if the patient is not satisfied, the fee will be cheerfully refunded. Can a conscientious physician arouse this degree of confidence in his patients? There is no doubt that some do.

What is the element which enables some physicians to hold the confidence of their patients? Think over the names of your personal friends who are highly successful general practitioners of medicine. What do they do that is different from the methods of their confreres? For one



thing, they examine their cases, and substitute certainty for guess work.

As a corollary to their examination, these successful physicians keep exact records of their patients—physical examination, diagnosis, treatment and follow-up observations. This still further promotes certainty on the part of the physician and confidence on the part of the patient, and if that patient wanders from the fold of the physician on the solicitation of a testimonial writing friend, he will come back some evening to the office where his exact physical state is recorded in writing rather than on the uncertain pages of memory. A patient thinks that his memory is as good as the doctor's, but he is convinced by a written record of his case. The most successful physicians make a complete physical examination of every new case.

Dr Frank Billings of Chicago has something to say in this line in the January issue of the *American Medical Association Bulletin*. He says

"I made a point never to take more than four new patients in any one day in my office. I saw some patients daily who had been to me before, but I wanted plenty of time to go thoroughly over new patients. I had always been struck by the fact that patients who stripped sometimes did it reluctantly and often made a remark that they had never been unclothed for examination before. So for two years I gave my secretary every night the number of new patients who had never been disrobed for examination before. During those two years there were approximately 500 patients, the members of doctors' families. Over 75 per cent of the total patients, members of doctors' families included, had never had their clothes off in an examination, and every one had suffered from a chronic disease."

Dr Billings sets a standard which is both ideal and practical. Not every physician can choose his cases and score one hundred per cent in making the examinations of his patients, but not all the work of a doctor consists of emergency, long distance calls, and in the course of five years a doctor could secure records of the examinations of practically every individual in the families whom he calls his patients. Think what this will mean in the practice of any doctor who maintains this standard of the practice of his profession.

Are physicians practising medicine according to the highest modern standards? No. Not all physicians have the time to give every new patient a complete physical examination. If the majority of physicians subjected every patient to all the examinations and laboratory tests that are available to the average practitioner, there would not be doctors enough to visit half of the existing cases of sickness, and the quacks would get hordes of patients who would like to employ competent physicians. It requires judgment to know when to insist on a general examination.

Are doctors treating all those who are really sick and would not get well without expert medical assistance? If they are, then physicians need not be envious of the success of quacks. Physicians reach a fairly high score in the diagnosis and treatment of acute conditions, but many doctors are not deeply interested in chronic cases and do not seem to care if they score a low mark in their diagnosis and treatment.

How much responsibility for the prosperity of quacks rests upon general practitioners who lack pride in diagnosing and treating chronic cases according to the highest medical standards?

F O

---

## HOW TO MAKE A PERIODIC HEALTH EXAMINATION

We sometimes receive letters asking how to make a periodic health examination. We might just as well be asked how to practice medicine. The one feature wherein a periodic health examination differs from the examination of a patient who is evidently sick is that the periodic examination deals with a patient who is presumably healthy, or at least his disability is of a mild degree. Hence there has arisen the term *pre-clinical* conditions, meaning those conditions which are not evident without a careful correlation of both the examination and the history.

Modern refinements of diagnosis enable a physician to read the human barometer for the signs of an approaching storm, and to prepare the patient for its onset, and even to steer the patient completely away from its path. The practice of pre-clinical medicine consists in the diagnosis and treatment of lowered states of health and of slight degrees of deviation from health. The field is as broad as that of medicine itself. It embraces

obstetrics, and surgery, dentistry and dietetics, and so on down the whole list of medicine and its allied sciences.

How shall anyone prepare himself to practice in all this broad field? If he is a general practitioner, he is already expected to be able to recognize a deviation from the normal in every line of examination. If he cannot explain a condition himself, he will call in a consultant who can explain it. He will consider every apparent abnormal symptom and sign, and will give his best effort to its interpretation. He will not be a pessimistic prognosticator and tell every patient that he is threatened with heart disease or Bright's, neither will he say to the patient "Run along and forget it." He will consider every point in its relation to the rest of the patient's body, and will do some honest thinking and possibly research in regard to it. This is what constitutes the practice of pre-clinical medicine.

F O

## LEGISLATURE OF 1925

By the time this Journal reaches the members of the Medical Society of the State of New York it is very probable that the Legislature of 1925 will have passed into history. And it can be said that in many respects it has been a peculiar situation. This is so because of the fact that the Legislature has been of one political faith and the Governor of opposite faith. Therein many phases of legislation may be said to have suffered through lack of interest on the part of the legislators in arguing what might become of features presented to the State Executive in view of this division in political allegiance.

In general, the Medical Society may be said to have been treated with the greatest courtesy by the legislators during this past year. Your Committee on Legislation has received far greater courtesy through its representatives and emissaries who have appeared before the various committees in the legislature, and the questions under discussion have received from the legislators a more free expression of reason in sound thinking than in several of the years past.

It is to be expected that with the desire on the part of reasonable people to learn more of the true aims of science and medicine in the prevention, treatment, and care of bodily ailments, it has been a pleasure on the part of the medical profession and its representatives to furnish such knowledge and answers to questions as were readily at hand.

The majority of the legislators, even some of those who are opposed to the medical profession because of a belief in the existence of a so-called medical trust, have shown the utmost courtesy in discussing and arguing the thoughts advanced by members of the profession.

There have been some, however, as is found in all groups, who through lack of desire, of education or of reasoning power or other reasons, have refused even to grant to the profession a meed of praise in its endeavor to alleviate human ills.

For such is the course of the political life of this nation.

Your profession has not asked for things unreasonable during this past year, but through its ramifications in the County Societies and the governing body of the State Society, it has endeavored to maintain calm and mature judgment that it might steer a clear course in questions pertaining to the public health.

It has opposed with vigor questions of legislation inimical even in thought to the welfare of the people who are to follow this generation. Most of this opposition has been advanced by reason of experiences gained in public health matters in other States and countries where these same questions have been tried out and have been found inadequate of practical application, or

absolutely at variance with the advances of the other sciences which go hand in hand in this life.

That the question of public health is one of vital importance can be gainsaid by no one.

The Chief Executive of this State, in his message to the Legislature on January 7th, 1925, devoted no less than over 10 per cent to public health topics, mentioning in detail the various efforts on the part of governmental branches of the State to promote public health and safeguard the citizens in this respect.

Some of his suggestions have already been put into law.

Unfortunately some have been so drafted as to bring criticism from medical and other sources, but in the main only because of the practical application as would be put in force rather than in the theory advanced, but to the credit of the Governor may it be said, that his thoughts and action have seemed consistently to bear out a set policy on his part to benefit the whole State in its needs regarding public health, while leaving the details to those who should know and who are looked upon as being most competent to advise.

No longer is the question of public health to be relegated to a secondary position but rather through the co-ordinate efforts of the State government and the various members of the profession of medicine it has been raised to a position of paramount importance in this State and from this position of the State of New York are other states now fashioning their public health measures.

It is to be hoped, but it would seem almost a miracle, that all of the measures in which the Medical Society of the State of New York has been interested in the affirmative, might be enacted into law, while those matters in which frank opposition has been voiced might be defeated, and yet greater interest has been shown on the part of the group of physicians as a whole and through the awakening of more individual physicians as to their duties than has been exhibited in past years.

Your Committee on Legislation has endeavored to fulfill its functions as interpreted by its members, and through the guidance by vote and opinion of the individual County Societies to forward or retard the various types of legislation. This has been no easy matter, and from year to year becomes harder by reason of more compact opposition on the part of individual groups wishing to forward their special types of legislation, and strange to say, by reason of these same lay groups, in the majority of instances, giving but half hearted support to such type of legislation as the Medical Society desires to see forwarded.

Credit without stint should be given on the part of the members of the profession to the

reawakening in the various County Society organizations, brought about undoubtedly through renewed interest in medical subjects, in civics and in politics, engendered by visits from your State officers and your Executive Officer and the weekly publication of the State Journal under the guidance of its Editor-in-Chief and his associates

The Presidents of the District Branches have improved the opportunities now and again offered through the Journal, undoubtedly to the betterment of legislative effort, but there still is vast room for advancement and improvement

Attention is called to this, the next to the last issue in which the columns on legislation will fill the larger part of the Journal. Your Committee on Legislation of the Medical Society must now turn its effort toward a report to be rendered to the House of Delegates and to give an account of its stewardship to the governing body of the Society. That its efforts may be along the lines of advance in suggestions and recommendations it asks from individual members of the Society,

communications, the thoughts of which may be embodied in its report to the House of Delegates, and suggestions, resolutions or recommendations from the county society groups which make up the State Society as a whole

It has tried to be fair in all of its actions to accord its views to the wishes of the majority of those who have been consulted on legislative matters. Physically it could not reach out and obtain the view of each individual member, but opportunity now is given for expression of thought on the part of any individual member who may have disagreed with the attitude of your Committee and who may not be in a position to project his thought into the governing body of the Society—the House of Delegates

In closing this, the last real editorial work of your Committee, it wishes to thank those who have endeavored to work with it, even though they may have advanced opinions opposite in principle to those brought forward by the Committee

J N V V

---

## THE NURSING SITUATION

One of the problems before the physicians of New York State is that of nursing. Physicians generally will agree that the following facts exist

1 The number of nurses is not equal to the demand for their services

2 There are many specialties in nursing—operating room, obstetrical, psychiatric, public health, contagious disease, tuberculosis, and so on for a long list of specialties

3 A skilled nurse who understands the post-operative care of cases of major surgery is the product of long training, and three years is none too long to develop that type of nurse

4 The nurse who is highly trained deserves special recognition with the title, "registered nurse," and the privileges and social standing which go with that title

5 The demand for highly trained nurses exceeds the supply

6 In nursing, as in any other line of work, an under supply of workers leads to undue independence both in accepting cases and in continuing with them under unpleasant conditions

7 The average highly trained nurse is a specialist who confines her activities to certain hours, and certain duties

8 Many persons object to having a trained nurse in their homes because of the necessity of having to have "some one to wait on the nurse"

9 There is a very great field for the services of nurses who are less highly trained,

and who are willing to do some kinds of house-keeping in addition to the care of the sick

10 There is a grave danger that unskilled nurses, like incompetent healers, may pretend to a knowledge which they do not possess, and may endanger the health or life of the patient and the reputation of the attending physician or surgeon

11 There are great difficulties in the way of establishing several degrees of fitness for nursing and of credentials of capabilities

12 The board for licensing nurses in New York State is constantly raising the standards for graduating nurses, and are continually adding training in the specialties such as psychiatry

13 Nurses in training are expected to study many branches which are preliminary studies in medical courses, and as a result of time spent on theoretical subjects, insufficient time is spent in practical bedside nursing

14 Is it not possible to give candidates a training of two years in the fundamentals of nursing, and graduate them with reliable credentials which indicate their fitness to care for common cases in either a private house or a hospital?

15 Who can consider these conditions and advise a remedy, better than the leaders of the Medical Society of the State of New York?

The State Society has a committee that is actively working on the subject, and a constructive plan of action may be expected to result from their labors

F O

# LEGAL

By GEORGE W. WHITESIDE, Esq.  
Counsel Medical Society of the State of New York

## FRACTURES OF BOTH FEMURS, DELAYED UNION, GANGRENE OF LEFT FOOT AND LEG WITH AMPUTATION

A man about 54 years of age, while crossing a public highway, was struck and run over by a taxicab, sustaining fractures of both of the femurs and numerous abrasions and contusions on both legs from the hips to the feet. He was removed to a hospital where the contusions were given first aid treatment and the fractured limbs placed in splints. The family physician, a general practitioner, was called to attend the man. He in turn called in a surgeon who had the patient removed to another hospital on the following day. Upon admission at that hospital there was found an abrasion of about an inch in diameter on the forehead, the patient was very nervous and his lips pale. There were abrasions on both hands on the left knee joint and over both legs and feet. The fracture of the right femur was at about the middle third and a sharp bony edge projected immediately under the skin. There was a definite false point of motion at this point, crepitus being elicited. The patient was unable to flex the right thigh. The left femur was fractured at about the middle third and in a transverse line, there being marked tenderness, and a false point of motion was present in the left leg. There was eversion of both feet. The upper fragments of the fractured bones were markedly displaced forward and outward and the lower fragments backward and inward. Under a general anaesthesia and using a Hawley table, reduction was made of both fractures, the surgeon procuring good alignment and end apposition being obtained. A plaster cast extending from the chest to and including both legs was then applied. The patient was returned to bed in fair condition.

On the following day X-rays were taken which showed a transverse fracture of the left femoral shaft four inches below the articular surface. The anterior posterior view showed good alignment, the lateral view showing a posterior displacement of the lower fragment. An X-ray of the right leg showed a transverse fracture of the femoral shaft. The lateral view showed a marked displacement with angulation, the anterior posterior view showing slight angulation. At the time of the taking of the pictures the patient was suffering from shock and was in severe pain. His pulse was weak, it being necessary to stimulate him. It was until April 11 that he waited four days, removed the

casts from both legs and applied Hodgens splints suspended on a Balkan frame. Traction was applied to both legs with counterweights and the knees bent. The patient was maintained in this apparatus until May 2, daily adjustments of the apparatus being made as was indicated by the patient's condition for the necessity for such adjustments. X-rays taken between April 11 and May 2 of the right leg showed angulation with slight over-riding. X-rays of the left leg likewise showed over-riding and slight angulation. During this time the patient was given the continuous personal care and attention of the surgeon, and the necessity of the performance of an open operation was discussed with the patient's family.

A physician specializing in bone surgery was called in consultation who approved of the treatment that was then being rendered to the patient, and advised the performance of an open operation upon the right leg. On May 2nd, under a general anaesthesia, using a Hawley table, an open operation was performed upon the right leg and a four-screw Lane plate inserted. Before the insertion of the Lane plate the various other methods of holding the fractured bones in apposition were considered, but due to the condition at the point of fracture and the patient's physical condition, the use of Lane plates was deemed the best and most advisable procedure to follow at that time. At the open operation a bone to bone apposition was obtained on the internal side, there being a hiatus on the external side. Upon completion of the operation a cast was applied to both legs, extending above the umbilicus. The cast on the left leg, however, did not reach the ankle, as there was an open wound on the lower left leg. At the time of the performance of the open operation upon the right leg, because of the patient's physical condition, it was not possible to operate upon the left leg. After the open operation the patient was returned to bed in poor condition and it was necessary actively to stimulate him. His pulse was rapid, skin cold and clammy and he complained of severe pain in the lower extremities. Within a few hours after the performance of the operation on the right leg, the left foot became cold and cyanosed and the cast on that leg was immediately removed, the foot elevated and heat applied and baking ordered in an endeavor to stimulate circulation. The patient continued under daily observation

and care of the surgeon and by May 23rd had developed bed sores rendering it necessary to remove the entire cast and there was then applied posterior and lateral splints to the right leg. At that time it was not possible to apply any splints to the left leg because of the gangrenous condition which had developed in the left foot. On May 12, an X-ray was taken of the right leg which showed the Lane plate in position with perfect apposition and no angulation. On May 13, a window was cut in the cast on the right leg over the site of operation. The wound was then found to be clean and was dressed at that time. This wound was dressed daily and on May 17, there was a slight serous discharge from the wound which was open and a large amount of greenish-black fluid with a sour odor was evacuated and a rubber tube inserted for drainage. This wound continued to drain for a long period of time. On May 26, on manipulation a pocket of pus was opened in the wound. From time to time the wound was irrigated with Dakin solution, but it was necessary to discontinue the use of this as the same cause an irritation to the skin. An X-ray taken on June 18 showed the Lane plate had lost its hold and the two upper screws were out of their original position. Two days later the Lane plate and the screws were removed. At various times between May 19 and June 20, it was necessary to remove parts of the cast on different portions of the right leg as the patient developed sores and complained of pain. On June 22, both legs were placed in a wire mesh splint, at that time it being impossible to apply traction as both legs were emaciated, particularly the left one. The gangrenous condition of the left leg progressed between May 4 and July 18 and during this period there was from time to time a sloughing of the tissues, and on July 18 the gangrenous part of

the left foot was amputated. After this amputation the patient remained in the care of this surgeon only until July 26, when he was removed to another hospital and passed into the care of another surgeon. He remained at that hospital from that date until about February 18 of the following year, during which time various methods of treatment and operation were performed upon him to produce union in the fractured femurs. It was also necessary to make a further amputation of the left leg, adhesions had formed in both of the knee joints which had to be broken up.

The operative wound on the right leg eventually healed and union was procured in both of the femurs, and with the aid of an artificial foot the patient was able to be about.

The first surgeon who treated him was paid only part of his bill. He then directed that an action be instituted to collect his unpaid bill. This action was met by a suit on behalf of the patient charging the surgeon with malpractice and alleging that his entire course of treatment, the operation and the use of the Lane plates were carelessly and negligently done and not in accordance with the proper and approved practice, that by reason of such alleged negligence, union was delayed in both of the fractured femurs, gangrene was permitted to develop in the left foot, resulting in amputation, and the patient was confined to a hospital for many months and sustained permanent injuries. The malpractice action came on for trial and after conference with the plaintiff's attorneys we were able to convince them that instead of the plaintiff having any complaint or cause of action against the surgeon, that he should be thankful for all that the surgeon had done to save the patient's life. As a result, the patient consented to the discontinuance of his action against the surgeon.

---



# LEGISLATION



By JAMES N. VANDER VEER, M.D.  
Chairman, Committee on Legislation

INDEX OF LEGISLATIVE BILLS				B—Bill printed		C—Comment	
Senate Int No	Assembly Int No	Law	Subject	Committee to which bill is referred		Page and Date	
29	527	Penal	Prohibition Enforcement	S Codes	A Codes	221	Feb 13
115	215	Public Health	THE NARCOTIC BILL	S Public Health	A. Public Health	80	Jan 23
116	216	Insanity	Institutions for Addicts	S General Laws	A Judiciary	382	Mar 6
211	307	Public Health	MEDICAL PRACTICE ACT	S Public Health	S Public Health	84	Jan 23
228	236	State Charities	Children's Institutions	S General Laws	A. Judiciary	382	Jan 30
263		Insanity	Insanity Examiners	S General Laws	A. Judiciary	123	Mar 6
283	399	County	County Nurses	S Internal Affairs	A Internal Affairs	329	Feb 27
302	748	Education	Health Service in Schools	S Public Education	A Public Education	174	Feb 6
380	570	Workmen's Comp	Choice of Physician	S Labor and Industry	A Labor and Industry	382	Mar 6
473		Public Health	Druggess Practitioner Bill (Gibbs)	S Public Health	A Public Education	175	Feb 6
586	850	Education	Med Exam in Schools	S Public Education	A Public Education	441	Mar 13
594	301	Workmen's Comp	Choice of Physician	S Labor and Industry	A. Labor and Industry	176	Feb 6
647	184	Workmen's Comp	Examination After Injury	S Labor and Industry	A. Labor and Industry	383	Mar 6
671	868	Penal Law	Physically Handicapped	S Judiciary	A Judiciary	272	Feb 20
693	950	Public Health	Persons	S Public Health	A Public Health	183	Feb 6
701		Public Health	Foreign Medical Degrees	S Public Health	A Public Health	383	Mar 6
789		Public Health	Revocation of License	S Public Health	A Public Health	288	Feb 20
943	1167	Public Health	Chiropractic Bill (Bouton's)	S Public Health	A Public Health	276	Feb 20
944	1423	Public Health	Laboratory Supplies	S Public Health	A. Public Health	336	Feb 27
127		Education	Chiropractic Bill (Fearon- Jenks)	S Public Health	A. Public Health	442	Mar 13
185			Health Service in Schools	S Public Health	A. Public Health	343	Feb 27
1378	1412		Chiropractic Bill (Nicoll's)	S Public Health	A Public Education	386	Mar 6
229		Education	Drug Addicts	General Laws	A Public Education	386	Mar 6
422		Civil Practice	Marriage Licenses	Public Health	A Codes	443	Mar 13
649		Public Health	Mentally Retarded Children	Public Health	A Codes	86	Jan 23
678		Public Health	Professional Secrets	Public Health	A Codes	341	Jan 23
908		Penal Law	Chiropractic (Esmonds's)	Public Health	A Codes	87	Jan 23
925		Public Health	Exam of Food Handlers	Public Health	A Codes	341	Jan 23
987		Penal	Wood Alcohol	Public Health	A Codes	341	Jan 23
1321		Public Health	Reciprocity in Licensures	Public Health	A Codes	341	Jan 23
1343		Public Health	Birth Control	Public Health	A Codes	341	Jan 23
1351		Workmen's Comp	Vital Statistics	Public Health	A Codes	341	Jan 23
1377		Penal Law	Chiropractic (Edmond's)	Public Health	A Codes	341	Jan 23
1421		Public Health	Medical Service	Public Health	A Codes	341	Jan 23
1429		Public Health	Antivivisection	Public Health	A Codes	341	Jan 23
1463		Public Health	Chiropractic and Podiatry	Public Health	A Codes	341	Jan 23
		Public Health	Chiropractic and Lenses	Public Health	A Codes	341	Jan 23
		Public Health	Chiropractic (Bolton)	Public Health	A Codes	341	Jan 23

# SPECIAL ATTENTION

To Chairmen of County Legislative Committees and  
Members of County Medical Societies:

Have you written your letters to, or personally interviewed, your  
legislators on the following legislative bills?

## FAVORING

## AGAINST

Senate Int 115, Conc Assembly Int 215—The Narcotic Bill	Senate Int 473—The Drugless Practitioner Bill
Senate Int 116, Conc Assembly Int. 216—Re- quiring the licensing of private institutions for the treatment of drug addicts	Senate Int 647, Conc Assembly Int 184—Ex- amination after injury
Senate Int 211, Conc Assembly Int 307—State Department of Education Bill on Medical Practice	Senate Int 789—Senator Bouton's Chiropractic Bill
Senate Int 380, Conc Assembly Int. 570—In- jured employee to select his physician	Senate Int 943, Conc Assembly 1167—Labora- tory Supplies
Senate Int. 594, Conc Assembly Int 301—Choice of Medical Attendants	Senate Int 944, Conc Assembly Int 1423— Practice of Medicine and licensing chiroprac- tors (Fearon-Jenks Bill)
Senate Int 671, Conc Assembly Int 868—Crip- pled Children	Assembly Int. 185—Assemblyman Nicoll's Chiro- practic Bill
Assembly Int 908—Control of wood alcohol	Assembly Int 422—Professional Secrets
Assembly Int 1351—Medical Director of Indus- trial Board	Assembly Int 649—Assemblyman Esmond's Chiropractic Bill
Senate Int 283—Conc Assembly Int 399— County Public Health Nurses Favor as now amended	Assembly Int 987—Birth Control
	Assembly Int 1423—Chiropractic (Jenks), Conc Senate Int 944
	Assembly Int 1463—Chiropractic (Bolton)

## BIRTH CONTROL HEARING

The hearing before the Assembly Committee on Codes on Assemblyman Boyle's Bill (A Int 987) which would authorize the use of contraceptive measures by physicians was attended by the leaders of the groups usually represented. The arguments presented were the same as in former years except that the proponents seemed inclined this year to speak more definitely of mechanical methods, which they said could be made 100 per cent perfect when applied by a physician, and that the scheme was applicable to married women only.

Among the proponents were Mrs Margaret Sanger and one or two persons in charge of her clinics.

The opposition was limited to a representative of your Committee on Legislation and the Rev William Sheaf Chase, who said that he represented nobody but himself, but is the President of the New York Civic League.

No action was taken by the Committee after the hearing because the Assembly had already gone into Rules.

Without doubt the bill will remain in committee.

In this connection, however, it might be well to speak of a point brought out by one of the proponents in the discussion, that, at present the

law is not sufficiently elastic to cover all occasions when the physicians may wish to advise contraceptive measures. The law reads that the physician may employ such measures to save life or prevent disease, and as was pointed out, that does not cover a case where it is thought wise that a woman should not bear children because of her tuberculosis, and the Chairman of the Committee on Codes suggested that perhaps in another year the law could be revised to read "to save life, prevent disease or *preserve the patient's welfare*"

The Representative of your Committee on Legislation was nonplussed for a minute in his opposition by a member of the committee exhibiting the result of a ballot taken on the bill by the physicians in a County Society. A majority of the society were recorded in favor of the enactment of the bill. It was concluded, however, that most likely those who voted affirmatively were not favoring the bill as it read but rather as Dr Elting had expressed it in his plea for the measure, "for the right to use measures to prevent conception when in their judgment they thought it was for the benefit of their patients." This controversy demonstrated the misunderstanding that can arise from a hasty or a prejudiced reading of a bill.

## LEGISLATIVE BUREAU

The work of this department will soon close to a very large degree and a perusal of page 26 of the January 16th, 1925, issue of the Journal, will tend to show that an advance has been made along the lines of information during this short period in which the Legislature has been in session.

While much of the legislation at the time of this writing is still pending, it is to be hoped that many of the bills still in committee may be passed which we have deemed as advanced by departmental government bureaus, and that such legislation as is inimical may be defeated.

Your Legislative Bureau has not been helped to the full extent sought in the recommendations,

and yet it is a well known fact that the medical profession moves slowly but surely in its efforts for a higher and higher stand in the protection of public health, and we as members of that profession in the State of New York have attempted to do our part as we saw it during this past session politically.

It is to be hoped that the same high standards will be maintained in the individual communities during the coming year and that when the next Committee on Legislation convenes it may find the ground prepared and the soil ready for more intensive work than has ever before been experienced.



## SUMMARY OF BILLS INTRODUCED IN LEGISLATURE IN SENATE

### Prohibition Enforcement

Senate Int No 29 (conc Assembly Int 527)  
—Assembly bill passed, on order of third reading  
in Senate

*Attitude* Neutral

### The Narcotic Bill

Senate Int No 115 (conc Assembly Int 215)

*Comment* Senate bill on order of third reading,  
Assembly bill still in committee No further  
comment

*Attitude* Favored

### Requiring the Licensing of Private Institutions for the Treatment of Drug Addicts

Senate Int No 116 (conc. Assembly Int 216)

*Comment* Still in committee

*Attitude* Favored

### The State Department of Education Bill Amending the Medical Practice Act

Senate Int No 211 (conc Assembly Int 307)

*Comment* Senate bill still in committee, Assembly  
bill on order of third reading, and will undoubtedly be on the calendar Tuesday or Wednesday,  
March 24th or 25th

*Attitude* Favored by State Society

### Inspection by State Charities Boards of Children's Institutions

Senate Int No 228 (conc Assembly Int 236)

*Comment* Still in committee

*Attitude* Neutral

### Qualifications of Examiners in Lunacy

Senate Int No 263

*Comment* Still in committee

*Attitude* Opposed by State Society

### County Public Health Nurses

Senate Int No 283 (conc Assembly Int 399)

*Comment* Senate bill passed March 16th,  
March 17th to Assembly Public Health Committee

*Attitude* Bill opposed by State Society in its  
original draft After certain amendments it was  
favored

### Health Service in Schools

Senate Int No 302 (conc Assembly Int 748)

*Comment* Senate bill on order of third reading,  
Assembly bill still in committee

*Attitude* Favored by State Society after  
amendments were made

### Vaccine Virus

Senate Int. No 351 (conc Assembly Int 536)

*Comment* Bill passed both houses Now in  
the hands of the Governor

*Attitude* Neutral

### Injured Employee to Select His Physician

Senate Int No 380 (conc Assembly Int 570)

*Comment* Still in committee

*Attitude* Favored by State Society

### The Drugless Practitioner Bill

(By Gibbs)

Senate Int No 473

*Comment* March 18th, amended and recom-  
mitted

*Attitude* Strongly opposed by State Society

### Inspection of School Children

Senate Int No 586 (conc. Assembly Int 580)

*Comment* Passed Senate, now in Assembly  
Public Education Committee

*Attitude* Neutral

### Free Choice of Physician

Senate Int. No 594 (conc. Assembly Int 301)

*Comment* Still in committee

*Attitude* Favored by State Society

### Practical Tests of Injured Persons

Senate Int No 647 (conc Assembly Int 184)

*Comment* Still in committee

*Attitude* Strongly opposed by State Society

### Physically Handicapped Persons

Senate Int No 671 (conc Assembly Int 868)

*Comment* On order third reading in Senate,  
also on third reading in Assembly

*Attitude* Neutral

### Abolishing Office of Coroner—Westchester County

Senate Int No 673

*Comment* Bill passed both Houses and was  
signed by the Governor on March 16th Now  
Chapter 139, Laws of 1925

*Attitude* Neutral

### Admission of Foreign Practitioners

Senate Int No 693 (conc Assembly Int 950)

*Comment* Still in committee

*Attitude* Neutral

### In Relation to Pharmacies

Senate Int No 632 (conc Assembly Int 802)

*Comment* Still in committee

*Attitude* Opposed

### Revocation of License to Practice Medicine

Senate Int No 701

*Comment* Still in committee

*Attitude* Neutral

### Hospital for Crippled Children at West Haverstraw

Senate Int No 786 (conc Assembly Int  
1074)

*Comment* Still in committee.

*Attitude* Neutral, until requested by Confer-  
ence of County Chairmen to urge that no action  
on this bill be taken for another year

### State Institute for Study of Malignant Disease

Senate Int No 787

*Comment* Still in committee

## BIRTH CONTROL HEARING

The hearing before the Assembly Committee on Codes on Assemblyman Boyle's Bill (A Int 987) which would authorize the use of contraceptive measures by physicians was attended by the leaders of the groups usually represented. The arguments presented were the same as in former years except that the proponents seemed inclined this year to speak more definitely of mechanical methods, which they said could be made 100 per cent perfect when applied by a physician, and that the scheme was applicable to married women only.

Among the proponents were Mrs Margaret Sanger and one or two persons in charge of her clinics.

The opposition was limited to a representative of your Committee on Legislation and the Rev William Sheaf Chase, who said that he represented nobody but himself, but is the President of the New York Civic League.

No action was taken by the Committee after the hearing because the Assembly had already gone into Rules.

Without doubt the bill will remain in committee.

In this connection, however, it might be well to speak of a point brought out by one of the proponents in the discussion, that, at present the

law is not sufficiently elastic to cover all occasions when the physicians may wish to advise contraceptive measures. The law reads that the physician may employ such measures to save life or prevent disease, and as was pointed out, that does not cover a case where it is thought wise that a woman should not bear children because of her tuberculosis, and the Chairman of the Committee on Codes suggested that perhaps in another year the law could be revised to read "*to save life, prevent disease or preserve the patient's welfare*".

The Representative of your Committee on Legislation was nonplussed for a minute in his opposition by a member of the committee exhibiting the result of a ballot taken on the bill by the physicians in a County Society. A majority of the society were recorded in favor of the enactment of the bill. It was concluded, however, that most likely those who voted affirmatively were not favoring the bill as it read but rather as Dr Elting had expressed it in his plea for the measure, "for the right to use measures to prevent conception when in their judgment they thought it was for the benefit of their patients." This controversy demonstrated the misunderstanding that can arise from a hasty or a prejudiced reading of a bill.

## LEGISLATIVE BUREAU

The work of this department will soon close to a very large degree and a perusal of page 26 of the January 16th, 1925, issue of the Journal, will tend to show that an advance has been made along the lines of information during this short period in which the Legislature has been in session.

While much of the legislation at the time of this writing is still pending, it is to be hoped that many of the bills still in committee may be passed which we have deemed as advanced by departmental government bureaus, and that such legislation as is inimical may be defeated.

Your Legislative Bureau has not been helped to the full extent sought in the recommendations,

and yet it is a well known fact that the medical profession moves slowly but surely in its efforts for a higher and higher stand in the protection of public health, and we as members of that profession in the State of New York have attempted to do our part as we saw it during this past session politically.

It is to be hoped that the same high standards will be maintained in the individual communities during the coming year and that when the next Committee on Legislation convenes it may find the ground prepared and the soil ready for more intensive work than has ever before been experienced.

## SUMMARY OF BILLS INTRODUCED IN LEGISLATURE IN SENATE

### Prohibition Enforcement

Senate Int No 29 (conc Assembly Int 527)  
—Assembly bill passed, on order of third reading  
in Senate  
*Attitude* Neutral

### The Narcotic Bill

Senate Int No 115 (conc Assembly Int 215)  
*Comment* Senate bill on order of third reading,  
Assembly bill still in committee No further  
comment  
*Attitude* Favored

### Requiring the Licensing of Private Institutions for the Treatment of Drug Addicts

Senate Int No 116 (conc Assembly Int 216)  
*Comment* Still in committee  
*Attitude* Favored

### The State Department of Education Bill Amending the Medical Practice Act

Senate Int No 211 (conc Assembly Int 307)  
*Comment* Senate bill still in committee, As-  
sembly bill on order of third reading, and will  
undoubtedly be on the calendar Tuesday or Wed-  
nesday, March 24th or 25th  
*Attitude* Favored by State Society

### Inspection by State Charities Boards of Children's Institutions

Senate Int No 228 (conc Assembly Int 236)  
*Comment* Still in committee  
*Attitude* Neutral

### Qualifications of Examiners in Lunacy

Senate Int No 263  
*Comment* Still in committee  
*Attitude* Opposed by State Society

### County Public Health Nurses

Senate Int No 283 (conc Assembly Int 399)  
*Comment* Senate bill passed March 16th,  
March 17th to Assembly Public Health Com-  
mittee  
*Attitude* Bill opposed by State Society in its  
original draft After certain amendments it was  
favored

### Health Service in Schools

Senate Int No 302 (conc Assembly Int 748)  
*Comment* Senate bill on order of third read-  
ing, Assembly bill still in committee  
*Attitude* Favored by State Society after  
amendments were made

### Vaccine Virus

Senate Int No 351 (conc Assembly Int 536)  
*Comment* Bill passed both houses Now in  
the hands of the Governor  
*Attitude* Neutral

### Injured Employee to Select His Physician

Senate Int No 380 (conc Assembly Int 570)  
*Comment* Still in committee  
*Attitude* Favored by State Society

### The Drugless Practitioner Bill (By Gibbs)

Senate Int No 473  
*Comment* March 18th, amended and recom-  
mended  
*Attitude* Strongly opposed by State Society

### Inspection of School Children

Senate Int No 586 (conc Assembly Int 580)  
*Comment* Passed Senate, now in Assembly  
Public Education Committee  
*Attitude* Neutral

### Free Choice of Physician

Senate Int No 594 (conc Assembly Int 301)  
*Comment* Still in committee  
*Attitude* Favored by State Society

### Practical Tests of Injured Persons

Senate Int No 647 (conc Assembly Int 184)  
*Comment* Still in committee  
*Attitude* Strongly opposed by State Society

### Physically Handicapped Persons

Senate Int No 671 (conc Assembly Int 868)  
*Comment* On order third reading in Senate,  
also on third reading in Assembly  
*Attitude* Neutral

### Abolishing Office of Coroner—Westchester County

Senate Int No 673  
*Comment* Bill passed both Houses and was  
signed by the Governor on March 16th Now  
Chapter 139, Laws of 1925  
*Attitude* Neutral

### Admission of Foreign Practitioners

Senate Int No 693 (conc Assembly Int 950)  
*Comment* Still in committee  
*Attitude* Neutral

### In Relation to Pharmacies

Senate Int No 632 (conc Assembly Int 802)  
*Comment* Still in committee  
*Attitude* Opposed

### Revocation of License to Practice Medicine

Senate Int No 701  
*Comment* Still in committee  
*Attitude* Neutral

### Hospital for Crippled Children at West Haverstraw

Senate Int No 786 (conc Assembly Int  
1074)  
*Comment* Still in committee.  
*Attitude* Neutral, until requested by Confer-  
ence of County Chairmen to urge that no action  
on this bill be taken for another year

### State Institute for Study of Malignant Disease

Senate Int No 787  
*Comment* Still in committee

*Attitude* Neutral, until requested by Conference of County Chairmen to urge that no action be taken on this bill by Legislature for another year

#### The Bouton Chiropractic Bill

Senate Int No 789

*Comment* Still in committee

*Attitude* Strongly opposed by State Society

#### Dissecting Material

Senate Int No 851 (conc. Assembly Int 1027)

*Comment* Senate bill still in committee, Assembly bill passed March 18th Now on order of third reading in Senate

*Attitude* Bill favored by State Society

#### Laboratory Supplies

Senate Int. No 943 (conc. Assembly Int 1167)

*Comment* Still in committee

*Attitude* Bill opposed by State Society

#### A Chiropractic Bill (By Fearon)

Senate Int No 944 (conc. Assembly Int 1423)

*Comment* Senate bill still in committee, Assembly bill on order of third reading

*Attitude* Strongly opposed by State Society

#### Foreign Licenses

Senate Int No 1123 (conc. Assembly Int 1478)

*Comment* Bill passed both houses and now in hands of the Governor

*Attitude* Favored by the State Society

#### Censors State Medical Society

Senate Int No 1176 (conc. Assembly Int 1348)

*Comment* Assembly bill passed, and now on order of third reading in the Senate

*Attitude* Favored by the State Society

#### Empowering Courts to Commit Drug Addicts to a City Hospital

Senate Int No 1378—A bill introduced in the Senate by Senator Leonard W Gibbs of Erie County, would add new section 115-a, Chapter 570, Laws of 1909, empowering courts to commit drug addicts to a City Hospital

To third reading without reference

No 1548

Int. 1378

IN SENATE,

March 16, 1925

Introduced by Mr Gibbs—read twice, and by unanimous consent, the rule was suspended, and said bill ordered to a third reading

#### AN ACT

To amend chapter five hundred and seventy of the laws of nineteen hundred and nine, entitled "An act to establish the city court of Buffalo, defining its powers and jurisdiction and providing for its officers," in relation to the jurisdiction of the court to commit drug addicts.

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Chapter five hundred and seventy of the laws of nineteen hundred and nine, entitled "An act to establish the city court of Buffalo, defining its powers and jurisdiction and providing for its officers," is hereby amended by adding a new section, to follow section one hundred and fifteen, to be section one hundred and fifteen-a, to read as follows

§ 115-a Power to commit drug addicts In addition to the jurisdiction conferred on courts of record by section one hundred and seventy-three, one hundred and seventy-four, one hundred and seventy-five and one hundred and seventy-six of the insanity law, such court, on the arrest by any peace officer of any person for unlawfully using opium, morphine, cocaine, euaine, heroin, or any of their derivatives, or any other habit forming drug or substance, or on information that any person is using the same, may commit such person to any hospital supported by the city, to be detained therein for a period not exceeding one year, or for such period less than a year as may be necessary, in the judgment of the physician in charge of such hospital, for the proper treatment and cure of such person, and any hospital supported by the city is authorized to receive and treat any person so committed

§ 2 This act shall take effect immediately

*Comment* Comment is invited

#### Statement for Marriage Licenses

Senate Int. No 1412—A bill introduced in the Senate by Senator Courtland Nicoll, of New York County, would amend Section 15, Domestic Relations Law, relative to statements for marriage licenses by striking out provision concerning venereal disease.

To General Laws Committee

Int 1412

IN SENATE,

March 18, 1925

An Act by Mr Nicoll to amend the domestic relations law in regard to applications for marriage licenses

Section 1 Section fifteen of Chapter nineteen of the laws of 1909, entitled "An act relating to the domestic relations constituting chapter fourteen of the consolidated laws," as last amended by chapter 317 of the laws of 1921, is hereby amended to read as follows

15 Duty of town and city clerk It shall be the duty of the town or city clerk when an application for a marriage license is made to him to require each of the contracting parties to sign \* \* \* maiden name of mother, country of birth, number of marriage [From each A statement in the following words "I have not to my knowledge been infected with any venereal disease, or if I have been so infected within five years I have had a laboratory test within that period which shows that I am now free from infection from any such disease"] (Remainder same as old law)

*Comment* No comment

## LEGISLATIVE INVESTIGATION OF ILLEGAL PRACTITIONERS

The following resolution was introduced by Senator Love, March 17

*Whereas*, it is of common report that medicine is being extensively practiced throughout the State of New York by graduates of low-standard institutions, who have obtained diplomas from sources not recognized by New York State authorities and that the general practice of such so-called physicians has become so great as to jeopardize the public health of the State,

*Be It Resolved* (if the Assembly concur), That a joint legislative committee is hereby created to consist of three members of the Senate to be appointed by the temporary president of the Senate, and five members of the Assembly, to be appointed by the Speaker of the Assembly, to inquire into and ascertain the following facts

If public health has been injured by the activity of self-styled medical institutions and "diploma mills," if graduates of any such low-standard institutions are employed by the State Public Health Service or any other branch of the State government, if the standing of the State medical institutions and of our medical profession generally has been injured in other States by the action of such self-styled medical institutions and diploma mills, if graduates of such institutions and diploma mills are now offering themselves as practitioners of medicine in the State of New York, if all the laws and requirements as to registration are being observed by practitioners of medicine in the State of New York, if any institutions giving degrees in medicine in the State of New York, are issuing diplomas or degrees to persons without sufficient

knowledge and training as to legitimately entitle them to such diplomas or degrees, to ascertain from the United States Government officials if the mails have been used by such self-styled medical institutions and organizations known popularly as diploma mills for purposes of fraud in connection with the sale of degrees or diplomas in preparation for medical practice, and to inquire to the fullest possible extent as to the legitimate transactions of all institutions or schools issuing such diplomas or degrees

Such committee shall choose from its members a chairman, may employ a secretary, counsel, stenographers and such other employees and assistants as may be necessary and fix their compensation. Such committee shall have power to sit within and without the city of Albany and within and without the State of New York, having authority to subpoena and compel the attendance of witnesses, including the production of any book, paper, document or record pertaining to the subject of its investigation and shall have and possess generally all of the powers of a legislative committee

Such committee shall report to the legislature of nineteen hundred and twenty-six the result of its findings, together with such remedial legislation as it may deem warranted in suggesting

*Be It Further Resolved* (if the Assembly concur), That the actual and necessary expenses of the committee in carrying out the provisions of this resolution, not exceeding the sum of thirty thousand dollars (\$30,000), be paid from the legislative contingent fund upon vouchers audited and approved by law

To Finance Committee

### IN ASSEMBLY

#### Health Service in Schools

Assembly Int No 127

*Comment* Still in committee

*Attitude* Opposed by State Society

#### Practical Tests of Injured Persons

Assembly Int No 184 (conc Senate Int 647)

*Comment* Still in committee

*Attitude* Opposed by State Society

#### The Nicoll Chiropractic Bill

Assembly Int No 185

*Comment* Still in committee

*Attitude* Strongly opposed by State Society

#### The Narcotic Bill

Assembly Int. No 215 (conc Senate Int 115)

*Comment* Still in committee

*Attitude* Favored

#### Institutions for Addicts

Assembly Int No 216 (conc Senate Int 116)

*Comment* Still in committee

*Attitude* Favored

#### Mentally Retarded Children

Assembly Int No 229

*Comment* Still in committee

*Attitude* Neutral

#### Children's Institutions

Assembly Int No 236 (conc Senate Int 228)

*Comment* Still in committee

*Attitude* Neutral

#### Free Choice of Physician

Assembly Int No 301 (conc Senate Int 594)

*Comment* Still in committee

*Attitude* Favored by State Society

#### State Department of Education Bill Amending the Medical Practice Act

Assembly Int No 307 (conc Senate Int 211)

*Comment* Assembly bill on order of third reading

*Attitude* Favored by State Society

**County Public Health Nurses**

Assembly Int No 399 (conc Senate Int 283)  
*Comment* Assembly bill on order of third reading  
*Attitude* Now favored, since it has been amended

**Disclosure of Confidential Communications**

Assembly Int No 422  
*Comment* Still in committee  
*Attitude* Opposed by State Society

**Prohibition Enforcement**

Assembly Int No 527 (conc Senate Int 29)  
*Comment* Passed Assembly, now on order of third reading in Senate  
*Attitude* Neutral

**Free Choice of Physician**

Assembly Int No 570 (conc Senate Int 380)  
*Comment* Still in committee  
*Attitude* Favored by State Society

**Chiropractic Bill  
(By Esmond)**

Assembly Int No 649  
*Comment* On order third reading in Assembly  
*Attitude* Strongly opposed by State Society

**Periodic Health Examination of Food Handlers**

Assembly Int No 678  
*Comment* Still in committee  
*Attitude* Neutral

**Health Service in Schools**

Assembly Int No 748 (conc Senate Int 302)  
*Comment* Assembly bill still in committee, Senate bill on order third reading  
*Attitude* Favored after amendments were made

**Medical Inspection in Schools**

Assembly Int No 850 (conc Senate Int 586)  
*Comments* Still in committee  
*Attitude* Neutral

**Physically Handicapped Persons**

Assembly Int No 868 (conc Senate Int 671)  
*Comment* On order third reading  
*Attitude* Neutral

**Regulating Sale of Wood or Methanol Alcohol**

Assembly Int No 908  
*Comment* Still in committee  
*Attitude* Favored by State Society

**Reciprocity in Licensure**

Assembly Int No 925  
*Comment* Still in committee  
*Attitude* Neutral

**Admission of Foreign Practitioners**

Assembly Int No 950 (conc Senate Int 693)  
*Comment* Still in committee  
*Attitude* Neutral

**Dissecting Material**

Assembly Int No 986 (conc Senate Int 681)  
*Comment* Still in committee  
*Attitude* Favored by State Society

**The Birth Control Bill**

Assembly Int No 987  
*Comment* Still in committee.  
*Attitude* Opposed by State Society See article on Birth Control Hearing, p 538

**Laboratory Supplies**

Assembly Int No 1167 (conc Senate Int 943)  
*Comment* Still in committee  
*Attitude* Opposed by State Society

**Another Esmond Chiropractic Bill**

Assembly Int No 1343  
*Comment* Still in committee  
*Attitude* Strongly opposed by State Society

**Medical Treatment of Injured Employees**

Assembly Int No 1351  
*Comment* Still in committee  
*Attitude* Strongly urged by State Society

**Scientific Experiments on Dogs**

Assembly Int No 1377  
*Comment* Still in committee  
*Attitude* Opposed by State Society

**Chiropractic Bill  
(By Jenks)**

Assembly Int No 1423 (conc Senate Int 944)  
*Comment* The Assembly Bill is on order of third reading  
*Attitude* Strongly opposed by State Society

**Sale of Eyeglasses and Lenses**

Assembly Int No 1429  
*Comment* Still in committee  
*Attitude* Favored by State Society

**Chiropractic Bill  
(By Bouton)**

Assembly Int No 1463  
*Comments* Still in committee  
*Attitude* Strongly opposed by State Society

**Foreign Licensure**

Assembly Int No 1478 (conc Senate Int 1123)  
*Comment* Bill passed both houses, now in hands of Governor  
*Attitude* Favored by State Society

**Practice of Pharmacy**

Assembly Int No 1539 (conc Senate Int 1231)  
*Comment* Passed Assembly, now in Senate Public Health Committee  
*Attitude* Favored by State Society



# State Department of Health



## ANOTHER CHILD MARTYR PROMOTES THE CAUSE OF DIPHThERIA IMMUNIZATION

A child, ten years of age, recently died of diphtheria in one of the cities of the State. This child was a pupil in a private school where immunization had been offered some time previously. At that time, however, the school principal had not consented that the work should be done, after the child died, however, the health officer again brought the subject to the attention of the principal. Realizing that one of the chil-

dren had died from diphtheria, probably unnecessarily, he then accepted the health officer's proposal to immunize the children in the school. Consents for the immunization were obtained from the parents of 102 of the 160 pupils who constitute the school. The health officer has recently reported that the work of immunization among those who presented the consents is practically complete.

## BUFFALO BETTER BUSINESS COMMISSION EXPOSES "MEDICAL SPECIALISTS'" METHODS

The Buffalo Better Business Commission, a non-stock, non-profit organization of business men organized for the purpose of protecting the public from fraud and deceit in the advertising and selling of merchandise, in its bulletin for January 5, gives an expose of the methods employed by a group of men posing as specialists in the treatment of diseases of man. Representa-

tives of the commission visited the offices of these men and had diagnoses made of their "condition." In one case a report was made to the patient of the results of an urinalysis when a sample of urine had not been submitted. The report states that newspapers which have been notified of the facts of the investigation have since refused the advertising of the firm.

## SOME CHURCHES REALIZE THEIR RESPONSIBILITY IN THE CONTROL OF VENEREAL DISEASES

Recently a church invited a physician from the Division of Venereal Disease Control to address the men in its "Problem Class." The speaker discussed the public health aspect of gonorrhea and syphilis and pointed out the responsibility of the church in their control. The men were so well impressed with the practical measures suggested for the reduction of the inci-

dence of these insidious diseases, and with their own opportunity actively to participate in the State program for their ultimate eradication that they requested the lecture be followed by a series of talks in order to help the men to organize as a church group and also to prepare them individually for the responsibility of instructing their own boys along sex hygiene lines.

## GRANVILLE PLANS BETTER NURSING SERVICE

At a combined meeting of the health and educational authorities of the village of Granville, Washington County, and the Chairman of the Committee on Health Promotion, it was decided that the present nursing service of the village

was inadequate, and that it was desirable that the schools and the village should each have a full-time nurse. The various boards represented at the meeting have been requested to take favorable action on the matter.

## WASHINGTON COUNTY SUPERINTENDENT IMPROVES SCHOOL SANITATION

The school superintendent of the second district in Washington County has been making a drive in her district to improve the sanitary condition of school houses.

She reports that no common drinking cups or dippers are now to be found in her entire district. A majority of schools are using individual

paper drinking cups, the rest individual metal cups. All outhouses have been thoroughly cleaned and repaired and several new ones have been built. In several of the schools complete rearrangement of seating has been accomplished in order to furnish proper light for the children and conserve their sight.



# NEWS NOTES



## 35TH REUNION CLASS OF 1890

The Class of 1890, Bellevue Hospital Medical College, dined at the Hotel Astor on the evening of March 10, celebrating the thirty-fifth anniversary of graduation. There were present Chancellor Brown, Professor Frederic S. Dennis, the only surviving member of the faculty of 1890, and Dr. Robert J. Carlisle, Drs. Reginald Sayre and Henry Mann Silver, who were instructors at that time. Dr. Thomas Manning of New Rochelle presided. The newly elected officers were Dr. Edward B. Hickel, Pittsburgh, President, Dr. Samuel G. Tracy, Vice-President, Dr. Henry W. Frauenthal, Treasurer, and Dr. John E. Virden, Secretary and Historian. Others

present were Drs. Charles W. Banks, East Orange, New Jersey, Clarence S. Kurtz, Malvern, Pennsylvania, William H. Murray, Danbury, Connecticut, Erasmus A. Pond, Brooklyn, Ernest E. Schierge, Scotch Plains, New Jersey, Paul H. Fairchild, Frank Hollister, N. B. Van Etten, and Robert J. Wilson, New York.

One hundred and forty-four men graduated in this class, sixty-four of whom still keep in touch with the secretary. A dinner has been held every March 10th for the last eleven years in the yacht room of the Astor and the room is engaged for ten years more.

## ALUMNI ASSOCIATION OF FORDHAM HOSPITAL

The Alumni Association of Fordham Hospital held the Fourth Annual Dinner on March 14th at the Concourse Plaza Hotel. One hundred and fifteen of the former internes and their guests enjoyed a very delightful evening. Dr. Fred Schaeffer presided and made the only speech of the evening.

The Fordham Hospital, now housed in a modern building accommodating three hundred patients, facing Bronx Park on the Southern Boulevard, is thirty-three years old. It was started by Dr. Robert A. Joyce and opened by the Department of Charities and Correction in 1892 in a

remodeled residence at the corner of Valentine Ave. and 188th Street.

It is interesting to note that this was previously the house of three physicians, Dr. Eugene E. R. Peuguet, 1861 to 1879, Dr. Havilah Sprague, 1868 to 1874, and Dr. John H. Eden, 1880 to 1890, and since the Fordham Hospital moved to larger quarters, this same site, with added property, has been occupied by the Union Hospital.

The ground is truly hallowed by sixty-four years of altruistic services.

## PROGRESS IN NEW MEDICAL CENTER

The work on the Medical Center of New York City which was initiated through the combined efforts of the Columbia University and the Presbyterian Hospital in the City of New York, is making steady progress. The Joint Administrative Board reports that the excavations for the combined School and General Hospital Building is now advancing rapidly, and that contracts for the steel, brick, sand, and gravel have been awarded, and that work on the foundation will commence May 1st.

There have recently been two important additions to the Center. The Babies' Hospital and the Neurological Institute of New York have both signed agreements with the Joint Administrative Board and will receive land for the erection of their new institutions as a part of the Medical Center.

The Babies' Hospital which is at present located at 55th Street and Lexington Avenue, is unique in its field as it is the only institution which up to this time has devoted its efforts ex-

clusively to children under four and a half years of age. It is well known also through the work of the late Dr. L. Emmet Holt, and its research work in feeding and surgery of infants. In the new Center the scope of the Babies' Hospital will be expanded to include older children.

The Neurological Institute of New York which has just completed its fourteenth successful year is equally unique in the medical field. It is the first cooperative effort of a neuropsychopathic group in America to meet the growing need for treatment and study of the neurosis and early mental disorders among the working classes. The growing menace of this increasing group of nervous disorders has been met with their limited facilities, not only by treatment but by research and the training of physicians and nurses in the care of this particular type of individual. Both institutions will not only bring to the Center a well organized unit which will contribute much to the success of the



Center, but through the change will find an enlarged expression for their endeavors

The Joint Administrative Board has been augmented by the addition of the president of the Babies' Hospital, John Sherman Hoyt, and the president of the Neurological Institute, Robert Thorne. The Joint Administrative Board is at the present time composed of General William Barclay Parsons, Chairman, Dean Sage, Robert

W de Forest, Walter B James, Edward S Harkness, John G Milburn, John Sherman Hoyt, Robert Thorne, with Dr William Darrach, Dean of the Medical School, acting in an advisory capacity, and Dr C C Burlingame as Executive Officer

THE JOINT ADMINISTRATIVE BOARD,  
17 East 42nd Street,  
New York

## AN EXPERIENCE WITH CHIROPRACTORS

It is not sufficient that the campaign against cultists be limited to one or two medical journals. There should be more publicity of the type which will reach the lay public, serious, severe, and unrelenting. If the chiropractors and other cults may use the lay press for their purposes, with frequent references of ridicule towards the medical profession, there is no reason why we should not do the same.

May I relate a personal experience with chiropractors? A young woman, in her late twenties became a patient of mine. A late evening hurry call brought me to the bedside of this young lady, whom I found in a condition very near the end. She sat crouched up in bed gasping for breath, cyanosed and coughing up bloody, frothy mucus, pulse almost imperceptible and irregular, an attack of cardiac decompensation as my readers will recognize. By a miracle she survived the night. She had suffered all the previous day, received chiropractic treatment without relief, and the seriousness of the condition becoming apparent to friends and neighbors, it was deemed advisable to call a physician. Seemingly the shadow of the undertaker was also apparent. Now, after two years of medical care at home and in hospitals, treated by myself and other physicians, she is quite well but not active as she once hoped to be in the capacity of a busy and flourishing lady chiro.

This young lady, by the way still a friend of mine, had shortly before the tragic occasion which caused our acquaintance, graduated a full-fledged Palmer chiropractor. A frail, sickly girl, having the strength of a sparrow, earnest and sincere but lacking in experience and practical knowledge, desiring a life calling, and means of independence, had decided to become a chiropractor. Might not publicity have avoided

this? She went through her course, despite several cardiac attacks while in Davenport, which by the way were "treated and cured" by spinal manipulation. And the chiro's say they do not practice medicine. But this is not at all in regards to the physical defects of this young woman, for she had besides a marked and advanced spinal deformity, a poor little hunchback. In credit to the chiro's let me say here, they did not attempt to cure her spinal deformity. The case of this young woman is authentic, histories can be obtained from several hospitals, and she has likewise been examined and treated by several of our prominent physicians.

The writer could go into considerable more detail, not only in reference to the above case, but also about a poor little infant, thin, emaciated and running temperature, with active tuberculosis of the spine as demonstrated by the X-ray. As the mother pitifully told us, whenever the chiropractor pounded the baby on the back, it shrieked in pain. There was also a case of violent mental disease housed in a chiropractic institute.

This issue of the chiropractor must be combated. We are glad to deal with any group that is open to reason. He who treats disease by way of the spine, is practicing medicine, and for this privilege he must accept the Oath of Aesculapius, and earn his license, even as you and I have. The writer believes that Medical Registration will help along these lines, but not without continuous publicity, directed towards the public, and so educating the people, that they shall know that a licensed and registered physician is the only one qualified and permitted to treat disease.

PHILIP KASSEN, M D,  
4515 14th Ave., Brooklyn

## A CORRECTION

My attention has been called to a misstatement which was made in my article on "The Treatment of Lobar Pneumonia with Pneumococcus Antibody Solution," which appeared in the New York State Journal of Medicine, March 6th, 1925. The last paragraph on page 357 begins with a statement that "During the last few months we have returned to the intravenous method of administering antibody solution." In

this sentence "months" should read "weeks." During this time several lots of antibody solution were sent us by Dr Huntoon for testing on patients in the ward. Some of these lots when injected intravenously produced no reaction whatever. Other lots caused thermal reactions similar to those described in our previous articles.

RUSSELL L CECIL, M D

### SUSPECTED POLIO PROVES TO BE BROKEN ARM

In your issue of March 13th, 1925, under State Department of Health Notes there is recorded an interesting case under the caption "Suspected 'Polio' Proves to Be Broken Arm." I would like to record an almost identical case which occurred during the big epidemic several years ago.

A baby was brought to a dispensary in New York and, because the child could not move his leg, it was regarded as a case of poliomyelitis. At once the authorities had an ambulance summoned to take the case to an isolation hospital where cases of poliomyelitis were being treated. While awaiting the ambulance, someone suggested that an X-ray examination would be advisable for possible early tuberculosis of the hip joint. The X-ray examination was found to be negative for this condition.

By this time the ambulance had arrived. Something in the appearance of the femur made me suspicious of a lesion lower down, so that I insisted on holding the ambulance while I made a lateral X-ray examination of the entire leg, and, sure enough, we found a fine linear fracture of the femur without any displacement of the fragments.

Needless to say, the ambulance was sent back to the Contagious Disease Hospital without a patient, and the child was saved from the possibility of contracting poliomyelitis. A proper splint was applied to the leg and the child made a good recovery.

L. T. LEWALD, M. D.,  
Professor of Roentgenology,  
New York University

### RICHMOND COUNTY MEDICAL SOCIETY

On Wednesday evening, March 11th, 1925, in lieu of the regular meeting, a testimonial dinner was given to Dr. Walker Washington by the Richmond County Medical Society at the Staten Island Masonic Club in commemoration of his fortieth year of active practice. Fifty members of the Society were present.

Dr. Washington graduated in 1885 and has been practicing medicine at Tottenville since that date. Dr. Washington described his early days here, stressing the difficulties of travel, both from

the standpoint of poor roads and that his first horse functioned only on three legs.

Dr. Soldini made a plea that doctors should not disparage the efforts of their contemporaries as it caused the public to lose confidence in the entire medical profession. He said that new advances in the science should be explained to the patients and charlatanry exposed.

Other speakers were Drs. Jessup, Coonley and Bryan. Dr. E. Warren Presley, President of the Society, acted as toastmaster.

CHARLES RIEGER, Secretary

### MEDICAL WOMEN'S NATIONAL ASSOCIATION

The women physicians attending the A. M. A. Convention in Atlantic City in May will have their headquarters at the Marlborough-Blenheim Hotel. On Wednesday, May 27, they will have a banquet at the Ambassador at \$5.00 a cover. Subscriptions, accompanied by check, should be received by Dr. Clara K. Bartlett, 4301 Atlantic

Avenue, Atlantic City, N. J., not later than May 25.

The Medical Women's National Association will hold its annual meeting May 25-26, 1925, at the Marlborough-Blenheim Hotel, Atlantic City, N. J.

## GORGAS MEMORIAL

### I WHAT IS THE OBJECT OF THE GORGAS MEMORIAL INSTITUTE?

This Institute, incorporated October 21st, 1921, has for its object and purpose the following

To conduct, assist and encourage investigations in the sciences and arts of hygiene, medicine and surgery and allied subjects, in the nature and causes of disease and the methods of prevention and treatment, and to make knowledge relating to these various subjects available for the protection of the health of the public and the improved treatment of disease and injury, particularly as applied to Tropical and Preventive Medicine

### II HAS IT A CHARTER?

Yes, it was incorporated under the laws of New Jersey, October 21st, 1921, after five informal conferences held during the period from January 31st to October 21st, 1921

### III HAS IT BY-LAWS?

Yes These were drafted by the Hon John Bassett Moore and adopted at a meeting of the incorporators held in Philadelphia, October 26th, 1921 At this meeting an Executive Committee was appointed, three members of which were to constitute a Finance Committee

### IV WHAT IS THE TABLE OF ORGANIZATION?

In accordance with the by-laws, the officers, elected by the Board of Directors, consist of President, one or more Vice-Presidents, Secretary and Treasurer There is a Board of Scientific Directors, an Executive Committee, a Finance Committee, Committee of Publicity and Education, State Governing Committees and County Committees The by-laws provide for the election of officers and appointment of committee members and their successors

### V HOW ARE FINANCES HANDLED?

In accordance with the by-laws, by the finance committee consisting of three members of the board of directors elected by the board at the annual meeting At a meeting of the finance committee, August 27th, 1923, Mr Geo M Reynolds was elected Treasurer, who has custody of funds All bills must be vouchered and signed by the Secretary or a member of the Finance Committee and no bills are paid except those incurred under the authority of the Executive Committee Books and accounts are open at all times to the inspection of the Board of Directors Accounts are subjected to annual audit by a person or persons not connected with the board

### VI IS THERE NOT A DUPLICATION OF WORK IN PREVENTIVE MEDICINE WHICH IS ALREADY BEING DONE BY EXISTING ORGANIZATIONS?

This is a personal health educational campaign directed to the public and the family physician and is nation wide in its scope The directors cannot find that any other organization specializes on personal health education The Gorgas Memorial does not plan to replace any existing health agency, but to augment and assist all methods now used in health education

### VII HAS THE GORGAS MEMORIAL THE SUPPORT OF REPRESENTATIVE MEMBERS OF THE MEDICAL PROFESSION?

Yes It has been formally endorsed by the House of Delegates of the American Medical Association, which has recommended that its subsidiary and county societies throughout the United States co-operate in its development All medical members of the Board of Directors and of Committees are physicians occupying the forefront in American medicine Over 1,400 physicians throughout the nation have already become members of State Committees through which health education will be conducted The American College of Surgeons and ten other national health organizations have officially endorsed the work

"Health is a saleable commodity and there is an eager market for it," said Dr Herman N Bundesen, Chicago Commissioner of Health, recently at a session of the congress on medical education of the American Medical Association

Dr Bundesen pointed out the obligation which the medical profession and scientific health organizations have to the American public

"The primary function of public health," the Commissioner said, "must be concerned with man-made laws to safeguard the masses Its chief concern is for communicable diseases—all those which can be controlled by legislation But mere laws to enforce health will not create it Good health must come from desire stimulated by knowledge"

"Since the health of a community is the combined health of the individuals composing it, such a nation-wide agency as the Gorgas Memorial Institute, to which I have the honor to belong, is a potent factor Its value lies in combating wrong habits of living which result in such maladies as heart disease and Bright's disease, and in supplementing the work of public health

"In securing closer co-operation between physicians of the country and the individual, the Institute is doing a far-reaching work by establishing scientific medicine as the best authority in health matters"



# THE DAILY PRESS



Articles criticizing vaccinations often appear in the public press, and evidently are making somewhat of an impression, judging by the circulation of the papers which make a specialty of such articles. One New York paper of this kind mixes the alleged impressions of a murderer awaiting execution with love advice and anti-medical propaganda. It is questionable how much effect these papers have on the medical thought of the public. The tendency of the times seems to be to give publicity to the unpleasant side of life. The moving pictures stress the inhumanity of the heroine in the hands of the selfish villain, the preachers deplore the darkening of the moral skies, and the anti-medical propagandists dwell upon the unpleasant side of medicine.

The calamity howler is always with us—always has been and always will be. He likes to hear the sound of his own voice, and he gets a crowd to listen out of curiosity. Modern folk, like the people of Athens, are overwhelmed with a desire to tell or hear some new thing. The usual and the common are not news. Curing people with diphtheria antitoxin and preventing smallpox with vaccine are ordinary events which are almost commonplace. But fatal anaphylaxis from antitoxin, and a sore arm in a careless boy who has been vaccinated, are decidedly uncommon and are therefore featured, for they draw a crowd and help to sell newspapers.

When the great majority of newspapers throughout the land give large amounts of space to medical news and reports of Departments of Health, it is good business for a few papers to print articles in opposition to scientific medicine. The opposing fellow often gets a hearing simply because he is in opposition. The public likes a fight, and some newspapers welcome a furious debate because it is unusual and sensational.

The fellow in opposition to scientific medicine always has the advantage in a debate or abuse, because he is not hindered or restrained by truth. He acts as if he had no need of truth, and he would not be convinced by truth if it were demonstrated to him.

Psychiatrists tell us that whatever goes into the brain by any other route than reason cannot be removed by reason. We wonder if medical men should take any notice at all of anti-vaccination propaganda, and of other anti-medical stories. We have been tempted to quote from a series of articles in a New York daily purporting to tell how smallpox vaccine is made. The articles were truthful to the extent that they described the processes of manufacture from the inoculation of calves to the final sealing of the packages, and the adver-

tising propaganda by which the product was brought to the attention of physicians and boards of health. But here is the joker. In every paragraph the greswome aspects of the process were magnified out of all proportion to the rest of the process. The bleating of the calves, the blood, the apparent joy of the microscope technician in examining a gory specimen, all these were set forth in a way to indicate that the physicians and technicians are hard-hearted demons. Of course such a write-up defeats its own object, and reveals the unreasonableness of the writers. Still some people will believe what is written and will create trouble by an insistence on their beliefs.

We are inspired to make these editorial comments by an article in the *Batavia News* of March 11, which we here quote in full.

"Vaccination provides certain immunity from smallpox. There is always the possibility of men, women and children coming in contact with a person having the disease and contracting it. Why not, therefore, be vaccinated? A bulletin from the state department of health cites this case in point.

"*Health News* of February 2d carried an item mentioning a fatal case of smallpox in a school teacher. An interesting feature of this case has just been brought to our attention by the health officer of the municipality in which the teacher lived. Following the teacher's death, mothers of two pupils in her class independently reported to the health officer that just before Christmas they had told the teacher that their children were to be vaccinated during the holidays. The teacher strongly urged against it on the ground that it 'was a medieval custom, was harmful to the welfare of the child, and that deaths were occasionally caused by such vaccinations.' On January 12th this teacher died of smallpox. Although she took her own advice, fortunately the mothers of her pupils did not."

"More than 200 pupils in the schools of Batavia recently have been vaccinated, and the parents of more than 400 have given consent to the vaccination of their children."

The fallacy of half truths is illustrated in an article in the *Brooklyn Citizen* of March 12, in which a chiropractor active in politics says:

"The Fearon Chiropractic bill in its amended form will be an impossible piece of legislation. Under the provision preventing the chiropractors from handling communicable diseases, the public would be denied the services of chiropractors in cases of influenza. When it is considered that during the epidemic in 1920, the deaths from

this disease under medical men were one out every seventeen cases handled while the drugless practitioners lost only one out of every 886 cases, the seriousness of this amendment can easily be appreciated

"It is well for the public to know that Dr Mathias Nicoll wishes all practitioners driven out of New York State.

"Realizing that the legislators are determined to enact some type of law licensing us, the State Health Commissioner is seeking by indirect means to prevent us from practicing under the terms of our own law. This amendment on communicable diseases places in his hands the power to prevent us from handling all diseases for it is the State Health Board which decide as to what diseases are communicable."

We are surprised that chiropractors and other drugless practitioners should have lost even one out of 886 cases of influenza that they handled during the epidemic. The principal element in our surprise is that any one who has influenza should put himself in the hands of a chiropractor, but it is evident that at least 886 persons entrusted their lives to the cultists.

We wonder how many of these people would have consulted the chiropractors if those practitioners had not made positive claims of their ability to diagnose and cure cases of influenza?

We wonder, too, why any chiropractor allowed a case to die on his hands? We have talked to chiropractors who are endowed with considerable worldly wisdom, and most of these practitioners say that they are anxious to drop every acute case that gets worse, for they are quite willing that physicians should get the notoriety of having cases die on their hands. Of course chiropractors have low death rates. The fact that they have any death rates at all is a confession of guilty negligence on their part.

The daily newspapers are unable to give prominence to follow-up stories of a movement after it has become a routine matter. The natural course which a movement takes is that at the beginning it blazes forth on the front pages with big headlines and illustrations. In a day or two it dwindles to a paragraph among inconsequential items about dinner parties and new buildings. Very little is said about the immense amount of detail work of investigation, conditions and of planning their remedies. We have tried to follow up conditions which we have described, and have often had great difficulty in getting information from the daily newspapers.

In our Daily Press of January 23rd, we commented on the ban against the importation of chickens into New York City on account of chicken plague. The papers have said very little regarding the further action taken by the Department of Health of New York City, or of the course of the epidemic.

The New York Times of March 12 contains an inconspicuous item two and a half inches long which reveals that an immense amount of work has been done on the epidemic throughout the eastern part of the country. The item is as follows:

"Dr Frank J. Monaghan, Health Commissioner, announced yesterday that the Board of Health would make radical changes next Wednesday in the live-chicken embargo, which has been in force for three months because of the chicken-plague.

"The Commissioner said the embargo against North and South Dakota, Missouri, Kansas, Iowa and Nebraska would be lifted, but that against Illinois and Indiana would be continued. He expected to see shipments into this State from Pennsylvania and Ohio prohibited.

"These changes, he said, had been agreed upon yesterday at a conference called by the Department of Agriculture of this State. Representatives of this State, New Jersey and Connecticut, New York City and Jersey City, and also of the commission merchants, were present. Adoption of the changes will make quarantine regulations uniform in New York and New Jersey and simplify enforcement. The States from which the embargo is to be lifted have rectified objectionable conditions."

The New York Evening World of March 12 uses the term "Prophetic" medicine by which it means the branch of medical practice which deals with tendencies toward sickness and the means of preventing their development. The World publishes a long description of a periodic health examination clinic conducted by a Post Graduate Medical school. The unique feature that is described is a booklet that is filled out by the patient with his own impressions about himself. The following quotations from the booklet indicate the scope of the patient's self-examination:

"My health is excellent—Good most of the time—Only fair—Rather poor—Quite bad—If it wasn't for I would be fine

"Customarily I am quite rugged—Very strong—Fairly strong—A little weak—Tire easily—Very weak. In my work I am very successful—Doing—Well—Holding my own—Indifferently well—Unsuccessful. I worry about my work, however—A great deal—Somewhat—Don't give it a thought at night. My work is administrative—Professional—Clerical

We believe it to be conducive to making the patient's answers full and truthful that he has before him the various degrees of the conditions on which he is questioned. This form of questionnaire is worthy of consideration by those who are devising blank forms for health examinations.



# BOOK REVIEWS



**ACIAL SURGERY** By H P PICKERILL, CBE, MD, MS Introduction by Sir W ARBUTHNOT LANE, Bart, CB, MS William Wood and Co, New York, 1924 Price, \$6 50

The Great War was responsible for several important and epoch making forward steps in the science and art of surgery, without which stimulus progress would undoubtedly have been much more tardy, and perhaps no greater advance may be noted than in the art of the plastic repair of facial defects due to the destructive effect of war injuries

From the necessity born of the injuries of war there arose a group of surgeons at Queen Mary's Hospital, Sidcup, to which place innumerable facial injuries were sent for relief, and where a vast amount of experience was acquired, who became wonderfully adept in facial plastic surgery In charge of the New Zealand Section was found H P Pickerill, the author of this work. Divided in three sections, it deals with (1) the principles and technique of plastic surgery, (2) Military Facial Surgery, and (3) Facial Surgery in Civil Practice.

The principles enumerated in this work appear to revolutionize the art of plastic surgery, and of especial interest may be mentioned pressure skin grafts, tube flaps, epithelial inlay, and caterpillar tube grafts, etc The subject matter of military surgery is fully illustrated and described, with case reports from the hospital at Sidcup, which illustrate the possibilities of the work and as a direct result of which have broadened the field and possibilities of facial surgery in civil practice, in making possible greater radicalism in the excision of malignant growths, the repair of congenital defects, and the remedy of destructive injuries

This book is a valuable contribution to the field of plastic surgery, and of profound interest to and a necessity for any surgeon attempting work in this special line

The methods and principles laid down also will apply in such congenital defects as hare-lip, cleft palate, nasal deformities, facial paralysis, absence or atresia of the vagina, and this work will bear careful reading and study It is not too much to expect that former methods will be discarded, when the possibilities of the new become known

ROGER DURHAM

**HUMAN CONSTITUTION A CONSIDERATION OF ITS RELATIONSHIP TO DISEASE.** By GEORGE DRAPER, MD Octavo of 345 pages with 208 illustrations and 105 tables Phila and London, W B Saunders Co, 1924 Cloth \$7 50

The author states that the object of this book is threefold "First, it attempts to present to the physician a dependable method for studying morphology, second, to point out the inadequacies of the existing observational and descriptive procedure, and third, to emphasize the interest and importance of the study of the Human Constitution"

This study has been made, apparently to determine certain basic constitutional differences, which are associated with various forms of disease It is the result of a series of studies made at the Constitutional Clinic of the Presbyterian Hospital in New York A small group of patients suffering from about six diseases were studied by various workers skilled in their own particular branch of science. Anthropometric determination and indices were calculated and the curves plotted The author has in mind a possibility that the anthro-

pological factors and the hereditary tendencies of an individual may have a significance in the pathological diagnosis If this is true then a closer study of the personality will be of great assistance in clinical medicine. Numerous interesting relationships are brought out even in this small group of cases, although the number of cases are much too small to draw generalizations This study is to be continued by Dr Draper and his group of workers and further developments are expected Clinicians who are not acquainted with the methods used in this type of research will find this book exceedingly interesting

O C P

**PATHOGENIC MICROORGANISMS A Practical Manual for Students, Physicians and Health Officers** By WILLIAM HALLOCH PARK, MD, ANNA WESSELS WILLIAMS, MD, and CHARLES KRUMWIEDE, MD Eighth Edition, enlarged and thoroughly revised Octavo 811, 211 engravings, 9 full-page plates Phila and New York, Lea & Febiger, 1924 Cloth, \$6.50

This is one of the standard works on bacteriology and needs no recommendation There have been some notable recent advances in bacteriology and these have been incorporated in the present edition They include experience with diphtheria immunization, new discoveries about scarlet fever and the pathogenic anaerobes, measles, typhus and tularemia Several sections, including those on paratyphoid and dysentery, have been rewritten There is an extensive list of culture media. One of the valuable features of this work is the portion dealing with the practical use of biologicals

E. B SMITH

**GYNECOLOGY, MEDICAL AND SURGICAL.** By P BROOKE BLAND, MD, Assistant Professor Gynecology, Jefferson Medical College. 644 Illustrations, 43 colored text figures, 12 insert plates F A. Davis Co, Phila, 1924 Students' Edition, \$11 00 net, Library edition, two volumes, \$14 00 net.

In this large, well illustrated volume, the author has covered gynecology in its medical and surgical aspects in a most thorough manner A large amount of space is devoted to the medical or conservative treatment of disease of the pelvic organs and, therefore, the book may be of special value to the general practitioner, as well as to the specialist.

The chapters on anatomy, etiology, symptomatology, and diagnosis are complete, concise and very readable.

Preoperative preparation and postoperative complications are covered thoroughly, while the chapter on therapeutics gives a wealth of detail Here are clearly discussed such subjects as organotherapy, proteinotherapy and the gynecological uses of and indications for radium and X-ray

Disorders of function, malformations, displacements inflammations and hemorrhage are thoroughly covered in chapters by themselves and the remainder of the volume is devoted to a consideration of all the phases of tumors of the pelvic organs

The author is to be congratulated upon the completeness of his work

W S SMITH

MEDICAL CLINICS, NORTH AMERICA

Published every other month by the W B Saunders Co Phila and London Per Clinic Year (SIX ISSUES) Cloth \$16 00 net, paper \$12 00 net

Vol VIII, Number 1, July, 1924 (New York Number)

Thirty one articles in this number many by personal friends, make it difficult for the reviewer to choose any

special paper for praise. It is only necessary to see the list of contributors to know that a complete medical survey is included in this issue which upholds the standard of these clinics. The reviewer recognizes the falsity of the statement "a prophet is not without honor save in his own land." Read this issue and prove it.

H. M. M

Vol. VII No. 5, May, 1924 (McGill University Number)

This issue of the *Clinics* contains many instructive, interesting articles in which the field of medicine is well covered. Henderson gives a carefully prepared paper on "The Successful Treatment of Asthma" and Related Conditions, on which there is still so much room for controversy. The circulatory system is covered by a number of papers on some of the various heart conditions. Mackay's paper on "Pituitary Dysfunction" tells much of this gland, and other conditions of the nervous system are presented by different writers. This issue contains many articles of value.

H. M. M

#### SURGICAL CLINICS, NORTH AMERICA

Volume IV, No. 3, June, 1924 (Chicago Number)  
Published every other month by the W. B. Saunders Company, Phila. and London. Per Clinic Year (6 issues) Cloth, \$16.00 net, paper, \$12.00 net.

The Chicago number covers so many subjects in the various departments of Surgery, and by so many contributors, that it would take up too much space to review them even briefly, and do justice. Suffice it to say, that all the topics are as interesting as they are instructive and important, whether it is the cases of abdominal tumor with the usual difficulties in diagnosis by Dr. Bevan, or the treatment of cancer by cautery by Dr. Ochsner, or the gynecological operations by Dr. Watkins, or genito-urinary conditions by Dr. Eisendrath, or fracture-work by Dr. Speed.

HERMAN SHANN

Volume IV, No. 4, August, 1924 (Cleveland Clinic Number)

The discussion by Dr. Crile on the factors that govern the surgical mortality of operations for hyperthyroidism is most enlightening. Even in the hands of this famous surgeon, certain types are hopeless with or without operation, and these are cases with delirium, or with persistent nausea and vomiting.

Another article by Dr. Crile is on the excellent results he has obtained in cases of carcinoma of larynx, citing a number of cases alive and well many years after laryngectomy.

The other contributions are all from the Cleveland Clinic, and cover a variety of subjects well worth reading.

HERMAN SHANN

MANUAL OF DISEASES OF THE NOSE, THROAT AND EAR. By E. B. GLEASON, M.D., LL.D. Fifth Edition thoroughly revised. 12mo of 660 pages with 212 illustrations. Phila. and London, W. B. Saunders Co., 1924. Cloth, \$4.00.

The fifth edition of Gleason's well known book is a very practical manual. Intended as it is, for students and general practitioners it is very acceptable for it abounds with practical suggestions that are given very little space or consideration in similar text books. The reviewer would recommend it as the starting point for the embryo specialist for its contents are both simple and fundamental. The formulary which carries with it instructions for the proper use of the prescribed medication is a distinctive feature and of value.

M. C. M

OPERATIVE SURGERY. Covering the Operative Technique Involved in the Operations of General and Special Surgery. By WARREN STONE BICKMAN, M.D., F.A.C.S. Vol. 5. Octavo of 880 pages with 1118 illustrations. Phila. and London, W. B. Saunders Co., 1924. Cloth, \$10.00 per volume. Sold by subscription only (To be complete in six volumes with desk index.)

The excellency and completeness of this splendid work is maintained in volume five, which contains the chapters on the kidneys, ureters, bladder, and scrotum. All the operations on these organs are very well described. The text is concise and to the point, and yet ample. Every step is clearly outlined by the text and also by a large number of excellent illustrations, most of them original. This volume should be read by every surgeon working in this field.

N. P. RATHBUN

COSMETIC SURGERY, THE CORRECTION OF FEATURAL IMPERFECTIONS. By CHARLES CONRAD MILLER, M.D. 140 illustrations. F. A. Davis Co., Phila. 1924. Price \$4.00 net.

This work contains twenty-two chapters devoted to the correction of featural imperfections. The work is well and profusely illustrated. Here one may learn how to remove doublechin, eradicate wrinkles and perform other operations which the beauty doctor may be called upon to do.

METHODS IN MEDICINE. The Manual of the Medical Service of George Dock, M.D., ScD, formerly Professor of Medicine, Washington School of Medicine, formerly Physician-in-Chief Robert A. Barnes Hospital, St. Louis. By GEORGE R. HERRMANN, M.D., Ph.D., Instructor in Medicine, University of Michigan, formerly House Officer, Peter Bent Brigham Hospital, Boston, formerly Assistant in Medicine, Washington University, formerly Resident Physician Robert A. Barnes Hospital, St. Louis. Illustrated. The C. V. Mosby Company, 1924, St. Louis. Price, \$6.50.

This manual includes the instructions to the staff, the responsibilities, the Hospital rules, the outline and methods of procedure in different conditions, the laboratory procedures, the general treatment of diseases and use of drugs, together with the history forms used on the service of Dr. George Dock at the Barnes Hospital, St. Louis. It is complete in every detail and indispensable to any one who is interested in the management of any service in a modern hospital. It is well written, readable, well-printed and valuable.

H. M. M

THE MOTHERCRAFT MANUAL, by MARY L. READ, B.S. illustrated. Little, Brown and Co., Boston, 1922.

This book is indeed excellent, not only in the choice of its name, but more important in the instruction provided. It is sound physiologically and psychologically. Its frequent diet lists as well as charts showing analysis of the various foods its frequent outlines for daily routine physical examinations its review of the common causes of fretfulness malnutrition etc. makes it indeed a most valuable book, not only for the mothers but the nurses and doctors as well.

The illustrations are good and the charts are well arranged.

It has one fault and that is that only the educated woman can use it.

G. W. P

**DOMICILARY TREATMENT OF PULMONARY TUBERCULOSIS**  
By F. RUFENACHT WALTERS, M.D. Second Edition  
Octavo of 288 pages New York, William Wood & Company, 1924

Your reviewer regrets to state that he found this a rather uninspiring text. In the arrangement of the subjects discussed there is a total lack of continuity of idea and expression. Much of that written has been stated before, and in much better form. There is a great deal of needless repetition and considerable time spent in the discussion of either obsolete or irrelevant matters such as that on the value of the Opsonic Index, and that on innumerable drugs that are supposed to aid recovery in Pulmonary Tuberculosis. The book abounds in footnotes devoted to references and bibliography, the dates of most of which run anywhere from 1881 to 1910. Of recent valuable contributions to the study of Tuberculosis, the book is strikingly deficient.

FOSTER MURRAY

**THE CURE OF PULMONARY TUBERCULOSIS BY REST AND EXERCISE.** By HUGH M. KINGHORN, M.D. Illustrations Richard G. Badger. Gorham Press, Boston, 1924

In this little book Dr. Kinghorn elaborates in interesting fashion his theories of the more successful method of treating pulmonary tuberculosis. He is well and favorably known as one of the foremost advocates of prolonged rest and of the use of exercise only with utmost caution.

Better to acquaint the reader with the theories underlying the use of rest and to create a favorable background in the reader's mind, the author starts with several chapters devoted to an historical consideration of the subject, giving in some detail interesting features in the lives and viewpoints of Brehmer, Dettweiler and our own Edward L. Trudeau. In the course of these chapters one is brought to realize the transition that occurred from the emphasis laid upon the importance of regulated exercise to that of complete rest. The author "views with alarm" the "Work Therapy" idea as put forth by Dr. Marcus Patterson of Brompton Sanatorium, Frimley, England. He totally disagrees with Dr. Patterson's theory of the beneficence of "Auto-inoculation in Pulmonary Tuberculosis." He contrasts the end results, in from 5 to 9 years, of those patients subjected to Patterson's "Work Therapy," with graduates out the same length of time from Trudeau Sanatorium, Saranac Lake, New York, and with those patients taking the home bed-rest treatment of Dr. Joseph H. Pratt of Boston, much to the advantage of the latter two groups.

Dr. Kinghorn and Dr. Patterson are both a big emphasis in their advocacy of their theories. In the experience of most of the tuberculosis workers in this country, the more practical course has been found to lie in a path somewhat between these two extremes, inclining, perhaps, a trifle more in the direction of Dr. Kinghorn, than of his English conferee.

FOSTER MURRAY

**TWO LECTURES ON GASTRIC AND DUODENAL ULCER, A RECORD OF TEN YEARS' EXPERIENCE.** By SIR BERKELEY MOYNIHAN, Leeds. John Wright & Sons, Ltd., Bristol, England, 1923

In these two lectures the author discusses very thoroughly the subject of gastric and duodenal ulcer, and relates his own experience with 715 cases, over a period of ten years. Of these, there were 531 cases of duodenal ulcer, with not a single operative death since 1912.

This remarkable record can be explained only on the basis of very careful work, thorough study of each individual case, a proper pre-operative preparation of the patient, and the application of the best possible methods in each particular case. The surgeon, he declares, must always be eager in search of a "under judgment, or

better method, and must always give the fullest consideration that increasing experience may seem to teach.

The author has very definite views as to the surgical pathology of ulcer. "I hold," says he, "that a 'chronic ulcer' whether of the stomach or duodenum, is a visible and palpable lesion, which has existed for months or years." There can be no doubt as to what he intends to convey by this statement.

Pain as a diagnostic symptom in ulcer must be of an absolutely characteristic kind. "In the same patient, after the same meals, it appears with the most exact regularity, after the same interval of comfort." Due credit is given to radiology as a diagnostic agent. "In competent hands," he insists, "it is far more accurate than any other method of diagnosis, chemical or clinical, or all other methods combined."

As regards operations. Notwithstanding the fact that gastro-enterostomy was the operation of choice in most cases, he speaks in high terms of Finney's gastro-duodeno pyloroplasty and its modification which is known as Chas. H. Mayo's gastro-duodenostomy, and he concludes with characteristic frankness that "It is more than probable that some of the cases treated a few years ago by gastro-enterostomy, would be dealt with if occurring today, by this method of gastro-duodenostomy with excision of the ulcer or its destruction by the cautery."

HERMAN SHANN

**PRACTICAL LECTURES** Delivered under the Auspices of The Medical Society of the County of Kings, Brooklyn, New York. 1923-1924 Series. Octavo of 484 pages with 132 illustrations and 3 color plates. New York, Paul B. Hoeber, Inc., 1925. Cloth, \$5.50

This book assembles twenty-five unusual lectures given before The Medical Society of the County of Kings (Brooklyn). These are the well known Practical Lectures which, as part of the Brooklyn educational program, have attracted so much attention.

The lectures are not heavy or pedantic but very readable and interesting, and given by famous teachers of medicine in their very best teaching manner.

The book is practical in the sense that the lectures meet the needs and answer the questions of every day medical practice. The specialist as well as the general practitioner will gain much by this easy reading in the broad field of general practice to which, finally, every patient belongs.

Though the blackboard and the patient are missing, the book is almost as good as the lectures which have had such phenomenal success. The illustrations are numerous and excellent and the book itself beautifully done. We are looking ahead to the second volume. It should be a great success.

C. A. G.

**INSANITY AND LAW** A Treatise on Forensic Psychiatry. By H. DOUGLAS SINGER, M.D., M.R.C.P. (London), and WILLIAM O. KROHN, A.M., M.D., Ph.D. P. Blakiston's Sons & Co., Phila., Pa. 1924

It has been a real pleasure to review this book. In fact, the subject was so well presented that we read the book a second time. In spite of its brevity, it fills a great want in forensic psychiatry. The authors will be remembered as the alienists for the prosecution in the recent Loeb-Leopold case. The first half of the book takes up the various mental disorders. The second half is devoted to the legal aspects. The authors are not like so many other recent writers in this field who indulge in speculative theorizing. And while evidently well acquainted with the modern views of certain criminologists, they do not follow their lead in attempting to show that all crime is due to disease. Neither do they regard the question of responsibility as a myth. The book can be well recommended as a sound scientific exposition of the relations of psychiatry to the law.

JOHN F. W. NEAGHER.



The National Health Series

CANCER NATURE DIAGNOSIS AND CURE By FRANCIS CARTER WOOD M.D. Director Institute for Cancer Research, Columbia University

MAN AND THE MICROBE HOW COMMUNICABLE DISEASES ARE CONTROLLED By C E A WINSLOW, Dr P H, Professor of Public Health, Yale School of Medicine

COMMUNITY HEALTH HOW TO OBTAIN AND PRESERVE IT By D B ARMSTRONG M.D., Sc.D., Executive Officer of the National Health Council

THE BABY'S HEALTH By RICHARD A. BOLT, M.D., Gr.P.H., Director Medical Service, American Child Health Association

PERSONAL HYGIENE THE RULES FOR RIGHT LIVING By ALLAN J McLAUGHLIN, M.D., Surgeon United States Public Health Service. Bound in full flexible fabricoid Price per volume, 30 cents Funk & Wagnalls Company, New York, 1924

This is a series of twenty small volumes averaging about 70 pages each, edited by the National Health Council, and intended for popular distribution. Below are brief comments on the first five of this series

A J McLAUGHLIN and J A TOBEY

*Personal Hygiene*

This volume is filled with good, sound advice in personal hygiene. First describing what good health is, the authors advocate for the reader an appraisal of health—otherwise a complete physical examination. Then follow several chapters on the proper care of the body with the ultimate aim of lengthening the span of life.

D ARMSTRONG

*Community Health*

The author's words on the Prevention of Infectious Diseases are worth recommending to everyone, the work of communicable disease control would be far easier if this were done. In another chapter, he also shows how the non-infectious diseases may be prevented. Dr Armstrong's final plea deserves special comment. 'A community will best attain health that seeks health not merely as an end in itself. We must end sickness and increase health so that each individual may have life and life more abundant, and so that each community may be fit to do its share in the life of the nation'

F C. WOOD

*Cancer*

This is the sanest statement for lay consumption which we have yet seen. Dr Wood writes briefly of the occurrence, the classification and the contributory causes of cancer in the first three chapters. There follows a brief statement regarding experimental study of cancer. He then describes the varieties and symptoms and treatment in subsequent chapters. The chapter on quacks should be published in heavy type on the first page of every newspaper in the country.

C. E. A WINSLOW

*Man and the Microbe*

Winslow has given us in his usual concise style an excellent little treatise on disease prevention. He describes briefly the roles of water, milk food and insects in the spread of diseases, devotes a chapter to the contact infections, and presents a final chapter on artificial control of immunity in which he describes the development of vaccine and serum prophylaxis and therapeutics.

R. A. BOLT

*The Baby's Health*

How anyone can condense so much information in so little space is a mystery until one reads this little essay of Bolt's. It should be given to every mother and every prospective mother in the country.

ALCOHOL AND PROHIBITION IN THEIR RELATION TO CIVILIZATION AND THE ART OF LIVING, by VICTOR G VECKI, M.D., San Francisco, Cal J B Lippincott Co, Philadelphia and London 1923 Price, \$2.00

The author has given us a clear, concise and unprejudiced presentation of the whole question of alcohol. One is struck by the evident fairness of his presentation of the situation. No matter what one's belief may be concerning this subject, he cannot but get a broader viewpoint through reading Dr Vecki's book.

E H M

HEALTH AND DISEASE, THEIR DETERMINING FACTORS, by ROGER I LEE, M.D., Professor of Hygiene in Harvard University, Visiting Physician, Massachusetts General Hospital Little, Brown and Co, Boston, 1923

This book is intended particularly for the laity, and its reading should be encouraged by every physician, for the successful practice of medicine depends so much upon the cooperation of the patient. It is a short-sighted policy to attempt to keep the layman in ignorance concerning matters affecting his health. It has been by education of the public that such vast strides have already been made in the reduction of death rates and yet the practice of medicine has never suffered thereby.

Lee has furnished a text simple in language, understandable by any reasonably intelligent individual, and outlining the principles of individual and community hygiene.

E H M

BASAL METABOLISM Determination of the Metabolic Rate in the Practice of Medicine. By JOHN T KING JR., M.D. Octavo of 118 pages Baltimore, Williams & Wilkins Company, 1924 Cloth, \$2.50

In this volume, the author attempts to survey the literature briefly and to stress the values of the determination of the basal metabolism which appear from its application in the actual practice of medicine. The physiologic factors involved in the test and the clinical deductions to be made from the readings are covered in a manner which, considering the present state of our knowledge of this subject, is quite commendable. Unfortunately, however, scant attention has been given to the actual clinical determination of the basal metabolism. The general underlying principles are well stated but there is a lack of specific detail to guide one in the performance of the test. Such a simple, definite description would be of great value. When one reads about the performance of the test in current periodicals he is told that the method is so simple as to be easily within the range of comprehension of the average high school student, in the twinkling of an eye, however, he is led into a maze of complexities of Einsteinian proportions and he finds that he is assumed to possess a knowledge of certain technical problems unknown to the unintelligentsia. As a matter of fact, the methods can be described in very simple form, and the reviewer cannot help but feel that the author has missed a great opportunity in failing to do so.

HENRY M FEINBLATT

**THE CULTURE OF THE ABDOMEN, THE CURE OF OBESITY AND CONSTIPATION** By F. A. HORNIBROOK Preface by SIR WILLIAM ARBUTHNOT LANE, Bart, C.B., M.S., Consulting Surgeon, Guy's Hospital etc William Wood & Co New York, 1924 Price, \$2.25

This sixty-seven page book has been rather lavishly produced, as regards binding and illustrations, probably because in a preface Sir William Arbuthnot Lane has highly recommended it as an authoritative work on the medical treatment of viceroposis. The author is a physical trainer, not a physician, and has based his conceptions of gastrointestinal physiology on obsolete theories and on Lane's well known obsessions. The greater part of the book is given over to a discussion of these theories and the value of regularity in eating, sleeping and exercise. The "systems of exercise" which are the excuse for the publication of this book and which are supposed to be the invention of the author, are but eight in number and are confined to the last chapter. They appear to be excellent exercises for development of the abdominal wall and thorax, but probably no better than many other systems in common use by other physico-therapists. They are beautifully illustrated. A

**DIABETES, A HANDBOOK FOR PHYSICIANS AND THEIR PATIENTS** By PHILIP HOROWITZ, M.D., with thirty-four text illustrations and two colored plates. Second Edition Revised and Enlarged. Paul B Hoeber, Inc., New York, 1924

This is a concisely written work on this subject showing by case reports the nature of the treatment used in the various types of diabetes and its complications.

Like other books on this subject, it also contains food recipes and a description of the various chemical tests used in the diagnosis and management of the diabetic patient.

It contains many practical points concerning the treatment of this disease and will be found worthy of the attention of medical readers. C E HAMILTON

**THE TREATMENT OF THE COMMON DISORDERS OF DIGESTION, A HANDBOOK FOR PHYSICIANS AND STUDENTS** By JOHN L KANTOR, Ph.D., M.D., Chief Gastrointestinal Diseases, Vanderbilt Clinic. Illustrated. The C V Mosby Co, St Louis, 1924 Price, \$4.75

This is a comprehensive treatise on the therapy of gastro-intestinal disorders. Few pages, good illustrations, well organized information are its characteristics. All detail is concise without "frills." Can be recommended to every physician's library. B M Eis

**PECULIARITIES OF BEHAVIOR, WANDERING MANIA, DIPLOMANIA, CLEPTOMANIA, PYROMANIA AND ALLIED IMPULSIVE ACTS** By WILHELM STEKEL. Authorized English version by James Van Teslaar. Vols 1 and 2. Boni & Liveright, New York. 1924

These two volumes represent quite an ambitious desire on the part of the author to present the value of psychoanalysis in the interpretation of disorders of human conduct. While many of his case studies are extremely interesting many of them are incomplete and it is felt that the deductions are based upon premises not well founded. It is also felt that interpretation symbolically is indulged in freely and often in an unwarranted manner. The author gives one the impression of being over enthusiastic as to the real therapeutic value of psychoanalysis.

The material is presented in a very disjointed manner and as a consequence difficult to review. He endeavors to cover a very large field in a comparatively small space. Although the book is intended for the beginner it is felt that the author gives the impression that psychoanalysis is easier for the patient and the physician than it really is. The beginner who wishes to learn the real principles of psychoanalysis is advised to defer the reading of this work until he has become familiar with some of Freud's better known works. However there is much that is interesting in the volumes but it must be emphasized that the claims of the author are often extravagant. S R. LEAHY



## BOOKS RECEIVED



Acknowledgment of all books received will be made in this column and this will be deemed by us a full equivalent to those sending them. A selection from these columns will be made for review as dictated by their merits or in the interest of our readers.

**CLINICAL THERAPEUTICS** By ALFRED MARTINET, M.D., Paris, France. Authorized English Translation from the Second Revised and Enlarged Edition. By LOUIS T D'EM SAJOUS, M.D., Philadelphia. Complete in two royal octavo volumes. Vol. I—Therapeutic Agents and Procedures. Vol. II—Treatment of Symptoms and Diseases. F. A. Davis Company, Publishers. Philadelphia, 1925. Price, \$16.00 net.

**A LABORATORY MANUAL OF PHYSIOLOGICAL CHEMISTRY** By ELBERT W ROCKWOOD, M.D., and PAUL REED ROCKWOOD, M.D. Fifth Edition, revised and enlarged. Illustrated with four colored plates and forty-three text engravings. F. A. Davis Company, Publishers, Philadelphia, 1924. Price, \$4.00 net.

**PSEUDO-APPENDICITIS** A Study of Mechanical Syndromes of the Right Lower Quadrant Simulating Appendicitis. By THIERRY DE MARTEL and EDOUARD ANTOINE. Authorization translation from the French. By JAMES A EVANS, M.D. Illustrated with forty-one engravings. F. A. Davis Company, Publishers, Philadelphia 1925. \$3.00 net.

**FEEDING, DIET AND THE GENERAL CARE OF CHILDREN** A Book for Mothers and Trained Nurses. By ALBERT J BELL, M.D. Second revised edition. Illustrated. F. A. Davis Company, Publishers, Philadelphia, 1924. Price, \$2.00 net.

**AN INTRODUCTION TO DERMATOLOGY** By SIR NORMAN WALKER. Eighth Edition. With ninety plates and eighty illustrations in the text. William Wood and Company, New York, 1925. Price, \$7.00.

**A CONTRIBUTION TO THE STUDY OF PERNICIOUS ANEMIA AND APLASTIC ANEMIA** By ARTHUR SHEARD, M.D. A Thesis presented for the degree of Doctor of Medicine in the University of Leeds, December 1923. William Wood and Company, New York, 1924. Price, \$2.50.

**INTERNATIONAL CLINICS** By Leading Members of the Medical Profession Throughout the World. Volume I. Thirty-fifth Series 1925. J B Lippincott Company, Philadelphia, 1925.

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 12

NEW YORK, N Y

APRIL, 1925

## RESULTS OF INVESTIGATIONS OF CAUSES OF DEATH AT CHILDBIRTH \*

By OTTO R. EICHEL, M.D

ALBANY, N Y

A Further Preliminary Note on Studies Being Made in the Vital Statistics Division,  
New York State Department of Health

IN this paper we shall present some general provisional statistics from studies of puerperal mortality which have been in progress in our office during the past year. I am pleased to acknowledge the help I have received from my Research Assistant, Miss Carolyn A. Bonds, in preparing this paper. I am indebted to her for most of the arduous labor involved in compiling and analyzing the primary data upon which my comment is based. In the brief time at our disposal it will be impossible to do more than merely indicate some of the more interesting features of these data from a descriptive standpoint.

The death rate from causes connected with childbirth has been relatively high in New York State for many years. During the seven years, 1915-1921, the death rate from all puerperal causes combined in the city of Birmingham, England, was below 35 per 10,000 births and stillbirths combined, in New York City during those years it ranged between 44 and 70, and in New York State, outside of New York City, it varied from 53 to 83. There occurred in the entire State of New York during the five years, 1918-1922, exactly 7,000 deaths from all puerperal causes, of which 3,461 were registered in New York City and 3,539 in the rest of the State. Puerperal sepsis comprised 27 per cent of these deaths in the entire State, 25 per cent in New York City, and 30 per cent in the rest of the State.

Although the trend of the death rate from all puerperal causes combined was generally downward from 1910 to 1916 in New York State, it rose sharply in 1917 and reached a high peak in 1918. Since then it has declined, but the mor-

tality has remained at a higher level than during the years 1912-1916. The rate fell from 65.1 in 1910 for the entire State, to 49.1 in 1916, rising sharply to 75.3 in 1918, and dropping to 51.7 in 1923. The death rate from puerperal sepsis declined from 22.3 per 10,000 births and stillbirths combined for the entire State in 1910, to 12.5 in 1923. (Chart I shows the trend of the death rate for New York City and for the State, exclusive of New York City.)

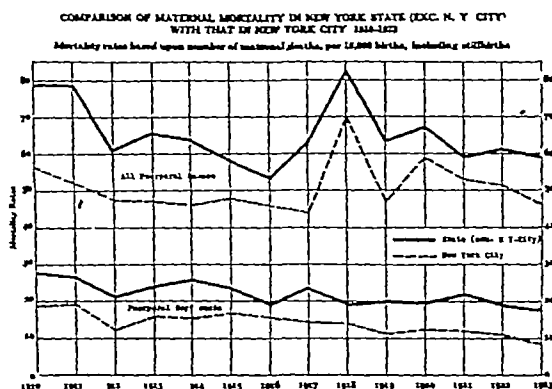


CHART I

There is a very regular seasonal variation in maternal mortality in New York State. The average monthly death rate from all puerperal causes combined is highest in March and then declines gradually to a low point in September, after which it again rises gradually to the highest rate in March. The average March rate during a recent seven-year period, 1914-1920, was 65.5, and the lowest average monthly rate, in September, was 41.2, or about two-thirds the March rate. There is a similar marked seasonal

\* Read at the Annual Meeting of the Medical Society of the State of New York at Rochester, N. Y., April 22, 1924.

variation in the death rate from puerperal septicemia and from all puerperal causes, exclusive of septicemia (see Chart II) This seasonal varia-

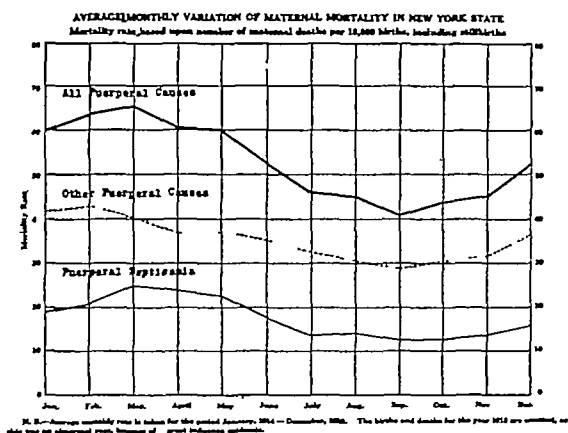


CHART II

tion may possibly be attributed to the greater prevalence of respiratory and renal diseases in the colder months, our final analysis may show definitely whether or not this will account for it

The average annual number of live births in the entire State of New York is 238,364 and of stillbirths, 10,110, the average annual number of deaths for mothers from all causes connected with childbirth is 1,364. During the five years, 1916-1920, stillbirths in this State comprised 4.07 per cent of the total births. During the same period the maternal death rate was 54.90 per 10,000 births, including stillbirths, the septicemia rate, 16.44, and that from all other puerperal causes, 38.46. The deaths from puerperal septicemia comprised just 30 per cent of the total deaths from puerperal causes.

During the five years, 1916-1920, the death rate from *all puerperal causes* was 46.72 per 10,000 births and stillbirths combined in New York City, and 65.87 in the rest of the State—nearly 20 points higher in the latter area. Dividing the rest of the State into urban and rural, the rate for places *under* 2,500 population was 58.51, that for cities *over* 2,500, 69.42, and that for villages *over* 2,500, 71.07. In other words, the death rate is lowest in the very *rural* area of the State.

The death rate from puerperal *septicemia* for the entire State for the five years, 1916-1920, was 16.44, for New York City, only 13.58, and for the rest of the State, 20.29. In the rest of the State the rural septicemia rate was 15.58, and for all cities over 2,500 population it was 23.04.

For the entire period of thirteen years, 1910-1922 inclusive, the mortality from all puerperal causes combined was higher for Upstate\* than

for New York City, the same being true for the death rate from septicemia.

Our publication on the geographical distribution of maternal mortality and stillbirths in New York State shows very great differences in the rates of mortality from causes connected with childbirth in the various counties, cities, and villages of the State. This local variation in rates cannot be accounted for by chance alone, nor are there any outstanding conditions which afford a ready explanation. The presence of many non-resident patients in hospitals is not a factor of great importance in most instances and the practise of arbitrarily excluding non-resident deaths from the rates is not warranted. If this were done, then births to non-resident mothers should likewise be excluded to make the adjustment honest. Moreover, various large cities which contain institutions receiving many non-resident patients, have very low rates, e.g., the average death rate from all puerperal causes in Buffalo, Rochester, Syracuse, Utica, Albany, Binghamton, Schenectady, etc., is below 74 while the rate runs as high as 166 in Watertown, Ogdensburg, Plattsburgh, Middletown, Batavia, etc. Likewise, the average mortality from puerperal septicemia is 20 or below in such large cities as Buffalo, Schenectady, Rochester, and over 40 in Little Falls, Middletown, Plattsburgh, Watertown, Ogdensburg, etc.

Of the many factors to be considered in studying these conditions, not the least important is perhaps the fact that the larger cities have more hospitals, skilled nurses and midwives, and more obstetrical specialists, including physicians who limit their practise entirely to their field. Also, in the large cities a high percentage of births occurs in institutions and the average maternity case probably receives better prenatal and postnatal care. A condition which is perhaps inconsistent with this speculation is the low rural rates, especially from septicemia. I think in this instance the non-resident factor is doubtless important, as many critically ill patients are removed from rural districts to city hospitals.

In this connection it is unfortunate that puerperal septicemia is not better reported as a disease. During the three years, 1920-1922, there were registered in the entire State of New York 1,148 deaths from sepsis and only 877 cases. As during this period there were reported in New York City more cases than deaths, it is obvious that failure to report sepsis must be very extensive among Upstate physicians, or else the infection is more promptly or effectively treated in New York City.

As the suspicion might reasonably exist that the septicemia deaths occur chiefly in the practise of a relatively few physicians and midwives, an attempt was made to determine the facts. Hence we analyzed the distribution of sepsis deaths in the cities to ascertain their prevalence.

\*The terms "Upstate" and "Rest of State" are synonymous.

in the practise of individual physicians. The result showed that they were not at all limited significantly to the practice of any one or any group of physicians in any city, indeed, they were more or less uniformly distributed among many physicians, including men of high reputation as to character and skill. In the city of Troy, during a recent five-year period, there occurred 26 septicemia deaths in the practice of 21 physicians, only one man having as many as three.

Perhaps the commonest explanation offered of our high maternal death rate is that midwives are chiefly to blame. The truth of this also was susceptible of rather close determination, by making direct inquiries of the physicians who registered puerperal deaths during the twelve months preceding July 1, 1923. There were recorded Upstate 687 deaths from causes connected with childbirth, replies to our inquiries, satisfactory for analysis, were received from physicians for 485, or 71 per cent of these deaths. In these replies we are confronted by the bald fact that only 18, or 3.7 per cent, of the patients had been under the care of a midwife at some period before a physician was called. This in itself shows at once that the midwife is by no means the important factor she is accused of being. It must also be remembered that the term "midwife" can be loosely used. The same careful distinction should be drawn between the irregular unlicensed "midwife" and the bona fide trained woman, licensed by the State to practice midwifery on the basis of her qualifications, as between the regular physician with an "M.D." degree and the chiropractor and other irregular practitioner. The professional midwife should not be blamed for the misdeeds of alleged midwives.

Careful reading of the physicians' reports on these 18 patients previously attended by midwives shows that 7 of them died of *septicemia* and 11 from other puerperal causes. These reports fail to show how many of the so-called midwives were licensed or qualified to practice midwifery. Of these 11 deaths there were only two in which it seemed definitely clear that the midwife may have been to blame, viz., deaths from hemorrhage due to placenta previa. Of the remaining 9 cases, one died of tuberculosis—the physician believed overwork and her large family were contributory causes and fails to blame the midwife. Another died of nephritis and profound anemia, although she had been attended by a midwife, the doctor's description of her general health shows it was so poor for two years preceding that pregnancy itself was inadvisable and dangerous, he exonerates the midwife by saying "her death was indirectly self-induced." Three other died of eclampsia, one complicated with broncho-pneumonia and one with acute nephritis. All three are blamed

on lack of prenatal care, for which, obviously, the midwife is not responsible. In another case, the patient died suddenly from pulmonary embolism following difficult labor, and the physician believes there was only a "very faint possibility of saving her had she been delivered earlier," and, therefore, does not seem to blame the midwife. Another died from postpartum hemorrhage, which the physician states was not recognized early enough, although he also states that he was called by the midwife. One patient, very anæmic, died from rupture of the uterus, the physician believing she might have been saved if a Caesarian section had been performed, it appears that he was called by the midwife when the patient's serious condition was discovered, hence she probably was not to blame and certainly not for the abnormal condition which existed. Another patient died following Caesarian section done for malposition and some very obscure obstacle to delivery, which three physicians were unable to positively diagnose. Detailed history of the case shows the midwife called a physician after the patient had been in labor about 12 hours—she had given birth to 12 children with no great difficulty. The physicians, themselves, attempted version, forceps, etc., without success, eventually delivering a child which died soon afterward. The report states it is possible that the patient might have been saved if a physician had been called earlier, but their clear history of the case shows her condition was extremely grave from the beginning. Finally, there are two cases in which it is highly probable that the midwives, both licensed, may have been at fault, both patients died from hemorrhage due to placenta previa and in both instances it seems probable that the seriousness of the condition was not recognized early enough or the physicians not called soon enough. Therefore, out of the entire 11 deaths from causes other than sepsis in which midwives, licensed or otherwise, preceded the physician, there are only two, or less than one-half of one per cent of the total classified deaths, in which the midwives' responsibility can be assumed with reasonable certainty.

During the 12 months preceding last July 1, 1923, 205 deaths from puerperal sepsis were registered in Upstate New York (this cause being given alone or associated with other causes). Inquiries sent to the reporting physicians resulted in 138 replies satisfactory for tabulation, or 67 per cent of the total 205 deaths. As we have just noted, only seven cases had a midwife in attendance before a physician was called. In only two of these does the physician directly blame the alleged midwife and in one, some other physician was in attendance after the midwife delivered the woman, in the other the criminal abortion was performed by an alleged midwife in New Jersey. Of the other five sepsis cases, in one the physician states the infection

variation in the death rate from puerperal septicemia and from all puerperal causes, exclusive of septicemia (see Chart II) This seasonal varia-

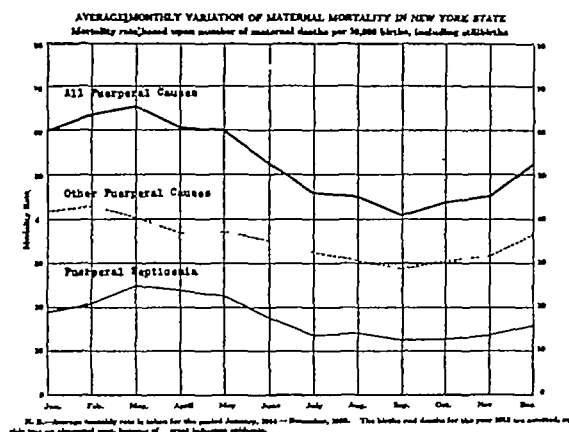


CHART II

tion may possibly be attributed to the greater prevalence of respiratory and renal diseases in the colder months, our final analysis may show definitely whether or not this will account for it

The average annual number of live births in the entire State of New York is 238,364 and of stillbirths, 10,110, the average annual number of deaths for mothers from all causes connected with childbirth is 1,364. During the five years, 1916-1920, stillbirths in this State comprised 4.07 per cent of the total births. During the same period the maternal death rate was 54.90 per 10,000 births, including stillbirths, the septicemia rate, 16.44, and that from all other puerperal causes, 38.46. The deaths from puerperal septicemia comprised just 30 per cent of the total deaths from puerperal causes.

During the five years, 1916-1920, the death rate from *all puerperal causes* was 46.72 per 10,000 births and stillbirths combined in New York City, and 65.87 in the rest of the State—nearly 20 points higher in the latter area. Dividing the rest of the State into urban and rural, the rate for places *under* 2,500 population was 58.51, that for cities *over* 2,500, 69.42, and that for villages *over* 2,500, 71.07. In other words, the death rate is lowest in the very *rural* area of the State.

The death rate from puerperal *septicemia* for the entire State for the five years, 1916-1920, was 16.44, for New York City, only 13.58, and for the rest of the State, 20.29. In the rest of the State the rural septicemia rate was 15.58, and for all cities *over* 2,500 population it was 23.04.

For the entire period of thirteen years, 1910-1922 inclusive, the mortality from all puerperal causes combined was higher for Upstate\* than

for New York City, the same being true for the death rate from septicemia.

Our publication on the geographical distribution of maternal mortality and stillbirths in New York State shows very great differences in the rates of mortality from causes connected with childbirth in the various counties, cities, and villages of the State. This local variation in rates cannot be accounted for by chance alone, nor are there any outstanding conditions which afford a ready explanation. The presence of many non-resident patients in hospitals is not a factor of great importance in most instances and the practice of arbitrarily excluding non-resident deaths from the rates is not warranted. If this were done, then births to non-resident mothers should likewise be excluded to make the adjustment honest. Moreover, various large cities which contain institutions receiving many non-resident patients, have very low rates, e.g., the average death rate from all puerperal causes in Buffalo, Rochester, Syracuse, Utica, Albany, Binghamton, Schenectady, etc., is below 74 while the rate runs as high as 166 in Watertown, Ogdensburg, Plattsburgh, Middletown, Batavia, etc. Likewise, the average mortality from puerperal septicemia is 20 or below in such large cities as Buffalo, Schenectady, Rochester, and over 40 in Little Falls, Middletown, Plattsburgh, Watertown, Ogdensburg, etc.

Of the many factors to be considered in studying these conditions, not the least important is perhaps the fact that the larger cities have more hospitals, skilled nurses and midwives, and more obstetrical specialists, including physicians who limit their practice entirely to their field. Also, in the large cities a high percentage of births occurs in institutions and the average maternity case probably receives better prenatal and postnatal care. A condition which is perhaps inconsistent with this speculation is the low rural rates, especially from septicemia. I think in this instance the non-resident factor is doubtless important, as many critically ill patients are removed from rural districts to city hospitals.

In this connection it is unfortunate that puerperal septicemia is not better reported as a disease. During the three years, 1920-1922, there were registered in the entire State of New York 1,148 deaths from sepsis and only 877 cases. As during this period there were reported in New York City more cases than deaths, it is obvious that failure to report sepsis must be very extensive among Upstate physicians, or else the infection is more promptly or effectively treated in New York City.

As the suspicion might reasonably exist that the septicemia deaths occur chiefly in the practice of a relatively few physicians and midwives, an attempt was made to determine the facts. Hence we analyzed the distribution of sepsis deaths in the cities to ascertain their prevalence

\*The terms "Upstate" and "Rest of State" are synonymous.

premature birth, whether criminal or otherwise.

As to diseases associated with important puerperal causes of death, it may be of interest to mention that out of 2,933 puerperal deaths we are studying, there were 1,347, or about one-half, in which the death was attributed by the physician to a single cause, and 1,337, or almost an equal number, in which the cause of death was associated with one contributory condition, either puerperal or other illness. There were only 243 deaths in which the primary cause of death was associated with two contributory causes. For example, out of 2,933 deaths the primary cause in 670, or 23 per cent, was due to toxemia of pregnancy, this toxemia of pregnancy occurred without any contributory cause in 420 cases, or 63 per cent of all the toxemias, 215, or 32 per cent of the toxemias had one contributory cause, and 33 cases had two contributory causes. Of the total 2,933 puerperal deaths, 370, or 13 per cent, were caused by abortion, miscarriage, and premature labor, including criminal and self-induced abortions. Ectopic gestation was the primary cause of death in 100 cases, or 3 per cent of the total. Acute and chronic infectious disease, such as typhoid, influenza, pneumonia, tuberculosis, etc., were the primary causes of death in 369, or 13 per cent of the cases. Puerperal hemorrhage, including placenta previa, was the primary cause of death in 240, or 8 per cent of the cases. Puerperal infection was the primary cause in 346, or 12 per cent of the cases. Our final results will, of course, show all the causes in detail and also associated with other contributory causes.

In order to discover, if possible, some of the basic conditions under which the deaths from puerperal causes occur in this State, certain questions were submitted, during a period of twelve months preceding last July 1, 1923, to each physician who reported a death from any cause connected with childbirth. Inquiries were made concerning 687 puerperal deaths and replies suitable for tabulation were received for 485 cases, or 71 per cent. Of the 485 deaths, 58 per cent occurred in hospitals. Puerperal sepsis as a cause of death in these cases has already been described in detail above, likewise the factor of the midwife. Other facts of importance found were that 30 per cent of the sepsis deaths were reported by physicians as having been *previously under the care of some other physician*, and only 2 per cent under the care of the same physician until death occurred. Of the 485 deaths, 72 per cent were reported as having had a trained nurse or other competent attendant during the puerperium, and 28 per cent were attended by friends, members of the family, neighbors, etc. Hospital care was advised by the physicians in 69 per cent of the cases and was not advised in 22 per cent, 4 per cent of the patients were unable to go to hospitals as they were too ill to go, or

hospitals were too far distant. Of those who were not advised to go, many were believed by physicians to be dying or too ill to be moved any distance. Of those who were advised to enter hospitals, 75 per cent consented and 17 per cent refused, 7 per cent of the patients consented to go to the hospital only after their condition became extremely serious. The reporting physicians stated they believed that the patients had received adequate medical care before confinement in 54 per cent of the cases, that they had not received adequate care in 37 per cent, and that the type of care was unknown for 9 per cent. Of those who had not received adequate medical care before confinement, the physician stated in many instances that it was due to ignorance, neglect, or poverty. Only 2 per cent of the patients refused consultation when it was advised by the attendant. In 9 per cent of the cases, the physician did not advise consultation—possibly because competent advice was not available or the patient was already dying when the physician was called. Obstetricians were available for consultation in the communities of 77 per cent of the decedents, were not available in only 12 per cent, and for only 3 per cent of the cases did the physicians report that obstetricians were many miles distant. This would indicate that for not less than one case out of ten there was no obstetrician available for consultation.

Obstetrical operations, such as version, Caesarian section, high and low forceps, traction, craniotomy, laparotomy, etc., were performed in just 50 per cent of the cases. *The physicians reported that in 42 per cent of the entire 485 puerperal deaths the patient had been previously suffering from an illness which endangered her life when she became pregnant.* Many of these illnesses were such chronic conditions as tuberculosis, heart disease, etc. In only 35 per cent of the cases did the physicians report that there were circumstances or conditions under which the patient's life might have been saved, and in 25 per cent that there were no conditions under which the patient could have been saved. In the remaining cases, on this point the physicians were doubtful or uncertain.

#### CONCLUSIONS

It is a fact, shown by our inquiries and well known to all physicians, that some patients, in spite of the most thorough and competent medical care from the time of conception, and under the most favorable circumstances, will develop abnormal puerperal conditions resulting in death, and that even fatal septic infection will occur from no cause which the physician can determine. The prevention of death in the remainder of the cases would seem to depend upon the following:

- 1 Education of the public as to the necessity for competent medical prenatal care, and as to

resulted from a previous pelvic disease and that the patient had adequate care preceding and during confinement, in another, the physician exonerates the midwife and states he "knows of no circumstances under which the patient might have been saved" In the remaining three cases, the midwife is not blamed and either the patients were seriously ill before she was called, other physicians followed the midwife, or for other reasons she can be absolved from suspicion.

Hence, to sum up, out of the total 18 cases in which the midwives were involved, critical examination of the physicians' own reports reveal that in only 4 cases, or less than 1 per cent, were they able to definitely implicate the midwife. In addition, in most of the 18 cases the question must be raised as to whether or not the so-called midwife who preceded the physicians was a bona fide licensed midwife or an irregular practitioner. Without elaborating further on the question I think these facts obtained from the Upstate medical profession may be accepted as showing definitely that the midwife is an almost negligible factor in the causation of puerperal mortality. This conclusion is consistent with many facts and conditions which there is insufficient time at our disposal to discuss.

An interesting and striking fact disclosed by our preliminary data is that where the fetus has developed to the fifth month or over of utero-gestation, the fetal mortality is 53 per cent among those born to mothers who died from causes connected with childbirth. Out of 1,885 deaths of mothers from maternal causes for which a corresponding birth was reported, 617 of the infants were stillborn and 1,268 live born. Of the live born, 374 died before they completed the first year of life, thus the mortality of the children born to these 1,885 mothers was 991, or 53 per cent. But, during this period there were, in addition to these 1,885 deaths, 1,048 other deaths of mothers in childbirth for whom no birth certificates were found. As the reasons for not finding them in many or most cases were that no child was born or that the fetus was under five months utero-gestation, it is plain that the fetal mortality is very much higher than 53 per cent.

The notes we have already published show that in Upstate New York the death rate of women from all puerperal causes, from puerperal septicemia, and from all other puerperal causes, in each five-year age group at from 15 to 50 years, in proportion to every 10,000 confinements of mothers of corresponding age groups, shows a striking regularity of increase at each successive age from 20 to 50 years, with a rate at the age 15 to 19 slightly above that at 20 to 24. The rate of stillbirths by ages of the mothers shows the same regular distribution upward (see Chart III). When the mortality among married

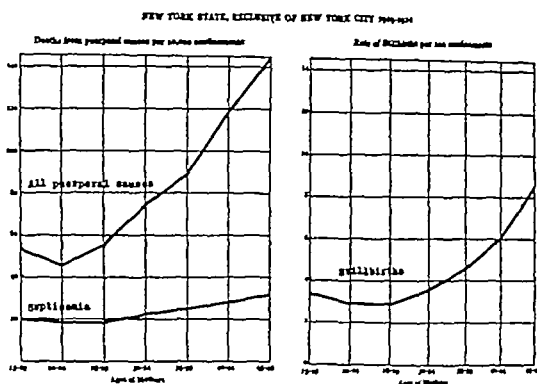


CHART III

mothers is shown separately, the general distribution is similar, viz, the death rate increasing with the ages of the mothers.

The death rate from all puerperal causes combined in proportion to 10,000 births and stillbirths increases steadily according to the number of children the mother has had. The mortality shows a high point for primiparae—being 606 per 10,000, for mothers who have had from two to seven children the mortality varies between 38 and 45, for each child the mother has beyond seven the mortality increases, reaching the very high point of 1556 per 10,000 for mothers who have had 14 children. The curve showing the distribution of these death rates resembles that of mortality of mothers by their ages described above. These data seem to be highly significant as showing that the risk of death to the mother increases with each child born beyond the number of seven. In fact, the rate shows a slight increase for each child born beyond the number of two, but rises rapidly after the seventh child is born.

Our data on the frequency of maternal mortality, according to the nativity of mothers, shows the mortality is higher among the native born white mothers than among the foreign born white. Of the foreign born, it is higher among Germans, Canadians, and Scandinavians, and lowest among the Russians (including Russian Hebrews), and next lowest among Austrians, Hungarians and Poles. The mortality among the colored is very high—nearly twice as high as the native white.

Our preliminary data indicate the frequency of abortion, miscarriage, and premature birth, including criminal and self-induced abortion, as the cause of puerperal sepsis. Out of 477 sepsis deaths which we are studying, 299, or 62.7 per cent, were from these causes. Criminal and self-induced abortion preceded septic infection in 82, or 17.2 per cent of the total 477 deaths, in other words, a little less than one-fifth of the septicemia deaths followed criminal interference, and over one-half followed abortion, miscarriage, or



Janet sums it all up as a weakening of the faculty of psychological synthesis

Moeibus says it is a state in which ideas, many fanciful, control the functions of the body

Strumpell declines to give a definition, but describes the condition by various examples, and summarizes the symptoms

Stevens says hysteria is a functional disease of the nervous system, manifested by symptoms of the most varied character, and associated with impaired will-power and increased impressionability

There are a good many other attempts to define hysteria, and it seems to the author that the average student becomes more and more involved in a muddle of perplexities. What seems to be the simplest definition, is that hysteria is a functional mental disease in which the field of consciousness is contracted, and the sub-conscious overshadows the conscious mind. The cause is a psychic trauma. It is much like a dream-state or a hypnoidal condition. The strongest outstanding feature is trouble of the will

*Etiology*—This disease has its origin from some shock to the nervous system. As individuals differ in their powers to withstand various physical hardships, so the mental resistances of people are not alike. Again as in a physical disorder, one with brittle bones is more liable to fracture, and the more likelihood depends on the greater friability of the osseous tissue, so in all the psychotic breakdown, the fibre of an individual nervous system foretells the ability to combat a particular misdirected psychic force. Whether an arm or a leg breaks, or whether the fracture is serrated stellate or simple in its division lines of the bone, also depends on the force of the power causing the trauma, and the quality of the bony texture. Thus, one may get analogous psychic disturbances of degree and kind, depending upon the amount of psychic shock and individual differences of resistance to such shocks.

There seems to be no age exempt from hysteria, although most cases occur when the psychosexual fantasies are on the most active ascendant as in the late puberty. In the writers experience, both sexes are about equally attacked. There seems to be little difference whether education or so-called culture is present, although farm hands seem to be the least affected, and school-teachers the most. The largest group fall into that class of people who have the greatest difficulty to make financial ends meet, so that they can live as their more intimate friends and relatives do.

More cases are seen when temperature extremes are present, as in the hottest summer and coldest winter days. One attack seems to predispose to others, and succeeding attacks develop more often in proportion to the number and severity of the previous ones.

Heredity plays quite a part and frequent cases are seen in the same families. Close affiliations with hysterical patients often predispose to the disease. A long-continued unpleasant mental strain at times needs only a comparatively minor psychic trauma to produce a major hysteria. This mental strain may be loss of a friend, sickness, financial reverses, unpleasant environment, an accident which may have happened to the patient or to another person, a disrupted love affair, etc., embracing every human process of reasoning and endeavor. The onset is usually acute.

*Symptoms*—These are of two different kinds: first, the stigmata or those symptoms which predominate in whole or in part, all hysterics, and then the others which vary with the cases. The most prominent stigmata are areas of anesthesia, anesthetic palate, anesthetic cornea, contracted visual field, hypersuggestibility, alterations of acts and person, fugues and flights, troubles of the will and habit, spasms and tics.

Among the second type of symptoms may be mentioned absentmindedness, feelings of incompleteness, need of attracting attention, transfers and equivalences of thoughts and acts, paralyses, contractures, absence or distortions of the special senses, dreams and nightmares, variations in the moods without apparent causes, and so-called tantrums. As in other diseases, when the patient recovers, all the symptoms disappear.

*Anesthesia*—The patient is often unaware of this symptom until the examiner points it out to him. The skin anesthesia is not distributed along any particular nerve course, but occurs in patches of varying size, at times taking in a whole extremity, and often stops at a definite line of demarcation. This has given rise to the term "stocking anesthesia" in the leg, or "glove anesthesia" when it occurs in the hand or forearm. There are no sensory nerves which have such a definite line of demarcation. It is not uncommon to see one-half of the whole body anesthetic, from the vertex of the head to the sole of the foot, while the other half of the body is perfectly normal. Such a condition must obviously be without anatomical foundation. The test may be made by pricking the patient with a needle and asking whether it is felt or not. A more discriminating way is to test out all the sensibilities, as heat and cold, with test tubes containing water of widely different temperatures, the touch sense, by lightly stroking the part with a fine hair or a small piece of cotton, and the pain sense by using the needle pricks before mentioned. For a hasty examination the needle gives sufficient data.

The cause of this symptom is entirely a functional affair, and in no way has to do with an abnormality of the sensory nerve endings. In fact in many cases the location of the anesthesia may vary from day to day. At times a casual suggestion is enough to indicate to a patient that

the very grave dangers of criminal or self-induced abortion

2 Education of the public as to the undesirability of confinement of the mother by any one except a person licensed to practice obstetrics or midwifery

3 Suppression of the criminal abortionist

4 Immediate and competent care of the patient suffering from spontaneous or accidental abortion

5 Education of the public as to the need for prompt medical care of any abdominal condition connected with pregnancy, or any other illness occurring during pregnancy

6 Adequate clinical and hospital facilities for the care of the poor and those of moderate means

7 Measures to make available, if possible, expert obstetrical advice for physicians in remote rural districts, or facilities for early removal of abnormal cases to the obstetrical expert

8 Elevation of the standards of obstetrical training and practice for physicians

N B—This conclusion is warranted by the reports of the physicians themselves on puerperal deaths, which show that in many cases delay or lack of skill on the part of the first physician called seriously endangered the patient's life or actually began the chain of events ending in her death

9 Extreme aseptic precautions in the care of the patient, especially during and after delivery, and particularly if the patient is suffering from a serious illness not connected with the puerperal condition

10 Clinical, pathological, and statistical research to discover facts at present unknown, and to determine the routes of puerperal infection

Finally, in conclusion, it may be added that it would be wrong to convey the impression to the public that pregnancy in itself is a dangerous condition. On the contrary, during a recent five-year period in New York State there were 1,242,374 live births and stillbirths combined, and 6,821 deaths from causes connected with childbirth, therefore, only one-half of one per cent of the mothers died

## HYSTERIA \*

### An Epitome

By SIEGFRIED BLOCK, A.M., M.D., F.A.C.P.,

BROOKLYN, N. Y.

THE uncertainty with which the diagnosis of hysteria is made by so many practitioners, together with the varied descriptions given in text books covering this subject, have suggested a short paper which shall include only the essentials of this functional psychoneurosis. It may not be amiss to give a few of the standard college book definitions, chosen at random, to get an idea how authorities vary in their elucidation of this subject.

Osler calls it a disorder in which the emotional states control the body, leading to perversion of the mental, sensory, motor and secretory functions.

Charcot says it is a psychosis in which morbid states are induced by ideas. The patient is hypersuggestible. The disturbance is in the personality in which the emotions influence the sensory, motor and secretory functions.

Babinski calls it a mental condition due to hypersuggestibility of certain sensory, motor and secretory functions, with a superimposed group of symptoms as muscular atrophy. The superimposed symptoms cannot be induced by suggestion.

Freud and Breuer follow the ancient Greek idea of a sexual base (hence the name). They

teach that before puberty often on a constitutional base there develop a group of sexual activities which are usually perverse and in the psychic sphere. There gradually grow out of this a series of fantasies which are suppressed, and a conflict between the repressions and normal libido gives rise to certain manifestations, which is termed hysteria. Thus, Freud's theory is based on sexual traumata in early childhood.

Starr claims there is a permanent functional mental condition which he calls the hysterical temperament, and certain temporary attacks of mental or emotional disturbance. The characteristics of the hysterical temperament are an abnormal sensitiveness to impressions and sensations, a susceptibility to suggestion, an unusual desire for attention and notice, variations of the moods not due to apparent causes, lack of judgment, and an incapacity to exercise control over thought, a tendency to act on sudden impulses, a foolish wilfulness, moral obliquity, and frivolous fancies.

Aschaffenburg, of Cologne, says the whole thing is a false relation between stimulation and reactions, and a tendency to convert these reactions into physical manifestations—this is especially true in the emotional sphere.

\* Read at the Annual Meeting of the Sullivan County Medical Society at Liberty, N. Y., October 10, 1923.

tastes are not so impossible as those of the casual dreamer. The hysterical dream also occurs more frequently and repeats itself either exactly or symbolistically at intervals.

The waking reaction to a dream, in those afflicted with hysteria, is very different from a normal healthy individual. The feeling of joy and sorrow, like and dislike, are often based upon a somnambulistic experience which the waking individual does not remember. That is, the person reacts to the dreams in his everyday life, but it is possible that the dream experience is forgotten and the individual cannot explain why he or she behaves in a particular way. On careful study of these hysterics as mentioned above, it is not difficult to realize that they do not really come out of this dream-state. They are, so to say, in a subconscious state when they should be wide awake, and fully alert to all those sensations, thoughts, stimuli, etc., which control active psychic life. Failing, they act only partially as one would expect they should, and the result is not only an inefficiency due to inability, but often a perverted action, an action uncontrolled by the proper associations, and through dissociations, as in dreams, unnatural thoughts and actions are produced.

*Fugues and Flights*—This is a peculiarity which is not uncommon in the hysterics. As a somnambulist walks in his sleep, and does things which in his waking state he will not do, so the hysteric, during an attack may wander away from home. He may not be able to recall his name or know how he reached the place where he was found, and he may be surprised when he is told that he is not normal and that his actions are peculiar. At a future time when the attack has passed over, he will not be able to remember how or why he wandered away. There are cases in which a perfectly lovely wife or devoted husband will go off with another partner, and on coming out of the hysterical trance regret the act and will be bitter against the second mate for assisting in the escapade. The psychology of such an act is described in various ways by different observers. Some claim that in most of the cases, as in a dream, a wish is fulfilled. That is, the hysterical patient had wished to run off with another, but his best judgment told him not to do it, yet he throws aside this sound reasoning and gives himself a sort of "mental knock-out blow." He is now unhampered by either experience or other mental restrictions. A subconscious feeling of "what do I care what happens? I am at liberty to do and act any way I please!"

*Alterations of Personality*—It is almost unbelievable how the hysterical patient at times may engage in a wild fugue. He may travel miles and deport himself in a manner so normal that no one's attention will be attracted to any misconduct. During this period, such an individual

may engage in a healthy conversation, often being able to argue on many points of interest to the people present. He frequently assumes not only different names, but also personalities not his own. The quiet, reserved person may become a bon-vivant, hilarious and light-spirited. Even a miser may become a free spender, and shyness may give way to boldness and impertinence. This all goes on when the subconscious supersedes the conscious level of thought.

It is with great difficulty that the subconscious activities can be grasped by the patient after he is again back to his normal or average self. However, if this subconscious state is again induced, either in a dream or in a hypnotic trance, the patient will react and speak freely, like in the afore-mentioned episodes. If one is in this trance or a dream or hypnosis, and can be made to talk freely about the subconscious fugue, it is often possible to bring out the reason for the peculiar activity, and one step toward a permanent relief of the state has been achieved.

It is very important that during such an examination, the examiner keep his mental poise, and not permit himself to be influenced by the patient's feeling-state. It is only in this way that one is able to properly to form conclusions and discover the reasoning defect.

*Tics and Paralyzes*—It is easy to understand how these patients may have symptoms involving any group of sensory or motor nerves. Sudden blindness, deafness or other sensory disturbance, equal on both sides of the body, following a psychic trauma, is by no means uncommon. Following a fright, a sudden paralysis of an extremity with normal reflexes is by no means rare. In these cases all tests except those of the disease in question are negative. A tic or spasm following or accompanying a psychic disturbance which may be brought about by a physical or mental strain, or sudden shock may be the only symptom of hysteria. In these cases, as in the paralysis above mentioned, the examination is negative, except for this particular symptom.

*Variations in Moods and Tantrums*—The variability of moods, without apparent cause, or night tantrums, both of which may be subconscious overpowering of the conscious mind, are frequently the outstanding feature of such patients. Thus, delusions and hallucinations may be a wish-fulfilling expression of the subconscious hysterical manifestation, which has long been held in abeyance by a conscious restraint. It is really a feeling of "the wildest dreams come true."

*Case Examples*—Fugue. Several years ago, a doctor sent the author L. R., with the following history, and with a diagnosis of hysteria. The man was 48 years of age, a printer, married, three children. Past history negative. He had always been devoted to his family, and worked steadily

he or she will be anesthetic at a certain point

*Anesthetic Palate*—The anesthesia of the palate is the second stigmata in frequency and importance. By having the patient open the mouth and touching the pharynx or the faucial pillars, no gagging reflex is noted. It is usually necessary to hold the tongue down with a suitable depressor to see the reflex action. In healthy individuals this is a very active and delicate reflex test. It is practically never unilateral, and when it occurs without a history of injury to the head or other bulbar symptoms, hysteria must be kept in mind. Many of these patients claim to feel a sort of ball in the throat when they feel ill. This is termed the "Globus Hystericus" and is usually a psychic disturbance, but has nothing to do with the palatal anesthesia. There is no anatomical accounting for this phenomenon. There is neither spasm nor swelling in the pharynx or larynx when this "Globus" is felt.

*Anesthetic Cornea*—As the palate is anesthetic one is often able to elicit a cornea which is minus sensation to the touch of a blunt instrument. Mere conjunctival anesthesia is not as delicate as corneal. A simple way to investigate this point is to ask the patient to look far upward and with the pencil to touch the edge of the iris where it joins the sclera. If one touches the cornea in front of the pupil, the sight of the foreign body makes the eye wink and this is a useless procedure.

*Contracted Visual Field*—This test is of value in confirmation of a suspected diagnosis of hysteria. Either an ordinary perimeter as used by ophthalmologists may be employed to map out the field of vision, or more crude methods will suffice. In most of the cases all that is necessary is to have the patient look straight in front and then with an object in one hand, the examiner slowly moves it in all directions. The patient is asked to tell when the object becomes invisible as it is moved gradually further from the axis of vision. The proper allowance should be made for ocular disturbances, such as astigmatism, etc. When the perimeter is at hand the color fields may be mapped out. In hysterical fields the color outlines are different from normal. In healthy persons, red can be seen over the widest area, while in the hysterics any other color is liable to take the place of red. No diagnosis should be made on this stigmata alone, but a combination of several stigmata with a proper history and the exclusion of organic disease is necessary.

*Hypersuggestibility*—These patients are more suggestible than any others who are not feeble-minded. They are always ready to receive ideas of what to do. This is especially true in matters concerning their personality. Often a mere word as saying an arm is weak or a particular hand is anesthetic, is enough to make it so. Of course this symptom varies in degree with the cases and

there are occasional hysterics who are not hypersuggestible. Hypnotism, which is a stronger suggestive phenomenon, is usually easy with these patients. On careful analysis, it is very difficult to differentiate the hypnotic state from the hysterical state of mind. Both of these conditions are much like a dream-state in which the subconscious realm overpowers the waking consciousness. It is a state of disassociation. It is this disassociation which describes the result of the narrowing fields of consciousness. It is a psychic clouding, so that the "feeling state" of the patient is not clear cut. Although he may be able to think very co-ordinately on those things not affecting his sentimental, spiritual, libidous and other psychic matters pertaining to himself, he is in a mental state of bankruptcy on the latter.

*Alternating of the Personality*—A peculiarity of hysterical patients is that in many cases during an attack they assume an attitude as if they were another individual. They have a sort of double personality. It may be described much like a nightmare. When awake, as a rule, the somnabulist does not know of his night walking, talking or other activity. He is surprised when he is informed of the things he does or says in his sleep. The hysterical patient is in the same way perplexed when his abnormal doings are explained.

Neurologists frequently see patients who have an entirely different self. The genteel girl becomes a boisterous, uncouth individual. The good man may become a criminal. The so-called wish-complex is often thought to play a part in this mental manoeuvre. That is when the patient does not hold back his activities, as in the waking state he is free to carry on a self-transposition and assume an individualistic characterization of what he, in his fondest and freest moments would wish to appear. He acts not what he really is, but how he wants the outside world to think he is. This idea is usually under control of the highest intellectual sphere, but when one is asleep and dreaming, the highest centres are overpowered by the subconsciousness and the person responds to an unmolested mind which in no way is hindered from acting as a child's, unhampered by convention or public opinion. Just as in the dream-state, so in the hysterical condition the patient is a free agent and the most preposterous disassociating mental activities play havoc. It is thus that daydreams materialize and night-terrors take on a real waking actuality.

*Dreams*—Thus it is, the more parallelisms that are drawn with the dream, the more is one inclined to think that a dream corresponds to a hysterical manifestation. Hysterical persons dream, as a rule, more than the average sleeper. Their dreams are more materialistic, and the fan-

tastes are not so impossible as those of the casual dreamer. The hysterical dream also occurs more frequently and repeats itself either exactly or symbolistically at intervals.

The waking reaction to a dream, in those afflicted with hysteria, is very different from a normal healthy individual. The feeling of joy and sorrow, like and dislike, are often based upon a somnambulistic experience which the waking individual does not remember. That is, the person reacts to the dreams in his everyday life, but it is possible that the dream experience is forgotten and the individual cannot explain why he or she behaves in a particular way. On careful study of these hysterics as mentioned above, it is not difficult to realize that they do not fully come out of this dream-state. They are, so to say, in a subconscious state when they should be wide awake, and fully alert to all those sensations, thoughts, stimuli, etc., which control active psychic life. Failing, they act only partially as one would expect they should, and the result is not only an inefficiency due to inability, but often a perverted action, an action uncontrolled by the proper associations, and through dissociations, as in dreams, unnatural thoughts and actions are produced.

*Fugues and Flights*—This is a peculiarity which is not uncommon in the hysterics. As a somnambulist walks in his sleep, and does things which in his waking state he will not do, so the hysteric, during an attack may wander away from home. He may not be able to recall his name or know how he reached the place where he was found, and he may be surprised when he is told that he is not normal and that his actions are peculiar. At a future time when the attack has passed over, he will not be able to remember how or why he wandered away. There are cases in which a perfectly lovely wife or devoted husband will go off with another partner, and on coming out of the hysterical trance regret the act and will be bitter against the second mate for assisting in the escapade. The psychology of such an act is described in various ways by different observers. Some claim that in most of the cases, as in a dream, a wish is fulfilled. That is, the hysterical patient had wished to run off with another, but his best judgment told him not to do it, yet he throws aside this sound reasoning and gives himself a sort of "mental knock-out blow." He is now unhampered by either experience or other mental restrictions. A subconscious feeling of "what do I care what happens? I am at liberty to do and act any way I please."

*Alterations of Personality*—It is almost unbelievable how the hysterical patient at times may engage in a wild fugue. He may travel miles and deport himself in a manner so normal that no one's attention will be attracted to any misconduct. During this period, such an individual

may engage in a healthy conversation, often being able to argue on many points of interest to the people present. He frequently assumes not only different names, but also personalities not his own. The quiet, reserved person may become a bon-vivant, hilarious and light-spirited. Even a miser may become a free spender, and shyness may give way to boldness and impertinence. This all goes on when the subconscious supersedes the conscious level of thought.

It is with great difficulty that the subconscious activities can be grasped by the patient after he is again back to his normal or average self. However, if this subconscious state is again induced, either in a dream or in a hypnotic trance, the patient will react and speak freely, like in the afore-mentioned episodes. If one is in this trance or a dream or hypnosis, and can be made to talk freely about the subconscious fugue, it is often possible to bring out the reason for the peculiar activity, and one step toward a permanent relief of the state has been achieved.

It is very important that during such an examination, the examiner keep his mental poise, and not permit himself to be influenced by the patient's feeling-state. It is only in this way that one is able to properly to form conclusions and discover the reasoning defect.

*Tics and Paralysis*—It is easy to understand how these patients may have symptoms involving any group of sensory or motor nerves. Sudden blindness, deafness or other sensory disturbance, equal on both sides of the body, following a psychic trauma, is by no means uncommon. Following a fright, a sudden paralysis of an extremity with normal reflexes, is by no means rare. In these cases all tests except those of the disease in question are negative. A tic or spasm following or accompanying a psychic disturbance, which may be brought about by a physical or mental strain, or sudden shock, may be the only symptom of hysteria. In these cases, as in the paralysis above mentioned, the examination is negative, except for this particular symptom.

*Variations in Moods and Tantrums*—The variability of moods, without apparent cause, or night tantrums, both of which may be subconscious overpowering of the conscious mind, are frequently the outstanding feature of such patients. Thus delusions and hallucinations may be a wish-fulfilling expression of the subconscious hysterical manifestation, which has long been held in abeyance by a conscious restraint. It is really a feeling of "the wildest dreams come true."

*Case Examples*—Fugue. Several years ago, a doctor sent the author L. R., with the following history, and with a diagnosis of hysteria. The man was 48 years of age, a printer, married, three children. Past history negative. He had always been devoted to his family, and worked steadily

and provided well for them. The firm that employed him discontinued operations during the war, and he spent several months trying to find another position. On one particular Monday morning, he left his home after telling his wife he was going to apply for some position he saw advertised in the newspaper. He was not heard of again for a year and three months, when his wife received a wire from the Cook County State Hospital in Chicago, stating that he was there ready to go home. When he got back to his home in Philadelphia, he could not recall and could not understand how he ever reached the Chicago hospital, or any reason for his having been there, or why he had a big abdominal scar.

Six months later, I saw the man for the first time, and tried every means to get a hint of his journey. His wife insisted he had only a few cents in his pocket when he left that morning to look for a position.

In the writer's office, in the presence of the patient's family doctor and his wife, the man was hypnotized, and then told the following story. He applied for that position, but it was already filled. He felt despondent. He had heard there was a strike in a big varnish factory in Chicago, and conceived the idea of going there to work as a strike-breaker. Opposite the Market Street Station in Philadelphia, he saw an auction sale going on. He took out his gold watch, brought it to the auctioneer to sell, and with this money paid his fare to Chicago. He secured the position in the varnish factory, and after he worked there two months, he was seized with severe abdominal cramps. He was taken to a local private hospital, where an exploratory laparotomy was done. After he was in this hospital for three weeks, and his funds gave out, they told him he would have to leave.

With his bandages still on, he walked the streets of Chicago, and was advised to apply for admission to the Cook County Hospital. It was late at night, and he sat on the steps of the hospital and fell asleep. In the morning he was taken into the hospital, and after being there a long time, and trying every method, it was impossible for him to say exactly where he came from, or who he was. One year later, he had a dream, in which it was revealed to him who he was and where he came from. He could sleep on longer. He told everybody about himself and his home, but the episode of his whole being and experience in Chicago was a blank.

When he was aroused from the hypnosis, the story was related to him. He would not believe it. And only after hypnotizing him again on different days, and each time assuring him his subconscious thoughts corroborated his previous subconscious expressions, did he gradually begin to believe the possibility of the story.

The authorities in Chicago confirmed the facts.

Two years later the man had a second attack of hysteria, and wandered away again and has not been heard from since.

This man had an anesthetic palate, a bilaterally contracted visual field, his right lower extremity was entirely anesthetic to every sensation. Mentally, he was unemotional, his memory was normal, and physically he was very well developed. All serology, blood morphology, and eye-ground examinations were negative. His blood pressure was 120 systolic and 80 diastolic.

*Case 2*—A girl of 18, the only daughter and twin sister of an only son. She was a stenographer in one of the large insurance companies. She was always a well-behaved girl, and had no history of any illness. Two o'clock one morning, the family doctor telephoned that this girl was in a terrible tantrum, in which she said she saw no use in being good, it didn't pay, and she was going to be like other girls, that nobody could stop her, and she was now announcing to the family that she was going to be immoral and stop at nothing. She was quieted with hyoscine and slept until noon the next day. The family then took her to a seaside resort for two weeks, and brought her back for an examination. The case seemed at an end and she returned to her work on the Monday of the next week. On the following Thursday, she sent a telegram from Philadelphia that she was stopping at a hotel with a young man, and that her dream came true.

When the parents arrived at that hotel, she had already left for Washington. Although the police there were notified, the girl was not found or heard from for eight months, when her twin brother accidentally found her in a cabaret chorus in New York.

She had been traveling under an assumed name, and did not recognize her brother. He had her arrested and the magistrate discharged her in the custody of her parents. She was home two months, when her grandmother died suddenly, and during the funeral service she started to cry, and then realized where and who she really was.

It was not so easy to hypnotize this girl as the previous case, but eventually under hypnosis she recounted her whole escapade, and gave as her reason that she was sick and tired of her work, that she wanted to travel, that she wanted to go on the stage, and she didn't care how she got there. She had just read a book in which another girl did almost what she had done, and she imitated her.

The night when she first had that wild dream, was about this book. The story, when told to her twin brother, made him hysterical, and he became amnesic and aphasic immediately. This condition lasted only about ten days. After he

became well, the brother and sister were so suggestible to each other, that whenever one had a pain or an ache, the other would have the same. This hypersuggestibility increased to such an extent, that if one would laugh, even in another room with the door shut, the other would experience laughter, as if there were a mental telepathic current connecting the two. Whenever one was sick in bed, so was the other. Since three years, the brother is dead, having had acute cardiac dilatation following an attack of rheumatism. The girl had an attack of rheumatism the same time as her brother. At present, her corneae, her palate and the soles of her feet are anesthetic to pin pricks. She talks in her sleep. Outside of this, she is apparently normal, has been married, and has a healthy child.

*Case 3*—An apparently healthy woman of 50 was walking through the street, and as she passed the shadow thrown on the pavement by an electric light, she fell. For a moment she thought the shadow was a hole. Her sister was with her and helped her to her feet. They had to call a taxi-cab to take her home, and although all findings were negative, it is now ten years that the woman is paralyzed in her entire right lower extremity, since the fall. When she sleeps, if the sole of her foot be tickled or pricked with a pin, she moves that leg, but when awake she is a helpless cripple. That leg is anesthetic when she is conscious.

*Case 4*—A child of 5 was in a railroad accident, and his father was killed. Since that event, the child is deaf and dumb. Otological and laryngological examinations are negative. Reflexes are all normal, and there is no evidence of brain injury. The condition has existed one year. Under no stress of pain can the child be forced to make any audible exclamation, except a grunt. Similarly, he shows absolutely no response to loud, shrill noises made right near the ear.

*Case 5*—A little girl of ten had her tonsils removed, and after coming out of the ether, she could not talk, and did not talk for two years, despite all forms of treatment. When this girl was given rhubarb and soda with the suggestion that it was a wonderful medicine from a foreign land, two or three doses brought back her speech. She is now about 17, a stenographer, and apparently very healthy. There are no stigmata of hysteria present in this case at this time. Such cases are frequent.

*Case 6*—The wife of a police commissioner had a set of false teeth made. In the beginning, the plate would drop from her hard palate, and she would use her tongue to push it back in place. After several weeks of discomfort, the

dentist suggested the only way to correct it was to make a complete set of lower teeth, figuring that a new, perfect alignment instead of the few remaining lower teeth, would keep the upper set properly adjusted. She then used the tip of her tongue to push the lower set down, and at the same time, the middle or back of her tongue to keep the top set up. This continued for months. Plate after plate of different materials, rubber, platinum, silver, gold, were tried, but gave no relief. This tic had become so firmly established, that even complete removal of the plates did not stop the movements. Osteopathic, chiropractic, Christian Science, psycho-analytic treatments, suggestive operations, fantastic medicines, changes of climate, all gave no relief. Her maseters became enormously developed from constant use. The tic increased to the jaws and neck muscles to such an extent that it interfered with her swallowing. The woman became so bad that she could not eat, and died of starvation.

*Case 8*—To illustrate a type of hysteria which affects the mental condition, without any physical manifestations at all. A girl, 19, was in love with a married man of 35, and as time passed her affection increased. The man was always dutiful to his family, never neglected his wife nor showed any particular attention to the girl. But his wife realized the condition. In the beginning she tried to hide her emotion, but after four years became sentimentally negative. It was impossible to arouse any feeling of love or hate or fear or anxiety, whatever the cause. After several years of this emotionless state, she could not be made to either laugh nor cry, and although she did her housework and acted as a good mother to her two children, and her memory and judgment seemed intact, and although the girl in the meantime married someone else and moved out west, the woman today walks about with a blank face, very much like a Parkinsonian syndrome.

She has also an anesthetic palate and a bilaterally-contracted visual field. When she talks in her sleep, which is very frequent, she talks of love and cries. At other times, in her sleep, she laughs and becomes very jocular, but as soon as she is fully conscious, she relapses into the aforementioned condition.

#### SUMMARY

Hysteria is a functional nervous disease in which the field of consciousness is contracted, and the subconscious overshadows the conscious mind. The cause is a psychic trauma. It is much like a dream-state or a hypnoidal condition. The strongest outstanding feature is trouble of the will.

# INFECTIONS IN THE TONSILS AND PARANASAL SINUSES IN A SERIES OF CARDIAC PATIENTS

By RAYMOND WILLARD HAWKINS, M.D.,

ROCHESTER N. Y.

THE relation between focal infections in the tonsils and paranasal sinuses, and cardiac disease has long been known, and in the case of the tonsils particularly an extensive literature has been developed. It is the purpose of the writer to point out the findings in a series of cases of organic heart disease examined routinely, and as a comparison, to show the incidence of infected tonsils in an unselected group.

The work on the cardiac cases was done at the Adult Cardiac Clinic of Bellevue Hospital, New York City. To Dr. John Wyckoff, the Chief of that clinic, grateful acknowledgment is made for the use of the material, and for suggestions as to its presentation.

In all cases where sinusitis was reported, except in the ethmoid infections, the diagnosis was confirmed by the presence of pus in the irrigating fluid on washing out the cavity, after a thorough cleansing of the nasal cavity to eliminate the possibility of retained secretion giving a misleading result.

As a criterion for the report of infected tonsils, the following points were considered: (1) Expression of purulent secretion on averting the tonsil with a Coakley tonsil hook. (2) The presence of enlarged tonsillar glands. (3) The amount of injection of the pillars of the fauces. (4) A history of recurrent sore throats. In cases where a recent tonsillar or upper respiratory infection was present, or when there was any doubt as to the diagnosis, repeated examinations were made until the usual condition of the tonsils was determined.

The most comprehensive estimate of the incidence of these types of focal infection may be made by considering the cardiac patient from the standpoint of the etiological factor in his cardiac disease.

As shown in Table I, the greater number of tonsillar infections, 62 per cent, in the rheumatic group is striking. The unknown group, because of the greater frequency of rheumatic heart disease, and its manifold manifestations, probably contains a large number of these cases.

In order to determine the significance of the percentage of infected tonsils found, a control series of 100 cases was worked out. Statistics of the Adult Cardiac Clinic show that practically the entire group of rheumatic cases are included within the ages of ten and forty years. At the Vanderbilt Clinic, patients between these ages were taken at random, just as they presented themselves for treatment in the Medical and Ophthalmological Departments. They were examined according to the same technique, and using the same points in making a diagnosis, as had been employed in the original series. Of the cases examined, 29, or 29 per cent had infected tonsils, as compared to the 62 per cent found in the rheumatic group.

In Table II, a report of the findings in the paranasal sinuses is made.

TABLE I

Etiological Group	Total No of Cases	No of Cases with Infected Tonsils	% of all Cases Having Infected Tonsils	No Having Tonsils Removed	No of Cases with Tonsils not Removed	% of Unoperated Cases Having Infected Tonsils
Rheumatic	122	62	50.8	22	100	62.0
Syphilitic	17	4	23.5	0	17	23.5
Arterio-sclerotic	24	8	33.3	0	24	33.3
Hypertension	4	0	0	0	4	0
Unknown	48	27	56.2	2	46	58.6
Total	215	101	46.9	24	191	52.8

TABLE II

Etiological Group	Total No of Cases	No. of Sinus Infections	% of Sinus Infections
Rheumatic	122	15	12.2
Syphilitic	17	2	11.7
Arterio-sclerotic	24	3	12.5
Hypertension	4	1	25.0
Unknown	48	4	8.3
Total	215	25	11.6

Considering the number of cases in each group on which to base an estimate, there is little variation in the occurrence of sinus disease. Of the 25 cases with purulent sinusitis, 16 had a maxillary sinusitis on one side, five had both sides involved, two had ethmoid infections, one had a pathological process in both the maxillary and sphenoid sinuses on the same side, and one had the sphenoid alone infected. The significant feature is the considerable number of patients with absorption from these cavities.

Another method of approach is by means of a functional classification. The groupings here given are those adopted by the New York Heart



Association Class 1 means the patient is able to carry on ordinary activities, Class 2A indicates slightly limited activities, Class 2B means markedly limited activity, Class 3 are confined to bed, and the potential cardiac cases fall in Class 4

TABLE III

Functional Group	Total No. of Cases	No. of Cases with Infected Tonsils	% of all Cases Having Infected Tonsils	No. of Cases with Tonsils Removed	No. of Cases with Tonsils not Removed	% of Unoperated Cases Having Infected Tonsils
1	16	10	62.5	2	14	71.4
2A	71	36	50.7	8	63	57.1
2B	88	36	40.6	7	81	44.4
3	15	9	60.0	0	15	60.0
4 (Potential)	25	10	40.0	7	18	55.5

Table III gives the result of the findings from this point of view. It is interesting to determine that if an effort is made to establish the usual condition of the tonsils as a standard for comparison, there is nothing in the findings to indicate that the presence of tonsillar infections lowers cardiac reserve. The fact that acute infections occurred was considered in making the diagnosis, but the final record was made when the resting state was established, and the functional capacity at that time was taken. The pathological process, when present in the tonsils examined, had become chronic, and the cardiac mechanism had become adapted to the toxic absorption. The difference would be noted on their removal.

In Table IV, which gives the effect of sinus infections on cardiac function the results of a more acute process can be studied.

TABLE IV

Functional Group	No. of Cases	No. of Sinus Infections	% of Sinus Infections
1	16	0	0
2A	71	11	15.5
2B	88	10	11.3
3	15	3	20.0
4 (Potential)	25	1	4.0

There are no cases of sinus infection, where definite organic cardiac disease is present, without functional loss, and the highest percentage of infections occurs in the group with the most markedly impaired function. Authorities universally agree that the presence of infection has a definite effect in lowering the functional capacity of the cardiac patient, and these findings are entirely in accord with their experience. Here we have clearly demonstrated that the problem is not only that of preventing greater cardiac disease, but of preventing cardiac failure as well.

In the cases of sinus disease found, only a few of the patients felt at all concerned about their nasal condition. Only six had headaches of varying severity. The complaints were mostly the indefinite ones of catarrh and nasal obstruction. Pain, the great stimulus which brings patients in for treatment, was conspicuous by its absence except in the few cases mentioned above.

Those who treat cardiac conditions should in all cases look for possible focal infections in the nose and throat, and should have the co-operation of a specialist. To the specialist comes the responsibility of utilizing every method of diagnosis at his command, and of seeing that prompt and thorough treatment is instituted.

# SUMMARY

In a series of 215 cardiac cases examined routinely at the Adult Cardiac Clinic of Bellevue Hospital, infected tonsils were found in 52.8 per cent of cases, and purulent sinusitis in 11.6 per cent.

In a group of cases with rheumatic cardiac disease 62 per cent had infected tonsils, as compared with 29 per cent in a control series of the same ages.

The diagnosis and treatment of infections of the tonsils and paranasal sinuses in cardiac patients is extremely important not only in preventing greater cardiac disease, but in preventing cardiac failure as well.

## THE CLINICAL USES OF CISTERNAL PUNCTURE

By ARTHUR S. CHITTENDEN, M.D., F.A.C.S.,

BINGHAMTON, N. Y.

**D**URING the past few years our ideas concerning the anatomy and the physiology of the pia-arachnoid system, with its contained circulation, have been considerably revised.

The present general conception appears to be that "the cerebro-spinal circulatory system is a closed system, with impenetrable walls, except at certain points, viz., through fine fasculi or prolongations of the arachnoid into the walls of the venous sinuses, and fasculi prolonged extracranially along the olfactory and auditory nerves and into the lymphatics of the nerve sheaths. The action of the choroid plexus is glandular, and its secretion passes down into expansions of the pia-arachnoid system which act as reservoirs of distribution, whence the fluid is delivered down the length of the cord, or up around the brain convexities along the courses of the surface blood vessels and into the sinuses.

"The cisterns or basilar reservoirs of distribution are three in number, two on the under side of the brain, inaccessible and shallow, and one posterior, accessible, long and deep, and located at the level of the foramen magnum. This pia-arachnoid or spider-web system cannot be adequately observed either at autopsy or during craniotomy because, like some marine forms of fine and succulent structure, loss of turgescence destroys its identity. For the same reason very slight fluid-tension causes circulatory block and oedema.

"Unlike the renal circulation which filters its refuse *only* into and out through the kidneys, the cerebro-spinal fluid passes in its *entirety* into the great venous sinuses. As the arachnoid passes over the cortex and along the deeper vessels, its fasculi or minute prolongations dip down into the parenchyma whence it receives a fluid differing from itself, a sort of brain juice containing waste products. Thus is established a communication between intra-cellular brain metabolism and the vascular system, this is accomplished by selective exosmosis on the brain side, and complete osmotic transudation on the vascular and lymphatic side."

A very large part of the damage wrought in the brain and cord through infection, neoplasms,

trauma and intoxications is brought about by blockade of this system. Exudates, transudations of blood, pressure of tumors, and osmotic disturbances from intoxications give rise ultimately to circulatory blockade, either focal or massive, causing a rise of intra-cranial pressure. Even a casual review of the sites of these blockades together with the associated causes, lie far beyond the limits of this paper. Quincke's lumbar puncture, although applied at a far outlying point in the cerebro-spinal system, gave us the first safe and direct approach to the pia-arachnoid spaces. Many will recall the ceremony, almost sacramental, which attended its early employment. Today few of us would care to go about our regular work unequipped with spinal needles and a knowledge of their uses. The value of lumbar puncture cannot be over stated, either from the standpoint of drainage, diagnosis or remedial approach. It will never be superseded. Its adoption has been slow, over thirty years, and in most acute disturbances of consciousness or locomotion it may be more often profitably used than any other simple procedure.

This paper concerns itself with restating the importance of another procedure having the same general uses as lumbar puncture—that of cisternal puncture. This approach will probably not be so generally employed as is lumbar puncture, perhaps it should not be, because it is not free from danger. The writer has, however, never known or heard of an accident arising from this method, although a mishap is readily conceivable.

Puncture of the great cistern was originally employed as an easy way of obtaining cerebro-spinal fluid from experimental animals. Almost immediately, however, application was made to the human patient. The width of the aperture, 1 cm., between the base of the skull and the atlas, together with the depth of the cistern, 1.5 cm., and the resistance of the occipito-atlantoid ligament, offer adequate safeguards to those who are familiar with puncture at the lumbar level. This great cistern is the first to receive the newly formed fluid as it arrives through the foramina of Magendie and Luscha, and is the chief dis-

tributing reservoir. Access to it means immediate approach to the very center of the cerebro-spinal circulation. The *spinal* pathway leading from the cistern is the longest of its ramifications and lumbar puncture is twenty inches removed. The usefulness of cisternal puncture in the localization of brain tumors, or in the differentiation of obstructive and communicating hydrocephalus, will not be here considered because these states require other combined and more difficult procedures higher on the skull.

Simple cisternal puncture, or combined with lumbar puncture, in addition to its advantages of immediate basilar approach, eliminates the difficulties of spinal pia-arachnoid block. Blockade of the spinal pathways is much more common than one would suppose. It occurs often in meningitis, encephalitis, intra-cranial hæmorrhage, spinal tumor, and in fracture or caries of the spine. Cranial hæmorrhage and infection commonly cause obstruction at the margin of the foramen magnum and in the thoracic spine, in the case of tumor, caries, or fracture, obstruction is of course at the point of pressure.

*Suspected Spinal Tumor.* A comparison of the fluids drawn from the lumbar and cisternal needles as to the amounts of albumen contained, will, in the case of block by tumor, show much more albumen in the lumbar fluid. Often the lumbar fluid will be definitely yellow in color—the "Xantho-chronia of Proin."

*Spinal Block of Meningitis.* Lumbar puncture may yield a small amount of fluid and under pressure. Immediate cisternal puncture, however, often gives a copious flow and under great pressure. Under these conditions serum administration by the lower route would be ineffectual because it would not reach the cistern or the convexities, nor would the puncture reduce the intra-cranial pressure.

*Spinal Block of Intra-Cranial Hæmorrhage.* Fulminating cases of meningo-encephalitis with marked hæmorrhage can be saved by prompt, repeated, high puncture, low puncture will not suffice because the blood coagulates about the brim of the foramen. Four of these cases have been seen in the past two years. In each the sequence has been the same—swift onset, spasticity, difficulty in swallowing, unconsciousness, and ocular palsies. In three the blood from the cistern passed under great pressure through a

large needle, and the cultures were sterile. The fourth case was not punctured, but died, and the diagnosis was verified at autopsy. The third was punctured once only and returned to consciousness whereupon further puncture was refused by the family. She promptly re-established the earlier clinical picture and died. The first two in this series made good recoveries. The hæmorrhagic features of these cases would probably not have been revealed or relieved by low puncture.

Subdural hæmorrhage, due to head injuries, accumulating in the posterior fossa and causing death, is often surprisingly small in its mass. Clotting may soon occur about the foramen margin and medullary pressure becomes apparent in the stertor of the breathing. Jackson of Chicago has unquestionably shown the enormous value of lumbar puncture in cases of intra-dural hæmorrhage. This procedure avoids temporal decompression (which often does not decompress the posterior fossa, and especially does it afford decompressive relief when the critical state of the patient renders subtemporal decompression on unthinkable. Semi-clotted, thick blood will often not drain well along the spinal pathways and down to the lumbar needle. The writer has demonstrated, to his own satisfaction at least, that prompt cisternal puncture will relieve medullary compression by a copious flow of thick blood, when the flow from a previous lumbar puncture had ceased and things had come to an impasse. This impression is not based on a few isolated cases but upon a considerable series afforded through the courtesies of my colleagues at the Binghamton City Hospital. The total amount of blood withdrawn is often not more than 30 c c. Experiments in spinal fluid displacement show, however, that an even smaller mass gives rise to serious symptoms.

Cisternal puncture may be readily done in these fracture cases with the patient in the lateral position, the needle being left in place for several hours. Change of the patients' position from the lateral to dorsal or contra-lateral position should not be permitted under twenty-four hours. The writer has seen sudden death follow change of position in patients who were apparently reacting favorably eight hours after puncture. Similar mishaps follow moving patients after cerebellar decompressive procedures for brain tumor.

## THE CLINICAL USES OF CISTERNAL PUNCTURE

By ARTHUR S CHITTENDEN, M D, F A C S,

BINGHAMTON N Y

**D**URING the past few years our ideas concerning the anatomy and the physiology of the pia-arachnoid system, with its contained circulation, have been considerably revised

The present general conception appears to be that "the cerebro-spinal circulatory system is a closed system, with impenetrable walls, except at certain points, viz, through fine fasculi or prolongations of the arachnoid into the walls of the venous sinuses, and fasculi prolonged extracranially along the olfactory and auditory nerves and into the lymphatics of the nerve sheaths. The action of the choroid plexus is glandular, and its secretion passes down into expansions of the pia-arachnoid system which act as reservoirs of distribution, whence the fluid is delivered down the length of the cord, or up around the brain convexities along the courses of the surface blood vessels and into the sinuses

"The cisterns or basilar reservoirs of distribution are three in number, two on the under side of the brain, inaccessible and shallow, and one posterior, accessible, long and deep, and located at the level of the foramen magnum. This pia-arachnoid or spider-web system cannot be adequately observed either at autopsy or during craniotomy because, like some marine forms of fine and succulent structure, loss of turgescence destroys its identity. For the same reason very slight fluid-tension causes circulatory block and oedema

"Unlike the renal circulation which filters its refuse *only* into and out through the kidneys, the cerebro-spinal fluid passes in its *entirety* into the great venous sinuses. As the arachnoid passes over the cortex and along the deeper vessels, its fasculi or minute prolongations dip down into the parenchyma whence it receives a fluid differing from itself, a sort of brain juice containing waste products. Thus is established a communication between intra-cellular brain metabolism and the vascular system, this is accomplished by selective exosmosis on the brain side, and complete osmotic transudation on the vascular and lymphatic side"

A very large part of the damage wrought in the brain and cord through infection, neoplasms,

trauma and intoxications is brought about by blockade of this system. Exudates, transudations of blood, pressure of tumors, and osmotic disturbances from intoxications give rise ultimately to circulatory blockade, either focal or massive causing a rise of intra-cranial pressure. Even a casual review of the sites of these blockades together with the associated causes, lie far beyond the limits of this paper. Quincke's lumbar puncture, although applied at a far outlying point in the cerebro-spinal system, gave us the first safe and direct approach to the pia-arachnoid spaces. Many will recall the ceremony, almost sacramental, which attended its early employment. Today few of us would care to go about our regular work unequipped with spinal needles and a knowledge of their uses. The value of lumbar puncture cannot be over stated, either from the standpoint of drainage, diagnosis or remedial approach. It will never be superseded. Its adoption has been slow, over thirty years, and in most acute disturbances of consciousness or locomotion it may be more often profitably used than any other simple procedure

This paper concerns itself with restating the importance of another procedure having the same general uses as lumbar puncture—that of cisternal puncture. This approach will probably not be so generally employed as is lumbar puncture, perhaps it should not be, because it is not free from danger. The writer has, however, never known or heard of an accident arising from this method, although a mishap is readily conceivable

Puncture of the great cistern was originally employed as an easy way of obtaining cerebro-spinal fluid from experimental animals. Almost immediately, however, application was made to the human patient. The width of the aperture, 1 cm, between the base of the skull and the atlas, together with the depth of the cistern, 1.5 cm, and the resistance of the occipito-atlantoid ligament, offer adequate safeguards to those who are familiar with puncture at the lumbar level. This great cistern is the first to receive the newly formed fluid as it arrives through the foramina of Magendie and Luscha, and is the chief dis-

pital to serve a wide territory. There are in this State large, flourishing, prosperous and progressive cities still sending the mentally sick to penal institutions, because no other provision has been made.

The provision for preventive work comes late in this consideration of the topic when, if importance were the sole criterion, that question should have had first thought. Prevention comes after recognition. It is only after the calamity that man thinks of measures designed to avoid its repetition. Even if the preventive measures are simple and sure they are often delayed. Prevention of the development of mental cases is neither easy nor sure. One often has to wait long for results, the steps are taken in the dark and at best are far from being bold strides toward universal mental balance. In the mental disturbances which we now think are due to faulty adjustments the effort should be made early and the result is something to be hoped for more than confidently predicted. When a psychiatrist sees a person struggling with a problem and is able to help him by advice, he does not flatter himself that the individual would not have made an adjustment without his assistance. People have struggled and have made satisfactory adjustments before now and they will continue to do so until the end. If we can help, perhaps shorten, or with psychiatric advice give the necessary assistance to help with loads, it is an

effort distinctly worth while. In this work the clinic assumes first place. Recognition that something is wrong may take place in the school, the shop or the office, and all of these places cannot have a psychiatrist, but the knowledge that there is a clinic where advice may be had can be widespread.

There is, however, one concrete suggestion, which easily can be put into effect and one which will give results. Without any attempt at reformation of character or changing the public thinking, the number of cases of general paresis can be materially reduced. It would, of course, be highly desirable to succeed in placing syphilis in the class of rare diseases or to eliminate it entirely. That may come, but while we are waiting we can impress upon physicians the fact that the invasion of the central nervous system occurs early in the course of the luetic infection and that cases should not be discharged as cured until the spinal fluid has been examined and found to be negative. Physicians are alert to the interests of their patients and most doctors estimate the progress of the anti-syphilitic treatment by blood Wassermans. If they were to make a spinal fluid Wassermann after the blood becomes negative, treatment would not be stopped too early, and the number of patients dying annually of general paresis, tabes and cerebral syphilis would be reduced.

---

## Deaths

CRUIKSHANK, WILLIAM J, Brooklyn, New York University, 1880, Fellow American Medical Association, Fellow American College of Physicians, Brooklyn Pathological Society, Member State Society, Consulting Physician, Wyckoff Heights and Broad Street Hospitals. Died March 3, 1925.

DEVNETT, WILLIAM SAWYER, New York City, Harvard, 1874, Fellow American Ophthalmological Society, New York Ophthalmological Society, Member State Society. Died March 6, 1925.

HYNES, EDWARD G, Brooklyn, College of Physicians and Surgeons of New York, 1900, Fellow American Medical Association, Member State Society, Visiting Gynecologist, Coney Island Hospital, Associate Surgeon, St Mary's Hospital. Died March 14, 1925.

MYERS, EDWARD E, New York City, Harvard, 1901, Fellow American Medical Association,

Member State Society. Died February 24, 1925.

PORTER, WILLIAM EVELYN, New York City, College of Physicians and Surgeons of New York, 1888, Fellow American Medical Association, New York Academy of Medicine, Member State Society, Alumni Association of Bellevue Hospital. Died March 26, 1925.

SEVERANCE, BENJAMIN W, Phoenix, Cleveland Homeopathic College, 1882, Member State Society. Died February 18, 1925.

STRATMANN, CHARLES FRANCIS, Brooklyn, College of Physicians and Surgeons of New York, 1906, Fellow American Medical Association, Brooklyn Pathological Society, Brooklyn Surgical Society, Member State Society, Alumni Association Norwegian Hospital, Assistant Attending Surgeon Norwegian Hospital. Died March 28, 1925.

# COMMUNITY PROVISION FOR MENTAL ILLNESS\*

By FREDERICK W PARSONS, M D

BUFFALO N Y

IN considering those steps which a community should take to provide adequately for the cases of mental illness threatening or developing in its midst, mention must be made of measures which are the special topics of other papers, read or to be read, during the course of this symposium on the relation of the state hospital to the community. The special features of such topics will be more completely covered by the essayists to whom those subjects have been confided. An answer to the question, "What facilities should a community provide" might formulate a conception of such perfection and of attainment so nearly impossible that efforts in that direction would be discouraged. In the local situations, which will be mentioned and discussed, the State hospitals play only the minor rôle of advisor, giving moral support to movements intended to promote the betterment of conditions and supplying personnel when the local resources are deficient.

All civilized societies make some provision for mental cases and that provision varies with the degree of civilization, the size and wealth of the individual community and the density of population. Much of this provision has not been altruistic. It was dictated by the desire to exclude those persons whose behavior did not conform to the standards then in force. The provisions were largely for the mass rather than for the individual. No community does its full duty when it limits its activity to the apprehension and the seclusion of persons who, by reason of mental ill health, threaten its peace and security. It is necessary, primarily, to recognize that in all communities there are people who, for certain reasons, have difficulties of adaptation with which they have to struggle. They may succeed in weathering storms and stresses or they may fail. They will have a much better chance to succeed if the community provides all of the help which can be given.

The general problem of what procedures a community should undertake can be considered under four main groupings

- 1 Provisions for discovery
- 2 Provisions for examination
- 3 Provisions for temporary care
- 4 Provisions for prevention

It might be thought that to discover the mentally sick persons resident in a community would be a relatively simple matter, but there are other types than the turbulent. They are easily located, in fact, it is not possible to miss them. The

problem is to locate those individuals who are trying to master a mental difficulty of which they perhaps, alone are conscious. Such persons may not realize that an inadequacy which may be thought to represent a physical ailment is but the outward evidence of an emotional struggle. This is the individual for whom the clinic is best suited, and a clinic fails to fulfill its entire purpose when it does not search out individuals of this class. It should make its presence known. Social agencies must know of the establishment of the clinic and when and where its resources are available. In addition, the prospective patient should be given an opportunity to know where to go in his difficulty. Physicians, the clergy, the courts, teachers, the shop and social agencies will supply the majority of the patients.

Provision for a more extended examination than the clinic yields and provision for temporary care are here considered together. Not all cases will require other opportunities for examination than those afforded by the clinic, nor do all cases need provision for temporary care. Certainly in some instances it is necessary to have a more thorough examination than is possible in a clinic and frequently home care is impossible. For the sick, hospitals are provided and for the provision for the temporary care now under consideration we must turn to the hospitals. There has been a disposition to think that the temporary care of persons mentally sick is a proper function of jails, police stations and almshouses, and even if separate quarters in such institutions have been provided the continued use should be discouraged. The care of the mentally sick is not a police question. It is a health problem with which only medically trained persons are competent to deal. Unfortunately, all of the medically trained do not completely realize what can be done with and for the mentally sick. Aside from financial restrictions, and they are not insurmountable, no moderately sized city with a hospital should be without a psychiatric ward where cases can be thoroughly examined, carried through a short mental illness or properly cared for while awaiting transfer to a State hospital. The psychiatric ward can be incorporated into and made a part of the general scheme without annoyance to the other departments. Such a ward in the Buffalo City Hospital, with forty patients, having a dispensary and diagnostic clinic below it and a medical ward above, operates without complaint. Small communities cannot be expected to provide care for its mental cases when it does nothing for those physically sick, but with good roads, automobiles, train and trolley services, each part of a county is brought into relation with other parts, making it possible for one hos-

\* Read at the Annual Meeting of the Medical Society of the City of New York at Rochester, April 23 1924

## GRADUATE MEDICAL COURSES

Every physician feels the need of instruction in not only the newer phases of medicine, but also in the elements of the more common specialties. It is not enough for a physician to read of the newest discoveries in order to be up-to-date, he must also refresh his memory regarding knowledge which he once had vividly in memory, but which through lack of use has become uncertain. And it is not to be considered reprehensible that a physician loses his keenness along lines that he has no occasion to use for years. If, for example, he was trained in genito-urinary work and later located in a rural district where he could not practice his specialty, he would lose his skill in the course of years. Now suppose his rural town became a prosperous center, and he wished to resume the practice of his former specialty, he would then wish to do graduate study along his former line of work.

The post-graduate medical study which we have in mind does not have for its object the imparting of a knowledge of new discoveries in order that the physician may ride the foremost crest of the wave of progress. We have known physicians who have adopted every new procedure. They have bought a chlorine apparatus with which to treat colds, they applied Lane plates for fractured bones, and got osteomyelitis as a result, and they adopted the intramuscular use of salvarsan and produced abscesses. The post-graduate education which we have in mind will enable the practitioner to choose the wheat from the chaff of new procedures.

We have in mind the needs of the family doctor, rather than the specialist. The family medical advisor is now called upon to express his opinion along every phase of medical practice. He need not be a specialist in any line, unless it be that of general internal medicine, but he is expected to recognize the signs of danger while they are yet far off, and if he does not understand a condition, he is expected to suggest what specialist shall be called.

It takes knowledge to enable a physician to know when to call a specialist, and when to manage a case himself. It takes thought and considerable practice to make those elementary tests and examinations which reveal the existence of trouble and the need of calling a specialist who is able to judge the finer details of the patient's condition, and assume the responsibility for his welfare.

The periodic health examination movement is revealing to physicians both the need of knowing the elements of several specialties and the comparative ease of acquiring such a degree of knowledge of a specialty as to recognize that a case belongs to a particular branch of medicine. Eminent specialists recognize the necessity of in-

forming general practitioners regarding the early signs which suggest serious trouble in an organ. The genito-urinary men, for example, are urging physicians to give heed to the warning signs associated with urination, such as pain, or increased frequency, or transient cloudiness, or blood. These signs are fully as evident to a general practitioner as to a specialist. In fact, they are evident to every patient no matter how ignorant he is. The difficulty lies in the interpretation of the symptoms and signs. The doctor is not up to the common standard in his practice of medicine if he does not take serious note of these symptoms and refer his case to an honest specialist.

The need of graduate medical education is not confined to the family physician. Every specialist needs it in the lines which he does not practice. It is becoming unfashionable for a specialist to boast of his ignorance of every branch of medicine except that which he practices. He cannot be a real specialist unless he knows the whole body. There may not be an extremely close relation between, for example, the eye conditions and orthopedics, but we would have an increased confidence in our oculist if we felt that he understood feet, and hearts, and kidneys, a little better than the ordinary physician. It is especially in the smaller cities and rural places that a specialist needs to have considerable knowledge of other conditions besides those in his own line.

These thoughts have been in the minds of the leaders of the Medical Society of the County of Kings as they have devised a new system for graduate medical education in co-operation with the Long Island College Hospital Medical School. The special feature of their plan is that the instruction is held at a time and place that suits the physician who must stay at home and earn his living while he takes his instruction. It is not intended to make specialists out of the students, but it gives family physicians instruction in the elements of the specialties which they will use. There are courses in the heart, the kidneys, venereal diseases, orthopedics, pediatrics, and so on through the whole ranges of specialties. The courses are open to physicians from all parts of the Island. The fee charged is only sufficient to pay the bare expenses of the course.

The committee that has the graduate instruction in charge felt that the physicians of Nassau and Suffolk counties could not afford the time or money required to come to Brooklyn for their instruction, and so they have offered to send instructors anywhere on the Island to any group that wishes to take up a line of study. The first group that has been formed consists of the members of a local society, the South Side Clinical

# EDITORIALS

The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication.

**Editor-in-Chief**—NATHAN B VAN ETEN, M.D.,  
New York  
**Associate Editor**—ORRIN SAGE WIGHTMAN, M.D.,  
New York  
**Executive Editor**—FRANK OVERTON, M.D. Patchogue

### COMMITTEE ON PUBLICATION

E. ELIOT HARRIS, M.D., *Chairman* New York  
ORRIN SAGE WIGHTMAN, M.D. New York  
EDWARD LIVINGSTON HUNT, M.D. New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

**President**—OWEN E JONES, M.D. Rochester  
**First Vice President**—GEORGE A. LEITCHER, M.D. Piermont  
**Second Vice President**—LUZERNE COVILLE, M.D. Ithaca  
**Speaker**—E. ELIOT HARRIS, M.D. New York  
**Vice-Speaker**—GEORGE M. FISHER, M.D. Utica  
**Secretary**—EDWARD LIVINGSTON HUNT, M.D. New York  
**Assistant Secretary**—WILBUR WARD, M.D. New York  
**Treasurer**—CHARLES GORDON HEYD, M.D. New York

### CHAIRMAN, STANDING COMMITTEES

**Arrangements**—FREDERICK H. FLAHERTY, M.D. Syracuse  
**Public Health and Medical Education**,  
JOSHUA M. VAN COTT, M.D., Brooklyn  
**Scientific Work**—ANDREW MACFARLANE, M.D. Albany  
**Medical Economics**—HENRY LYLE WINTER, M.D. Cornwall  
**Legislation**—JAMES N. VANDER VEER, M.D. Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex-President and the Councilors of the District Branches.

**First District**—EDWARD C. RUSHMORE, M.D. Tuxedo Park  
**Second District**—FRANK H. LASHER, M.D. Brooklyn  
**Third District**—ARTHUR J. BEDELL, M.D. Albany  
**Fourth District**—CHARLES C. TREMBLEY, M.D. Saratoga Lake  
**Fifth District**—NELSON O. BROOKS, M.D. Oneida  
**Sixth District**—GEORGE H. FOX, M.D. Binghamton  
**Seventh District**—WILLIAM I. DEAN, M.D. Rochester  
**Eighth District**—HARRY R. TRICK, M.D. Buffalo

### COUNSEL

GEORGE W. WHITESIDE, Esq., 27 William St. New York  
Telephone, Broad 1744

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St. New York

### EXECUTIVE OFFICER

JOSEPH S. LAWRENCE, M.D. 51 Chapel Street, Albany

### SECTION OFFICERS

**Medicine**  
**Chairman**—ROBERT L. LEVY, M.D. New York  
**Secretary**—L. WHITTINGTON GORHAM, M.D. Albany

**Surgery**  
**Chairman**—MARSHALL CLINTON, M.D. Buffalo  
**Secretary**—EDWARD S. VAN DUYN, M.D. Syracuse

**Obstetrics and Gynecology**  
**Chairman**—HAROLD C. BAILY, M.D. New York  
**Secretary**—NATHAN P. SEARS, M.D. Syracuse

**Pediatrics**  
**Chairman**—JOSEPH C. PALMER, M.D. Syracuse  
**Vice-Chairman**—ROGER H. DENNETT, M.D. New York  
**Secretary**—ARTHUR W. BENSON, M.D. Troy

**Eye, Ear, Nose and Throat**  
**Chairman**—ARTHUR G. BENNETT, M.D. Buffalo  
**Secretary**—EUGENE E. HINMAN, M.D. Albany

**Public Health, Hygiene and Sanitation**  
**Chairman**—PAUL B. BROOKS, M.D. Albany  
**Secretary**—ARTHUR D. JACOBS, M.D. Lynbrook

**Neurology and Psychiatry**  
**Chairman**—EUGENE N. BOUDREAU, M.D. Syracuse  
**Secretary**—CLARENCE O. CHENEY, M.D. Utica

For a list of the officers of the county medical societies, see this issue, advertising page viii

## THE ANNUAL MEETING

Preparations for the annual meeting of the Medical Society of the State of New York are progressing satisfactorily, and the meeting promises to be one of the best that has ever been held. Reservations at the Syracuse Hotel are being taken and those who expect to be present will do well to engage their rooms in advance. A list of the principal hotels is printed on page 587 at the end of the scientific program. There will be the usual features, including the scientific sessions and the annual banquet. But in addition to these, plans are almost perfected for a tuberculosis exhibit and demonstration all day on Thursday. In this exhibit an unique array of material covering every phase of tuberculosis has been brought together. Lecturers and demonstrators have been secured, specimens and pic-

tures, X-ray films and microscopic slides. It is also expected to have a multiple stethoscope by which a whole roomful of physicians may listen to the lungs at the same time.

What is common is likely to be considered commonplace. Tuberculosis is one of the most common of all the diseases which every doctor treats. It has no spectacular features and it brings neither profit nor glory to the physician. Success in its treatment requires attention to ordinary details which doctors are likely to overlook because they are almost self-evident. The demonstration at the annual meeting will give interest to a subject that is too often avoided, and will give the physician a mental picture of the conditions which are present in every stage of a case of tuberculosis.

F O



each County Legislative Chairman at the semi-annual meeting of his individual county society in the early summer, and plans should be laid at that time for future action in the fall. It is for each county society to judge of the action of its legislators and of its own officers and in the freedom of the State Society and of the body politic of the State as citizens, it is for the county society to judge what its action will be in relation to its legislators.

Your Committee on Legislation, voluntary in the work that it gives to the physicians at large, asks that the delegates from the county societies to the annual meeting have in hand from the individuals of the county society or from the officers of the same, or the Chairman of the Legislative Committee, such criticisms, suggestions and the

like as may seem of import to the individual county society or in relation to the House of Delegates as a whole, and that the delegates be prepared to file in writing such propositions as are handed to them in order that the Reference Committee to which the report of the Committee on Legislation is ordinarily assigned may deal with these suggestions and in their report to the House of Delegates may bring them up for open discussion. Only in this manner will the Medical Society of the State of New York keep its enthusiasm at highest pitch and raise itself and its individual members from the narrow ruts of medical practice into which it is so easy to fall and to 'let the other follow do the thinking and the acting'

J N V

### 1925 LEGISLATIVE SEASON CLOSES

Not until the adjournment of the Senate at 4 P M Friday, March 27th, was it definitely known that the Dunmore bill, in which we had such great interest, would not be enacted into law this year. The bill was passed by the Assembly about midnight Thursday and introduced to the Senate on Friday morning as an Assembly message. Attempt was made at the time of its introduction to advance it in the Senate to third reading, but was lost by the objection of Senators Fearon and Gibbs, after which it was referred to the Public Health Committee, who reported it again to the Senate a few hours later together with the Gibbs Drugless Therapy bill but by the objection of Senator Fearon it was not admitted to the floor for discussion, but referred to the Committee on General Orders, from which it proved impossible to have it extricated, in spite of the fact that every known parliamentary procedure was invoked. Governor Smith also was urgent and sent an emergency message to the Senate urging its consideration and passage, and there was plenty of evidence that a majority of the Senate would support the bill.

Since there was no debate in the matter, it is impossible to state what actually incited the objection raised by the two Senators but it is interesting to know that each was sponsor for a bill that would have licensed chiropractors.

At the time the Dunmore bill was approved by the Assembly it also considered bills incorporating the Dunmore bill, but amended so as to provide for licensing chiropractors.

The Dunmore bill was the first to be voted upon and was passed by a vote of 107 to 37. The sentiment of the Assembly was such that a slow roll-call was not called for, hence there is no record as to who voted for or against the bill.

The Esmond bill was next to be considered, but powerful opposition in the Assembly induced

Mr Esmond to allow it to be recommitted rather than take a final vote at that time.

There was more uncertainty as to the strength of the Jenks bill, hence it was submitted to a slow roll-call, which resulted in 50 in favor of and 85 opposed to the bill. Both Mr Esmond and Mr Jenks immediately moved that the votes on their bills be reconsidered. These motions were laid on the table for the time. Mr Esmond attempted to have his bill brought out on Friday, but was defeated again by a large vote. No further effort was made to bring the Jenks bill out.

The other bills that aimed to secure a license for chiropractors and other cultists, namely

#### In the Assembly

The Nicoll Chiropractic bill,  
The Esmond Healing Art bill,  
The Jenks Chiropractic bill,  
The Bolton Chiropractic bill

#### In the Senate

The Bouton Chiropractic bill,  
The Fearon bill,  
were never reported out of committee.

The combined thought and efforts of those who truly have the interest of public health at heart, have again failed in the desire to more strongly bulwark the same, but the deep interest taken in the Karle-Dunmore bill by more of the legislators than ever before augurs well for the solid defense desired by the state citizenry in protecting the uneducated and helpless from the prey of the charlatan. We have given our best efforts to this rightful legislation in no compromising terms and it is to be hoped we do not reverse our position.

The amendments to the Workman's Compensation Law which would have provided for the free choice of physician did not pass, to our

Society, which is practically a sub-group within the Suffolk County Medical Society, and is composed of those who live in the southwest section of the county and form the staff of the South Side Hospital at Bay Shore. This group will take up the study of pediatrics, and will meet once a week for a clinical demonstration upon cases brought by the members of the class.

The Brooklyn plan of graduate instruction does not sell itself to physicians. The idea must be presented to the doctors before they will enroll in any considerable number. It is well adapted to any section of New York State, and the Medical Society of the State of New York is the official body which could sponsor it with authority and grace. F O

## HISTORY OF 1925 LEGISLATURE

The history of the legislature of this State for 1925 is now written and in many respects can be said to be satisfactory to the vast majority of the lay people and the medical profession of the State.

Again has New York State through its representatives upheld the standing of the State in its refusing to break down the definition of the practice of the healing art and in refusal of recognition of individual cults who loudly proclaim the efficiency of this or that method of treatment for any and all types of deviation from the normal health standards.

That those who have been deeply interested in seeing that the public health of this State was conserved in advancing medical standards, and in the denial to cultists of their proclaimed rights to foist themselves upon the public in defiance of known physical and scientific principles, have lost in their efforts politically to impress the legislators with what is right and true, is no reason in the future to lower standards or talk of compromise when the right principle is involved.

The Medical Society of this State should be congratulated in its efforts and desires to combine with all such groups who look forward into the future and who can assuredly wait for that time when the right will assert itself and be put into laws.

In our form of government the individuality of one placed in high position to pass on questions of importance to the people at large, whether it be a social group or as an elected representative of the people, may be swayed many times to take a position other than the broad viewpoint of the State at large.

The House of Delegates and the Council of your State Medical Society gives careful thought, and it should so give this careful thought to the choice of those whom they would care to elevate to positions of prominence within their body. It is through these elected representatives of the medical profession that the voice of the culosis exhibit projected into State thought, and Thursday. In the physician of the present day is material covering ever far greater import to the been brought together. Case fifty years ago strators have been secured, spranced in thought

more rapidly than in any other line of endeavor, and he it is who must be in touch with every phase of life, as business, sciences, advances along professional lines and thought, and like highways, such as no other man of the present day.

How often do we see the business man so immersed in his own selfish interests as to be unversed in the life of his city and refusing to participate in civic, charitable or political activities, and how many are those with whom the doctor has come in contact who seek to evade jury duty and like compulsory matters which bind up our government into its whole?

Just so do we find the legislators of varying degrees of education, of representation in the business and professional world of varying selfish desires on their parts to advance their own positions, be it civic, political or mercenary.

And so as a Medical Society, through the Committee on Legislation, has this been portrayed during the moving picture of the legislature of 1925.

With the ringing down of the curtain there is food for conjecture and deep thought on the part of those who have been the actors and the audience during the unfolding of the play. And this conjecture with resulting judgments should be put in play by the various county medical societies of the State Society during the coming months, for opposition to right thinking and selfishness in thought and action is as subtle and persistent in endeavor as has ever been put forward by any opponents in State or Nation.

With the cessation of legislation the burdens of the State Committee on Legislation and of the County Legislative Chairmen become lessened. But it is not to be thought that work should absolutely cease and these burdens be laid aside until another session convenes, and the same questions are to be met as in these years past.

A county society little knows of the work asked of its County Legislative Chairman, and while in the main each one has given much time to action and thought as to how to act properly, it rests with each County Society to judge as to the results of its own individual Chairman's efforts.

A resume of the year's work in a report written and ready for filing should be delivered by

each County Legislative Chairman at the semi-annual meeting of his individual county society in the early summer, and plans should be laid at that time for future action in the fall. It is for each county society to judge of the action of its legislators and of its own officers and in the freedom of the State Society and of the body politic of the State as citizens, it is for the county society to judge what its action will be in relation to its legislators.

Your Committee on Legislation, voluntary in the work that it gives to the physicians at large, asks that the delegates from the county societies to the annual meeting have in hand from the individuals of the county society or from the officers of the same, or the Chairman of the Legislative Committee, such criticisms, suggestions and the

like as may seem of import to the individual county society or in relation to the House of Delegates as a whole, and that the delegates be prepared to file in writing such propositions as are handed to them in order that the Reference Committee to which the report of the Committee on Legislation is ordinarily assigned may deal with these suggestions and in their report to the House of Delegates may bring them up for open discussion. Only in this manner will the Medical Society of the State of New York keep its enthusiasm at highest pitch and raise itself and its individual members from the narrow ruts of medical practice into which it is so easy to fall and to 'let the other follow do the thinking and the acting'

J N V

### 1925 LEGISLATIVE SEASON CLOSES

Not until the adjournment of the Senate at 4 P M Friday, March 27th, was it definitely known that the Dunmore bill, in which we had such great interest, would not be enacted into law this year. The bill was passed by the Assembly about midnight Thursday and introduced to the Senate on Friday morning as an Assembly message. Attempt was made at the time of its introduction to advance it in the Senate to third reading, but was lost by the objection of Senators Fearon and Gibbs, after which it was referred to the Public Health Committee, who reported it again to the Senate a few hours later, together with the Gibbs Drugless Therapy bill, but by the objection of Senator Fearon it was not admitted to the floor for discussion, but referred to the Committee on General Orders, from which it proved impossible to have it extricated, in spite of the fact that every known parliamentary procedure was invoked. Governor Smith also was urgent and sent an emergency message to the Senate urging its consideration and passage, and there was plenty of evidence that a majority of the Senate would support the bill.

Since there was no debate in the matter, it is impossible to state what actually incited the objection raised by the two Senators but it is interesting to know that each was sponsor for a bill that would have licensed chiropractors.

At the time the Dunmore bill was approved by the Assembly it also considered bills incorporating the Dunmore bill, but amended so as to provide for licensing chiropractors.

The Dunmore bill was the first to be voted upon and was passed by a vote of 107 to 37. The sentiment of the Assembly was such that a slow roll-call was not called for, hence there is no record as to who voted for or against the bill.

The Esmond bill was next to be considered, but powerful opposition in the Assembly induced

Mr Esmond to allow it to be recommitted rather than take a final vote at that time.

There was more uncertainty as to the strength of the Jenks bill, hence it was submitted to a slow roll-call, which resulted in 50 in favor of and 85 opposed to the bill. Both Mr Esmond and Mr Jenks immediately moved that the votes on their bills be reconsidered. These motions were laid on the table for the time. Mr Esmond attempted to have his bill brought out on Friday, but was defeated again by a large vote. No further effort was made to bring the Jenks bill out.

The other bills that aimed to secure a license for chiropractors and other cultists, namely

#### In the Assembly

The Nicoll Chiropractic bill,  
The Esmond Healing Art bill,  
The Jenks Chiropractic bill,  
The Bolton Chiropractic bill

#### In the Senate

The Bouton Chiropractic bill,  
The Fearon bill,  
were never reported out of committee.

The combined thought and efforts of those who truly have the interest of public health at heart, have again tailed in the desire to more strongly bulwark the same, but the deep interest taken in the Karle-Dunmore bill by more of the legislators than ever before augurs well for the solid defense desired by the state citizenry in protecting the uneducated and helpless from the prey of the charlatan. We have given our best efforts to this rightful legislation in no compromising terms and it is to be hoped we do not reverse our position.

The amendments to the Workman's Compensation Law which would have provided for the free choice of physician did not pass, to our

regret But on the other hand we should be quite satisfied with our efforts in preventing any serious consideration of the following

The cult bills,  
The birth control bill,  
The anti-vivisection bill,  
The laboratory supply bill

We have the satisfaction of knowing that we introduced, or aided in securing the passage of, the following

Medical Society Censors bill,  
The amended Public Health Nurses bill,  
The Cadaver bill,  
The Workmen's Compensation Silicosis bill  
J S L

### THE CONSULTANT'S FEE

Patients often complain about the fees charged by consultants to whom they are sent by their family physician. When a patient goes to a consultant of his own accord, the family physician of course has no responsibility in the matter. If a poor patient puts on his very best clothes, and is taken to the private office of the consultant through the kindness of a rich neighbor who loans his automobile and chauffeur, can the consultant be blamed for charging the maximum fee? He judges the stranger by his appearance.

If the family physician sends his patient to a consultant, he owes a duty to both the consultant and the patient. To the patient he owes the duty of ascertaining the consultant's fee, in order that the patient may be prepared to pay it without embarrassment. The argument, of course, is that he shall not go to the consultant unless he is satisfied with what the fee is to be, and that, fur-

ther, he shall not expect unusual attention for a reduced fee.

To the consultant the family physician owes the duty of informing him about the financial ability of the patient. A city consultant cannot judge the financial status of a rural patient by his dress and environment. The plainly dressed, awkward gentleman may be the president of his bank in the country, and the lady in the limousine may be the poor laborer's daughter in the loaned car. Much embarrassment to everybody will be avoided if the family physician will make the arrangements with the consultant for the details of the patient's visit, including the fee.

We are constrained to write this because we believe that it is to the best interests of both the family doctor and the consultant, as well as of the patient, that the general practitioner shall prove his interest in the case by attending to all possible details for the patient. F O

### A NURSE'S DUTIES

We wonder if trained nurses have forgotten their duties as high class maids-in-waiting upon the sick? That is the primary duty of every nurse, and is all a so-called practical nurse is supposed to know.

Is any bedside nurse so highly trained that she can afford to neglect her maid-in-waiting duties? Are those duties so menial that she does not care to do them?

Why is it difficult to get good bedside nurses?

There is much dissatisfaction all over New York State over the shortage of bedside nurses. The shortage also extends into the field of public health nursing, but it is doubtful that there would be enough bedside nurses if all the public health nurses should go back to nursing the sick.

We wonder if the requirements for graduation as a trained nurse are not entirely too high? The answer depends on what kind of nurse is wanted.

A nurse's accomplishments are along two lines, first as a maid-in-waiting, and second, technical, to enable her to carry out the doctor's orders.

It would seem that both of these subjects could be well acquired in two years. Why then spend three years in training? The third year

is spent in the study of subjects, such as bacteriology, which are medical and of no practical use to the nurse. Why does she need to study them?

The theoretical instruction is of value to a nurse who expects to be a public health nurse. Why not give the scientific and theoretical subjects as a post-graduate work to those who expect to be public health nurses or to do supervisory work?

Is there need that a trained nurse should have months of practice in every known specialty?

Why should she go to an insane asylum to take care of crazy people? Why should she study specialties in her fundamental course?

We are simply repeating questions which we hear asked almost daily. The committee of the Erie County Medical Society has devised an answer to the question, and other physicians are proposing other answers. (Page 590)

Our suggestion is that there be two grades of nurses, or possibly even three. Why not train one set for a year to be maids-in-waiting to the sick, another set for two years to do scientific bedside nursing, and another group for three years to do supervisory and public health work.

F O



# LEGAL



By GEORGE W. WHITESIDE, Esq.  
Counsel Medical Society of the State of New York

## FIVE THOUSAND PHYSICIANS SHOULD THINK THIS OVER.

Four years ago the medical profession in this State faced a crisis in meeting law suits brought by patients against doctors. Lawyers who had found it lucrative to bring suits based on negligence were confronted with a dwindling practice due to numerous changes in the law, not the least of which was the passage of the Workmen's Compensation Act. The attention of such lawyers was directed to a new field—that of malpractice. Some insurance companies that had written policies of protection against such law suits deemed it necessary to treble their rates. The cost of malpractice defense through the State Medical Society was increased through the increased number of cases to an amount beyond what it could afford. Some insurance companies were abandoning entirely the writing of such protection. At this time it was with no little difficulty that we consummated with the Aetna Life Insurance Company the group insurance plan which brought insurance protection against malpractice suits within the means of every member of the State Society. The insurance company regarded this somewhat as a bold experiment, which they were assuming heavy potential liabilities, but were willing to undertake a trial.

The experience for the past four years has been directed to the placing of malpractice defense on a scientific basis, both as to methods of intensive preparation on the law and the medicine of the cases, as well as on the financial basis upon which the insurance can be written. There is no mystery about the computations by which rates are made under this plan. There is no thought on the part of the company of gouging the doctors, or on the part of the doctors of mulcting the company. The highly scientific principles governing insurance are applied to the facts, and conclusions are arrived at which the facts justify.

It is pleasing that at a recent conference with the representatives of the company, when costs for suits and claims past and pending and for projected future law suits were computed, it was found for the coming year it would not be necessary to increase the rates of such insurance. Four years experience helps to stabilize this type of insurance and place it upon a basis of cost. One company dealing in a commodity may afford to sell below cost in a given locality to overcome competition, but as a settled policy of business it cannot continue such practice. Other insurance companies may, in a similar way, for a short time, undertake to undersell the State

group plan, but they cannot ultimately escape, if they desire to continue to do this type of business, the necessity of basing their rates upon the cost of insuring the hazard. Companies now doing the business below cost would have to make future rates sufficiently high to make up for the loss which they would occasion by such practice.

The members of the State Society have the benefit of directing the policy of the defense of malpractice suits, of participating in the tabulation of the costs upon which are based the rates, and in addition, have a policy that is broad and liberal in its terms and backed by the faith and credit of a financially powerful and honestly administered company.

The situation existing today, by which this insurance is available to the members, is not the result of mere accident, but is the result of four years of constructive work on the part of the Executive Committee and council of the State Society and of the legal department of the Society, together with the co-operation and good faith of the Aetna Life Insurance Company. Without these elements this plan would have gone on the rocks and the members of the Society today would have found it difficult to procure adequate protection, except at excessively high rates.

It seems strange, under these circumstances, that upwards of five thousand members of the State Society are still either unaware of the benefits to themselves of such protection, or are indifferent to the legal hazard under which they are practicing medicine.

Nothing that has been written in this column sufficiently expresses the ease with which a clever lawyer can, in a malpractice suit against a doctor, place in jeopardy that intangible, yet priceless possession—a doctor's reputation for integrity, skill and care, and likewise subject the doctor to the hazard of a lay jury's decision.

It is the purpose of your counsel to thwart this effort when injustice is sought to be done to the physician, and to mobilize the force of his office for the intensive preparation and trial in the defense of such a doctor, and fortunately, it is within his power, where an injury has been done to a patient for which a doctor is legally responsible, to be able fairly to compensate the injured party. This plan benefits the doctor, benefits the just claimant, and is of inestimable value to the profession of the entire State.

We have no interest of a financial character in the writing of the policies. We receive no profit and have no participation in that phase of

the insurance. So we feel we can urge its adoption, support and acceptance by each doctor, keeping in mind his interest and his welfare.

### NON-PREGNANCY, LEUCORRHOEAL DISCHARGE, ATTEMPT TO CURETTAGE, SUBSEQUENT OVARIECTOMY

In an action instituted against a physician it was charged that the plaintiff had consulted him with reference to the fact of her failing to become pregnant though she had been married for some time, that the physician after examination diagnosed her case as being one where an unnatural condition of the womb existed and further advised the application of certain electrical treatments for the elimination of the patient's complaint, that the patient submitted to the application of violet ray and after eleven treatments was advised by the physician that these treatments having failed to produce the desired effect, a curettage would be necessary, that the patient, relying upon the advice of the physician, consented to the performance of the operation, that arrangements were made for the performance of such operation, the attending physician to act as anaesthetist and a gynecologist to perform the curettage, that both the physician and the gynecologist were negligent in the performance of the operation and that by reason thereof the patient was confined to her bed for many days and suffered from fever and considerable pain. It was claimed that a few days thereafter the physician advised that the patient's condition was satisfactory and that she would be all right within a few days. That this physician left the city and was not available upon call from the patient and that the patient then called two other physicians, one of whom continued to take care of the patient for several weeks, at the end of which time the plaintiff's condition growing worse, a surgeon was called in consultation. About three weeks thereafter the surgeon performed a left ovariectomy. That after the performance of this operation the plaintiff remained in poor health and suffered pain for several months, during which time she was confined to the hospital or to her bed at home. She claims that this condition was brought about by the improper treatment of the physician originally consulted and the gynecologist, and sought to recover damages for her alleged injury. An action was also instituted on behalf of the husband to recover for the loss of his wife's services and moneys expended by him for medical care.

In about the middle of February the patient, accompanied by her husband, who was her second one, to whom she had been married about a year, consulted the defendant physician with respect to her not becoming pregnant. She also complained of a leucorrhoeal discharge. On a vaginal examination it was found that the uterus was swollen and soft, there being a large amount of leucorrhoeal discharge. A general physical examination was negative. After the examination the defendant physician advised that her con-

dition might be relieved in one of two ways, either by the application of violet ray or the performance of a curettage. The patient submitted to the application of violet ray, and over a period of about six weeks eleven applications were made. At the termination of this treatment the patient had left the city and was gone for some time. Upon her return she again consulted the defendant physician, and as her condition of which she complained had not improved, she then consented to the performance of a curettage. The attending physician advised the patient that he would administer the anesthesia and that a certain named gynecologist would perform the operation, to which the patient and her husband consented. The proper pre-operative instructions were given to the patient, and at the time arranged the defendant physician, accompanied by the gynecologist at the home of the patient, the husband being present, administered the general anesthesia of chloroform to the patient. The gynecologist then made a vaginal examination by means of a speculum and found the uterus soft and swollen and a profuse leucorrhoeal discharge. A smear examination of the discharge showed a resemblance to gonococcus which, however, was not definite. Upon dilatation the uterus was found to be soft, swollen and tender, the gynecologist stated to the defendant physician that the curettage could not be performed and all that was done at that time was to paint the surface of the uterus with iodine. Both physicians stayed with the patient until she had fully come out of the anesthesia. The husband being present at that time, they were both advised that the patient should remain in bed for several days, and should then come to the office of the gynecologist for further treatment. The defendant advised the patient that he was about to leave the city and would be gone for several days and would see her upon his return. That in the meantime, if necessary, she should call the gynecologist, giving to the patient his name, address and telephone. Several days later, on his return from out of town the defendant called upon the patient and was then advised by the patient that they had called in another physician and that his services were no longer needed. This was the last that he attended or treated the patient. He subsequently, however, treated the husband.

The defendant not being paid for his services made various attempts to collect the amount that was due him but was met with these suits of alleged malpractice. The actions not having been begun within two years after the cause of action accrued, upon our motion the complaints were dismissed on the ground that the actions were barred by the Statute of Limitations.



# LEGISLATION



By JAMES N VANDER VEER, M.D.  
Chairman, Committee on Legislation

## SUMMARY OF BILLS INTRODUCED IN LEGISLATURE IN SENATE

### Prohibition Enforcement

Senate Int No 29 (conc Assembly Int 527)  
—Assembly bill passed, but lost in Senate Codes Committee

### The Narcotic Bill

Senate Int No 115 (conc Assembly Int 215)  
—Senate bill passed, but died in Assembly Committee on Public Health

### Requiring the Licensing of Private Institutions for the Treatment of Drug Addicts

Senate Int No 116 (conc Assembly Int 216)  
—Died in committee in both houses

### The State Department of Education Bill Amending the Medical Practice Act

Senate Int No 211 (conc Assembly Int. 307)  
—Senate bill did not get out of committee  
Assembly bill 307 passed Assembly by a vote of 107 for to 37 against, but after being reported out in Senate, was recommitted to General Orders Committee, from which it could not be rescued

### Inspection by State Charities Boards of Children's Institutions

Senate Int No 228 (conc Assembly Int 236)  
—Died in committee

### Qualifications of Examiners in Lunacy

Senate Int No 263—Died in committee

### Lawful Orders of Local Health Boards or Officers

Senate Int No 278 (conc Assembly Int 414)  
—Died in committee

### Lawful Orders of Local Health Boards or Officers

Senate Int No 282 (conc Assembly Int 413)  
—Died in committee

### County Public Health Nurses

Senate Int No 283 (conc Assembly Int. 399)  
—Amended bill passed both houses, now in the hands of the Governor

### Health Service in Schools

Senate Int No 302 (conc Assembly Int 748)  
—Senate bill passed, but died in Assembly Public Education Committee

### Women's Compensation Law, in re Fibroid Phthisis

Senate Int No 308 (conc Assembly Int 386)  
—Bill passed both Houses, now in hands of Governor

### Relative to Powers and Duties of Local Health Boards

Senate Int No 349—Bill passed Senate, but died in Assembly Public Health Committee

### Vaccine Virus

Senate Int No 351 (conc Assembly Int 536)  
—Bill passed both Houses, now in hands of Governor

### Injured Employee to Select His Physician

Senate Int No 380 (conc Assembly Int 570)  
—Died in committee

### The Drugless Practitioner Bill

(By Gibbs)

Senate Int No 473—Reported on March 26th, but was not brought up for action

### Providing for Cleanliness in Shellfish Industry

Senate Int No 530 (conc Assembly Int 756)  
—Assembly bill lost, Senate bill died in committee

### Inspection of School Children

Senate Int No 586 (conc Assembly Int 850)  
—Bill passed both houses, now in hands of Governor

### Free Choice of Physician

Senate Int No 594 (conc Assembly Int 301)  
—Died in committee

### Practical Tests of Injured Persons

Senate Int No 647 (conc Assembly Int. 184)  
—Died in committee

### Physically Handicapped Persons

Senate Int No 671 (conc Assembly Int 868)  
—Bill passed both Houses, now in hands of Governor

### Dissecting Material

Senate Int No 681 (conc Assembly Int. 986)  
—Bill passed both Houses, now in hands of Governor

**Admission of Foreign Practitioners**

Senate Int No 693 (conc Assembly Int 950)  
—Died in committee

**In Relation to Pharmacies**

Senate Int No 632 (conc Assembly Int 802)  
—Died in committee

**Revocation of License to Practice Medicine**

Senate Int No 701—Died in committee

**Rural Hygiene**

Senate Int No 716 (conc Assembly Int 969)  
—Died in committee

**Hospital for Crippled Children at West Haverstraw, N Y**

Senate Int No 786 (conc Assembly Int 1074)—Died in committee

**State Institute for Study of Malignant Diseases**

Senate Int. No 787 (conc Assembly Int 973)  
—Died in committee

**The Bouton Chiropractic Bill**

Senate Int No 789—Died in committee

**Dissecting Material**

(Relative to delivery of cadavers to medical colleges)

Senate Int No 851 (conc Assembly Int 1027)—Bill passed both Houses, now in hands of Governor

**Laboratory Supplies**

Senate Int No 943 (conc Assembly Int 1167)—Died in committee

**A Chiropractic Bill**

(By Fearon)

Senate Int No 944 (conc Assembly Int 1423)—The Senate bill remained in committee. The concurrent Jenks bill in the Assembly was lost on March 25th by a vote of 85 to 50

**Foreign Licenses**

Senate Int No 1123 (conc Assembly Int 1478)—Bill passed both Houses, now in hands of Governor

**Censors State Medical Society**

Senate Int No 1176 (conc Assembly Int 1348)—Bill passed both Houses, now in hands of Governor

**Empowering Courts to Commit Drug Addicts to a City Hospital**

Senate Int No 1378—Bill passed both Houses, now in hands of Governor

In accordance with request received from Erie County Medical Society, your Committee on Legislation has filed objection to this bill

**Statement for Marriage Licenses**

Senate Int No 1412—Died in committee

**Bill in Opposition to Birth Control**

Senate Int. 1453—A bill introduced March 23rd, by Senator Thomas Burchill, of New York, would add new section 83, Penal Law, making it a misdemeanor to administer any drug or medicine or give any treatment to a woman for purpose of preventing conception, or to advertise to give such drug or treatment. Referred to Codes Committee

Died in committee

**IN ASSEMBLY****Health Service in Schools**

Assembly Int No 127—Died in committee

**Practical Tests of Injured Persons**

Assembly Int No 184 (conc. Senate Int 647)  
—Died in committee

**Nicoll Chiropractic Bill**

Senate Int No 185—Died in committee

**The Narcotic Bill**

Assembly Int No 215 (conc. Senate Int 115)  
—Senate bill passed, but died in Assembly Public Health Committee

**Institutions for Addicts**

Assembly Int No 216 (conc Senate Int 116)  
—Died in committee

**Mentally Retarded Children**

Assembly Int No 229—Died in committee

**Children's Institutions**

Assembly Int No 236 (conc Senate Int 228)  
—Died in committee.

**Free Choice of Physician**

Assembly Int No 301 (conc. Senate Int 594)  
—Died in committee.

**The State Department of Education Bill Amending the Medical Practice Act**

Assembly Int No 307 (conc Senate Int 211)  
—The Dunmore bill passed Assembly March 25th, by a vote of 107 to 37, but died in Senate Committee on General Orders



**County Public Health Notices**

Assembly Int No 399 (conc Senate Int 283)  
—Bill passed both Houses, now in hands of Governor

**Disclosure of Confidential Communications**

Assembly Int No 422—Died in committee

**Prohibition Enforcement**

Assembly Int No 527 (conc Senate Int 29)  
—Assembly bill passed, but lost in Senate Codes Committee

**Providing for Removal to Hospitals of Prisoners  
Requiring Medical or Surgical Treatment**

Assembly Int No 434—Bill passed both Houses, now in hands of Governor

**Free Choice of Physician**

Assembly Int No 570 (conc Senate Int 380)  
—Died in committee

**Chiropractic Bill  
(By Mr Esmond)**

Assembly Int No 649—Bill recommitted on March 25th

**Periodic Health Examination of Food Handlers**

Assembly Int No 678—Died in committee

**Health Service in Schools**

Assembly Int No 748 (conc Senate Int 302)  
—Senate bill passed, but died in Assembly Public Education Committee

**Medical Inspection in Schools**

Assembly Int No 850 (conc Senate Int 586)  
—Died in committee

**Regulating Sale of Wood or Methanol Alcohol**

Assembly Int No 908—Bill lost

**Reciprocity in Licensure**

Assembly Int No 925—Died in committee

**Rural Hygiene**

Assembly Int No 969 (conc Senate Int 716)  
—Died in committee

**The Birth Control Bill**

Assembly Int No 987—Died in committee

**Another Esmond Chiropractic Bill**

Assembly Int No 1343—Died in committee

**Medical Treatment of Injured Employees**

Assembly Int No 1351—Died in committee

**Scientific Experiments on Dogs**

Assembly Int No 1377—Died in committee

**Practice of Chiropody and Podiatry**

Assembly Int No 1421—Died in committee

**Chiropractic Bill  
(By Jenks)**

Assembly Int No 1423 (conc Senate Int 944)—Lost on March 25th, by vote of 85 to 50

**Sale of Eyeglasses and Lenses**

Assembly Int No 1429—Died in committee

**Chiropractic Bill  
(By Bolton)**

Assembly Int No 1463—Died in committee

**Practice of Pharmacy**

Assembly Int No 1539 (conc Senate Int 1231)—Passed both Houses, now in hands of Governor



# State Department of Health



## STATE HEALTH DEPARTMENT CONFERENCE

Forty-four members of the staff of the State Health Department, including the district state health officers, attended a conference at the Albany office on March 3d and 4th. Several matters of interest to physicians were discussed.

The Legislature being in session, considerable attention was given to pending health legislation. The district officers unanimously endorsed the Karle bill, increasing the compensation of local health officers and providing for the appointment of temporary acting health officers, a bill introduced at the request of the Department. They also favored requesting that the Webb-Lattin measure relating to the supervision of county nurses, a bill introduced at the request of the Department and the State Charities Aid Association, be amended in accordance with a suggestion of the Legislative Committee of the State Medical Society.

Dr. Ruth Gilbert, of the Division of Laboratories and Research, reported that during 1924 the following county laboratories had received state aid in accordance with provisions of Chapter 638, Laws of 1923: Montgomery, \$7,500, Ontario, \$3,000, Warren, \$3,700, Madison, \$2,325, Saratoga, \$4,200, Wyoming, \$3,100. It was stated that there had been marked development in three laboratories following the granting of state aid.

Dr. Branham, psychiatrist for the State Commission for Mental Defectives, outlined the plan which the commission is following in holding mental clinics for children in various localities, and requested the assistance of the district officers in getting children found to be in need of medical attention into the hands of physicians. He said that a limited appropriation and small staff made it difficult to make necessary contacts with local physicians.

In the forenoon of the second day the conference which was devoted to discussion of communicable diseases, was held in the auditorium of the City Hall, a number of health officers and other physicians from Albany and vicinity attending by invitation to hear a talk by Dr. William H. Park on the Dick test, immunization and serum treatment in scarlet fever.

Dr. Godfrey predicted for the coming year a low incidence of measles, with relatively high mortality if outbreaks occurred in children's institutions. He said that measles outbreaks in children's institutions were often reported too late to permit the use of serum as a preventative, and called attention to the fact that the serum might be effective if the ordinary precautions as to isolation were neglected.

In discussion of smallpox and vaccination it was brought out that the technique used in vaccination was at times open to serious criticism. It was suggested that, upon the occurrence of smallpox cases, the local physicians should always be gotten together if possible for discussion and demonstration of approved methods of vaccination. It was the consensus of opinion that the best dressing was a piece of sterile gauze strapped loosely to the arm with two strips of adhesive plaster, although some felt that no dressing was necessary in the first few days, if the vaccinated area was allowed to dry. It was agreed that the use of a bandage was inadvisable.

District officers reported that vaccination shields were still being used to some extent, describing several cases recently observed in which, upon removal of shields, collections of moist detritus and areas of hyperemia had been found. They recommended to the Public Health Council that it consider enacting a regulation prohibiting the sale of vaccination shields.

## UNCOOKED PORK APPARENTLY CAUSES THREE DEATHS IN TWO FAMILIES

According to a report recently received from Dr. H. J. Ball, district state health officer, three deaths occurred in two Indian families living in his district, the cause of which was apparently the eating of raw pork. A pig belonging to one of these families was killed about January 19. Six members of the family ate of this uncooked meat and became ill, and one of them, a child aged ten years, died February 16. On February 14 some of this meat was procured by a neighboring family and eaten raw by four children in the family. Two days later two of these children developed symptoms of gastroenteritis and one of

them died on February 19, the other on February 22. The other two children were not taken sick until February 21 and February 24. The former of these had a rise of temperature to 103 degrees and suffered with abdominal pain, vomiting, and aching in arms and legs. The latter complained of pain in the abdomen and legs. There were five other children in the second family who did not eat of the pork and who did not become ill.

The cases were brought to the attention of the district state health officer so late that a diagnosis was impossible.

# Medical Society of the State of New York

## ANNUAL MEETING

### SUMMARY OF SCHEDULE

*House of Delegates, Monday afternoon and evening, and Tuesday morning Section meetings, Tuesday afternoon and Wednesday morning and afternoon Tuberculosis demonstration all day Thursday Annual Dinner, Tuesday Evening General Meeting, Wednesday evening*

### HOUSE OF DELEGATES

The regular annual meeting of the House of Delegates of the Medical Society of the State of New York will be held on Monday Afternoon, May 11, 1925, in the Ballroom of the Hotel Syracuse, Syracuse, N. Y.

OWEN E. JONES, M.D., *President*

E. ELIOT HARRIS, M.D., *Speaker*

EDWARD LIVINGSTON HUNT, M.D., *Secretary*

### 119TH ANNUAL MEETING

The regular annual meeting of the Medical Society of the State of New York will be held on Wednesday Evening, May 13, in the Ballroom of the Hotel Syracuse, Syracuse, N. Y.

OWEN E. JONES, M.D., *President*

EDWARD LIVINGSTON HUNT, M.D., *Secretary*

### PROGRAM

Calling the Society to order by the President, Owen E. Jones, M.D.

Address of Welcome by the Chairman of the Committee on Arrangements, Frederick H. Flaherty, M.D.

Reading of the minutes of the 118th Annual Meeting by the Secretary, Edward Livingston Hunt, M.D.

President's Address, Owen E. Jones, M.D.

Address, George E. Vincent, Ph.D., President, Rockefeller Foundation, New York City

### SPECIAL TUBERCULOSIS DEMONSTRATION

The committee on scientific work of the Medical Society of the State of New York has arranged a special day, Thursday, May 14 for a demonstration of Tuberculosis and all its varied phases. The special committee of which Dr. Edward R. Baldwin of Saranac Lake is chairman, has secured the co-operation of the outstanding specialists in tuberculosis of this country for this meeting. It has been planned that any physician will be able to obtain any information on any phase of tuberculosis. There has never been a meeting in this country in which this subject has been so completely covered as it will be on this occasion.

For program, see page 586

### ANNUAL BANQUET

The Annual Banquet will be held in the Hotel Syracuse Tuesday evening May 12th. Chancellor Flint of Syracuse University as well as other prominent speakers will be present.

### SECTION PROGRAMS

#### SECTION ON MEDICINE

Chairman—ROBERT L. LEVY, M.D., New York City

Secretary—L. WHITTINGTON GORHAM, M.D., Albany

Place of Meeting—Hotel Syracuse.

Tuesday, May 12th, 2 30 P.M.

"Some Observations on Constitutional Factors in Disease," George Draper, M.D., New York City

"The Present Status of Insulin Therapy," Elliott P. Joslin, M.D., Boston, Mass. (by invitation)

Discussion opened by H. Rawle Geyelin, M.D., New York City

"The Specific Serum Treatment of Scarlet Fever," Francis G. Blake, M.D., New Haven, Conn. (by invitation)

Discussion opened by Augustus B. Wadsworth, M.D., Albany

"The Therapeutic Value of Oxygen in Pneumonia," Carl A. L. Binger, M.D., New York City (by invitation)

Discussion opened by Nelson G. Russell, M.D., Buffalo

Wednesday, May 13, 9 30 A.M.

Joint Session with Section on Neurology and Psychiatry

Symposium on "Mind and Medicine"

"Psychological Aspects of Medical Research," Thomas W. Salmon, M.D., New York City



# State Department of Health



## STATE HEALTH DEPARTMENT CONFERENCE

Forty-four members of the staff of the State Health Department, including the district state health officers, attended a conference at the Albany office on March 3d and 4th. Several matters of interest to physicians were discussed.

The Legislature being in session, considerable attention was given to pending health legislation. The district officers unanimously endorsed the Karle bill, increasing the compensation of local health officers and providing for the appointment of temporary acting health officers, a bill introduced at the request of the Department. They also favored requesting that the Webb-Lattin measure relating to the supervision of county nurses, a bill introduced at the request of the Department and the State Charities Aid Association, be amended in accordance with a suggestion of the Legislative Committee of the State Medical Society.

Dr. Ruth Gilbert, of the Division of Laboratories and Research, reported that during 1924 the following county laboratories had received state aid in accordance with provisions of Chapter 638, Laws of 1923: Montgomery, \$7,500, Ontario, \$3,000, Warren, \$3,700, Madison, \$2,325, Saratoga, \$4,200, Wyoming, \$3,100. It was stated that there had been marked development in three laboratories following the granting of state aid.

Dr. Branham, psychiatrist for the State Commission for Mental Defectives, outlined the plan which the commission is following in holding mental clinics for children in various localities, and requested the assistance of the district officers in getting children found to be in need of medical attention into the hands of physicians. He said that a limited appropriation and small staff made it difficult to make necessary contacts with local physicians.

In the forenoon of the second day the conference which was devoted to discussion of communicable diseases, was held in the auditorium of the City Hall, a number of health officers and other physicians from Albany and vicinity attending by invitation to hear a talk by Dr. William H. Park on the Dick test, immunization and serum treatment in scarlet fever.

Dr. Godfrey predicted for the coming year a low incidence of measles, with relatively high mortality if outbreaks occurred in children's institutions. He said that measles outbreaks in children's institutions were often reported too late to permit the use of serum as a preventative, and called attention to the fact that the serum might be effective if the ordinary precautions as to isolation were neglected.

In discussion of smallpox and vaccination it was brought out that the technique used in vaccination was at times open to serious criticism. It was suggested that, upon the occurrence of smallpox cases, the local physicians should always be gotten together if possible for discussion and demonstration of approved methods of vaccination. It was the consensus of opinion that the best dressing was a piece of sterile gauze strapped loosely to the arm with two strips of adhesive plaster, although some felt that no dressing was necessary in the first few days, if the vaccinated area was allowed to dry. It was agreed that the use of a bandage was inadvisable.

District officers reported that vaccination shields were still being used to some extent, describing several cases recently observed in which, upon removal of shields, collections of moist detritus and areas of hyperemia had been found. They recommended to the Public Health Council that it consider enacting a regulation prohibiting the sale of vaccination shields.

## UNCOOKED PORK APPARENTLY CAUSES THREE DEATHS IN TWO FAMILIES

According to a report recently received from Dr. H. J. Ball, district state health officer, three deaths occurred in two Indian families living in his district, the cause of which was apparently the eating of raw pork. A pig belonging to one of these families was killed about January 19. Six members of the family ate of this uncooked meat and became ill, and one of them, a child aged ten years, died February 16. On February 14 some of this meat was procured by a neighboring family and eaten raw by four children in the family. Two days later two of these children developed symptoms of gastroenteritis and one of

them died on February 19, the other on February 22. The other two children were not taken sick until February 21 and February 24. The former of these had a rise of temperature to 103 degrees and suffered with abdominal pain, vomiting, and aching in arms and legs. The latter complained of pain in the abdomen and legs. There were five other children in the second family who did not eat of the pork and who did not become ill.

The cases were brought to the attention of the district state health officer so late that a diagnosis was impossible.

# Medical Society of the State of New York

## ANNUAL MEETING

### SUMMARY OF SCHEDULE

*House of Delegates, Monday afternoon and evening, and Tuesday morning Section meetings, Tuesday afternoon and Wednesday morning and afternoon Tuberculosis demonstration all day Thursday Annual Dinner, Tuesday Evening General Meeting, Wednesday evening*

### HOUSE OF DELEGATES

The regular annual meeting of the House of Delegates of the Medical Society of the State of New York will be held on Monday Afternoon, May 11, 1925, in the Ballroom of the Hotel Syracuse, Syracuse, N Y

OWEN E JONES M D, *President*

E. ELIOT HARRIS, M D, *Speaker*

EDWARD LIVINGSTON HUNT, M D, *Secretary*

### 119TH ANNUAL MEETING

The regular annual meeting of the Medical Society of the State of New York will be held on Wednesday Evening, May 13, in the Ballroom of the Hotel Syracuse Syracuse, N Y

OWEN E JONES, M D, *President*

EDWARD LIVINGSTON HUNT, M D, *Secretary*

### PROGRAM

Calling the Society to order by the President, Owen E. Jones, M D

Address of Welcome by the Chairman of the Committee on Arrangements, Frederick H. Flaherty, M D

Reading of the minutes of the 118th Annual Meeting by the Secretary, Edward Livingston Hunt, M D

President's Address, Owen E. Jones, M D

Address George E. Vincent, Ph D., President, Rockefeller Foundation, New York City

### SPECIAL TUBERCULOSIS DEMONSTRATION

The committee on scientific work of the Medical Society of the State of New York has arranged a special day, Thursday, May 14 for a demonstration of Tuberculosis and all its varied phases. The special committee of which Dr. Edward R. Baldwin of Saranac Lake is chairman, has secured the co-operation of the outstanding specialists in tuberculosis of this country for this meeting. It has been planned that any physician will be able to obtain any information on any phase of tuberculosis. There has never been a meeting in this country in which this subject has been so completely covered as it will be on this occasion.

For program, see page 586

### ANNUAL BANQUET

The Annual Banquet will be held in the Hotel Syracuse Tuesday evening, May 12th. Chancellor Flint of Syracuse University as well as other prominent speakers will be present.

### SECTION PROGRAMS

#### SECTION ON MEDICINE

Chairman—ROBERT L. LEVY, M D, New York City

Secretary—L. WHITTINGTON GORHAM, M D, Albany

Place of Meeting—Hotel Syracuse.

Tuesday, May 12th, 2 30 P M

"Some Observations on Constitutional Factors in Disease," George Draper, M D, New York City

"The Present Status of Insulin Therapy," Elliott P. Joslin, M D, Boston, Mass. (by invitation)

Discussion opened by H. Rawle Geyelin, M D, New York City

"The Specific Serum Treatment of Scarlet Fever," Francis G. Blake, M D, New Haven, Conn. (by invitation)

Discussion opened by Augustus B. Wadsworth, M D, Albany

"The Therapeutic Value of Oxygen in Pneumonia," Carl A. L. Binger, M D, New York City. (by invitation)

Discussion opened by Nelson G. Russell, Buffalo

Wednesday, May 13, 9 ~ 8  
Joint Session with Section on Chemical

Psychiatry, M D, New York City

Symposium on "Colitis in Childhood," Henry

"Psychological" led by Henry L. K. Shaw, M D, W. Salmon, M D,



# State Department of Health



## STATE HEALTH DEPARTMENT CONFERENCE

Forty-four members of the staff of the State Health Department, including the district state health officers, attended a conference at the Albany office on March 3d and 4th. Several matters of interest to physicians were discussed.

The Legislature being in session, considerable attention was given to pending health legislation. The district officers unanimously endorsed the Karle bill, increasing the compensation of local health officers and providing for the appointment of temporary acting health officers, a bill introduced at the request of the Department. They also favored requesting that the Webb-Lattin measure relating to the supervision of county nurses, a bill introduced at the request of the Department and the State Charities Aid Association, be amended in accordance with a suggestion of the Legislative Committee of the State Medical Society.

Dr. Ruth Gilbert, of the Division of Laboratories and Research, reported that during 1924 the following county laboratories had received state aid in accordance with provisions of Chapter 638, Laws of 1923: Montgomery, \$7,500, Ontario, \$3,000, Warren, \$3,700, Madison, \$2,325, Saratoga, \$4,200, Wyoming, \$3,100. It was stated that there had been marked development in three laboratories following the granting of state aid.

Dr. Branham, psychiatrist for the State Commission for Mental Defectives, outlined the plan which the commission is following in holding mental clinics for children in various localities, and requested the assistance of the district officers in getting children found to be in need of medical attention into the hands of physicians. He said that a limited appropriation and small staff made it difficult to make necessary contacts with local physicians.

In the forenoon of the second day the conference which was devoted to discussion of communicable diseases, was held in the auditorium of the City Hall, a number of health officers and other physicians from Albany and vicinity attending by invitation to hear a talk by Dr. William H. Park on the Dick test, immunization and serum treatment in scarlet fever.

Dr. Godfrey predicted for the coming year a low incidence of measles, with relatively high mortality if outbreaks occurred in children's institutions. He said that measles outbreaks in children's institutions were often reported too late to permit the use of serum as a preventative, and called attention to the fact that the serum might be effective if the ordinary precautions as to isolation were neglected.

In discussion of smallpox and vaccination it was brought out that the technique used in vaccination was at times open to serious criticism. It was suggested that, upon the occurrence of smallpox cases, the local physicians should always be gotten together if possible for discussion and demonstration of approved methods of vaccination. It was the consensus of opinion that the best dressing was a piece of sterile gauze strapped loosely to the arm with two strips of adhesive plaster, although some felt that no dressing was necessary in the first few days, if the vaccinated area was allowed to dry. It was agreed that the use of a bandage was inadvisable.

District officers reported that vaccination shields were still being used to some extent, describing several cases recently observed in which, upon removal of shields, collections of moist detritus and areas of hyperemia had been found. They recommended to the Public Health Council that it consider enacting a regulation prohibiting the sale of vaccination shields.

## UNCOOKED PORK APPARENTLY CAUSES THREE DEATHS IN TWO FAMILIES

According to a report recently received from Dr. H. J. Ball, district state health officer, three deaths occurred in two Indian families living in his district, the cause of which was apparently the eating of raw pork. A pig belonging to one of these families was killed about January 19. Six members of the family ate of this uncooked meat and became ill, and one of them, a child aged ten years, died February 16. On February 14 some of this meat was procured by a neighboring family and eaten raw by four children in the family. Two days later two of these children developed symptoms of gastroenteritis and one of

them died on February 19, the other on February 22. The other two children were not taken sick until February 21 and February 24. The former of these had a rise of temperature to 103 degrees and suffered with abdominal pain, vomiting, and aching in arms and legs. The latter complained of pain in the abdomen and legs. There were five other children in the second family who did not eat of the pork and who did not become ill.

The cases were brought to the attention of the district state health officer so late that a diagnosis was impossible.

## SECTION ON EYE, EAR, NOSE AND THROAT

Chairman—ARTHUR G BENNETT, M D, Buffalo  
Secretary—EUGENE E. HINMAN, M D, Albany  
Place of Meeting—Hotel Syracuse

**Tuesday, May 12th, 2 30 P M**

"Thyroid Feeding in Pituitary Disease," Frank W Marlow, M.D., Syracuse  
"Relation of Diet to the Eye," Arthur M Yudkin, M D New Haven, Conn (by invitation)  
'The Efficiency Values of Visual Acuity as Determined by the Snellen Text,' Albert C. Snell, M D, Rochester  
"Rapid Muscle Testing without Apparatus," James W White, M D, New York

**Wednesday, May 13th, 9 30 A M**

'Correction of Nasal Deformities" William Wesley Carter, M D, New York City  
"Bronchoscopic Treatment of Bronchial Asthma" William Moore, M D, Philadelphia, Pa. (by invitation)  
"Value of Blood Transfusion in Sinus Thrombosis" Harold Hays, M D, New York City  
'Some Nasal Problems," Roy S Moore, M D Syracuse

**Wednesday, May 13th, 2 30 P M**

'Local Anesthesia of the Eye," Edmund Blaauw M D, Buffalo  
"Local Anesthesia of the Nose and Throat," Clayton M Brown, M D, Buffalo  
"Local Anesthesia of the Nose and Throat by Cocainization of the Naso-Palatine Ganglion," Simon L Ruskin M D, New York City  
"The Clinical Significance Orbital and Intraocular Tumors," Conrad Berens, M D, New York City

**Thursday, May 14th**

Tuberculosis demonstration For program, see page 586

## SECTION ON NEUROLOGY AND PSYCHIATRY

Chairman—EUGENE N BOLDREAU, M D Syracuse.  
Secretary—CLARENCE O CHENEY, M D, Utica  
Place of Meeting—Hotel Syracuse

**Tuesday, May 12th, 2.30 P M**

Joint Session with Sections on Pediatrics, Public Health, Hygiene and Sanitation

'The Part of Prevention in Pediatric Practice." J H Mason Knox, M.D., Chief Bureau of Child Hygiene, Baltimore, Md (by invitation)  
"Mental Hygiene of the Child and Its Relation to Mental Stability in Adult Life," Douglas A. Thom, M.D, Boston, Mass (by invitation)

Discussion opened by George S Amsden, M.D., Albany

"Mental Hygiene of the Child in Its Relation to the Development of Character" Ira S Wile, M D New York City

Discussion opened by William C Garvin, M.D, Binghamton

"The Serum Treatment of Poliomyelitis" Wardner D Ayer, M D Syracuse.

**Wednesday, May 13th, 9 30 A M**

Joint Session with Section on Medicine

## Symposium on "Mind and Medicine"

"Psychological Aspects of Medical Research," Thomas W Salmon, M D, New York City

"Mental Hygiene and Its Relation to General Medicine," Charles MacFie Campbell, M D, Boston, Mass. (by invitation)

"Mental Factors in General Medical Diagnosis," Lewellys F Barker, M D, Baltimore, Md (by invitation)

"Uses of Psychotherapy in General Medical Treatment" Austen Fox Riggs M D, Stockbridge, Mass (by invitation)

Discussion by George Draper, M D, New York City, and Clarence O Cheney, M D, Utica.

**Wednesday, May 13th, 2 30 P M**

"Epidemic Encephalitis and the Vegetative Nervous System," Foster Kennedy, M D, New York City

'Chronic Symptoms Following Acute Epidemic Encephalitis," illustrated by Moving Pictures, S Philip Goodhart, M D, New York City

"The Effect of Producing Aseptic Meningitis upon Dementia Praecox," Everett Sperry Barr, M D, Philadelphia, Pa. (by invitation)

"New Observations upon Drug Therapy in the Psychoses," William W Wright, M D, Utica

'Physiological Action of Luminal, Preliminary Report on Animal Experimentation," Professor M S Dooley, M D, Eugene N Boudreau, M D, Syracuse (read by title)

**Thursday, May 14th**

Tuberculosis demonstration For program, see page 586

## SECTION ON PEDIATRICS

Chairman—JOSEPH C PALMER, M D Syracuse,  
Vice-Chairman, ROGER H DENNETT, M D New York  
Secretary—ARTHUR W BENSON, M D, Troy  
Place of Meeting—Hotel Syracuse.

**Tuesday, May 12th, 2 30 P M**

Joint Session with Sections on Neurology and Psychiatry and Public Health, Hygiene and Sanitation

"The Part of Prevention in Pediatric Practice." J H Mason Knox, M D, Chief Bureau of Child Hygiene, Baltimore, Md (by invitation)

Mental Hygiene of the Child and Its Relation to Mental Stability in Adult Life," Douglas A Thom, M D Boston Mass (by invitation)

Discussion opened by George S Amsden, M D, Albany

Mental Hygiene of the Child and Its Relation to the Development of Character," Ira S Wile M D, New York City

Discussion opened by William C Garvin, M D, Binghamton

The Serum Treatment of Poliomyelitis," Wardner D Ayer, M D, Syracuse

**Wednesday, May 13th, 9 30 A M.**

Consideration of the Diagnostic Value on Chemical Study of the Spinal Fluid," Herbert B Wilcox, M D, New York City

'Pediatric Viewpoint in Treatment of Diabetes Mellitus" Roger H Dennett, M D New York City

"Chronic Ulcerative Colitis in Childhood," Henry F Helmholtz, M D, Rochester, Minn (by invitation)

Discussion opened by Henry L K Shaw, M D, Albany

"Mental Hygiene and Its Relation to General Medicine," Charles MacFie Campbell, M D, Boston, Mass (by invitation)

"Mental Factors in General Medical Diagnosis," Le-wellys F Barker, M D, Baltimore, Md. (by invitation)

"Uses of Psychotherapy in General Medical Treatment," Austen Fox Riggs, M D, Stockbridge, Mass (by invitation)

Discussion by George Draper, M D, New York City and Clarence O Cheney, M D, Utica

### Wednesday, May 13, 2 30 P M

Joint Session with Sections on Pediatrics and Public Health, Hygiene and Sanitation

### Symposium on "The Problem of the Chronic Cardiac Cripple"

"General Survey," James B Herrick, M D, Chicago, Ill (by invitation)

"Statistical Aspects," Louis I Dublin, Ph D, New York City (by invitation)

"A Program of Procedure," Homer F Swift, M D, New York City

"The Organization of a Cardiac Clinic," John Wyck-off, M D, New York City

Discussion opened by Haven Emerson, M D, New York City

Discussion from the Pediatric Viewpoint, De Witt H Sherman, M D, Buffalo

### Thursday, May 14th

Tuberculosis demonstration For program, see page 586

### SECTION ON SURGERY

Chairman—MARSHALL CLINTON, M D, Buffalo

Secretary—EDWARD S VAN DUYN, M D, Syracuse

Place of Meeting—Hotel Syracuse.

### Tuesday, May 12th, 2 30 P M

"Etiology of Cancer," Isaac Levin, M D, New York City

"Surgical Treatment of Malignancy," George W Crile, M D, Cleveland, Ohio (by invitation)

"Present Status of Radium Radiation," Burton J Lee, M D, New York City

"Present Status of X-Ray Therapy," Bernard F Schreiner, M D, Buffalo

"Present Status of Treatment of Cancer," Burton T Simpson, M D, Buffalo (by invitation)

### Wednesday, May 13th, 9 30 A M

Dr "Surger of the Bladder under local Anaesthesia," Highland Scott Pugh, M D, New York City

"Diagnosis of Tertiary Lesions," Grover Wende M D.

of these developments in Cholecystography," (illus-Six member—H Stewart, M D, New York City

meat and became morose," Arthur H Stein, M D,

aged ten years, die.

14 some of this meat Anesthesia in Prostatectomy," boring family and eaten Earl Rogers, M D

the family Two days later in the family developed symptoms of gastroenter, Syms M D,

### Wednesday, May 13th, 2 30 P M

"Uses of Enterostomy in Cases of Acute Ileus," Fred erick van Beuren, Jr, M D, New York City

"Lymphatic Drainage," William Alfred Costain, M.D., Toronto, Canada (by invitation)

"Pyloric Obstruction in Infancy," Thew Wright, M D, Buffalo

"Present Status of Surgery for Ulcer," Charles H Peck, M D, New York City

"Study of Gastric and Duodenal Ulcers with Especial Reference to Hemorrhage," Fordyce B St John M D New York City

### Thursday, May 14th

Tuberculosis demonstration For program, see page 586

### SECTION ON OBSTETRICS AND GYNECOLOGY.

Chairman—HAROLD C. BAILEY, M D, New York City

Secretary—NATHAN P SEARS, M D, Syracuse, N Y

Place of Meeting—Hotel Syracuse.

### Tuesday, May 12th, 2 30 P M

"Idiopathic Uterine Bleeding from the Pathological Standpoint," Emil Novak, M D, Baltimore, Md (by invitation)

"Idiopathic Uterine Bleeding from the Clinical Stand point," William P Healy, M D, New York City

"Fertility and Health," Donald Macomber, M D, Bos ton, Mass (by invitation)

"Pregnancy Following Transuterine Insufflation," Isidor C Rubin, M D, New York City

"Endocrine Treatment of Sterility in Women," Timothy F Donovan, M.D., Buffalo

### Wednesday, May 13th, 9 30 A M

"The End Results following the Sturmdorff Opera-tion," Harvey B Matthews, M D, Brooklyn.

"Preliminary Report of the Radium Work at the Woman's Hospital," Lillian K. P Farrar, M D, New York City

"Protein Injections in Gynecological Infections," Reginald M Rawls, M D, New York City

"Teratomata—Ovarian and Retroperitoneal," Onslow A Gordon, Jr, M D, Brooklyn

"Onset of Labor," Isidor Kross, M D, New York City

### Wednesday, May 13th, 2 30 P M

"Use of Paraldehyd in Obstetrics," William Edgar Caldwell, M D New York City

"Morphine in Eclampsia," Hervey C Williamson, M D, New York City

"Syphilis in Pregnancy," Alfred C Beck, M D Brook-lyn

"Use of the Kiehland Forceps," James Knight Quig ley, M D, Rochester

"The Version and Spinal Cord and Cerebral Injuries" William E Caldwell, M D, and Richard N Pierson, M D, New York City

"Elective Version and Extraction," Paul T Harper, M D, Albany

### Thursday, May 14th

Tuberculosis demonstration For program, see page 586





# NEWS NOTES



## HOTELS IN SYRACUSE

### HOTEL SYRACUSE.

Room with shower bath, single bed, for 1 person, \$3 00  
Room with shower bath, double bed, for 1 person, \$3 50-\$4 00 for two persons, \$4 00-\$4 50-\$5 00  
Room with shower bath, twin beds, for two persons, \$6 00  
Room with tub bath, double bed for 1 person, \$4 00-\$4 50-\$5 50, for 2 persons, \$5 00-\$6 00-\$7 50  
Room with tub and shower bath, double bed, for 1 person, \$4 00, for 2 persons, \$5 00  
Room with tub and shower bath, twin beds, for 2 persons, \$7 00-\$8 00  
Suite consisting of parlor and bedroom, tub and shower, 1 person \$10 50-\$11 50  
Suite consisting of parlor and two bedrooms, tub and shower, 2 persons, \$15 50-\$21 00

### THE ONONDAGA

Single room, without bath \$2 00 and up  
Single room, with shower 2 75 and up  
Single room with tub bath 3 00 and up  
Room with double bed and bath 5 00 and up  
Room with two single beds and bath 5 50 and up

### THE YATES

Room with running water, single \$2 00  
Room with running water, double 3 00  
Room with running water, single 2 50  
Room with running water, double 3 50  
Room with running water and lavatory, single 2 50  
Room with running water and lavatory, double 3 75  
Room with private bath, single 3 00  
Room with private bath, double 4 50

## TEACHING CLINICS IN PEDIATRICS

A series of five teaching clinics in pediatrics has been planned to be given in the South Side Hospital, Bay Shore, Long Island on Tuesday afternoons, beginning on March 31st, under the auspices of the Suffolk County Medical Society. They will be a part of the graduate education scheme of the Joint Committee on Graduate Education of the Medical Society of the County of Kings and the Long Island College Hospital Medical School. The plan is sponsored by the Second District Branch Medical Society of the State of New York and the Associated Physicians of Long Island, and is largely the result of conferences among the officers of the two societies.

The organization which will have charge of the actual operation of the clinics is the South Side Clinical Society, which is a group composed of the members of the Suffolk County Medical Society who live in the southwest corner of the county and compose the staff of the South Side Hospital. While all the plans have not been perfected, it is expected that the State Department of Health will lend its assistance.

The clinics which have already been announced are as follows:

March 31st—Simplified Infant Feeding, Dr. Frank H. Richardson, representing the Brooklyn Pediatric Society.

April 7th—Malnutrition, Dr. Charles Hendee Smith, of Bellevue.

April 14th—Prenatal Care, Dr. John O. Polak, of the Long Island College Hospital.

April 21st—General Pediatrics, Dr. Royal Storrs Haynes, of Sloane Maternity Hospital.

April 28th—Tonsils and Adenoids, Dr. Albert D. Kaiser, of Rochester.

It is expected that the local physicians will supply cases for demonstration, and that the teachings will be the discussion of the cases.

These clinics have been carefully planned and could readily be adapted to the needs of other parts of New York State. The request for the clinics came spontaneously by the unanimous vote of the members of the South Side Clinical Society, twenty-two of whom were present at a meeting on March 18th, at which the plan was considered. The promoters of the series feel that the clinics will be a practical demonstration which will result in requests for similar clinics held under the auspices of the district branches and county medical societies in other parts of New York State. Suffolk County is as rural as the counties around Syracuse, Rochester, Binghamton, and other up-State cities, and the teaching facilities of those cities are as available as those of Brooklyn.

A great merit of the Suffolk County plan is that it can be put into operation wherever a group of physicians will voluntarily ask for the clinics. Suffolk County happens to be favorably organized to support such a series of clinics, because there is a general hospital in each of the four corners of the county, each with an organized staff. But similar groups who desire teaching in any line of medicine could be readily organized in any county.

"Trichinosis in Children A Report of Cases,"  
John Aikman, M D, Rochester  
Discussion opened by W Parker Stowe, M D,  
Rochester

### Wednesday, May 13th, 2 30 P M

Joint Session with Sections on Medicine and Public  
Health, Hygiene and Sanitation

### Symposium on "The Problem of the Chronic Cardiac Cripple"

"General Survey," James B Herrick, M D, Chicago,  
Ill (by invitation)

"Statistical Aspects," Louis I Dublin, Ph D, New  
York City (by invitation)

"A Program of Procedure," Homer F Swift, M D,  
New York City

"The Organization of a Cardiac Clinic," John Wyck-  
off, M D, New York City

Discussion opened by Haven Emerson, M D, New  
York City

Discussion from the Pediatric Viewpoint, De Witt H  
Sherman, M D, Buffalo

### Thursday, May 14th

Tuberculosis demonstration For program, see page  
586

### SECTION ON PUBLIC HEALTH, HYGIENE AND SANITATION

Chairman—PAUL B BROOKS, M D, Albany

Secretary—ARTHUR D JAKES, M D, Lynbrook

Place of Meeting—Hotel Syracuse.

### Tuesday, May 12th, 2 30 P M

Joint Session with Sections on Pediatrics and Neu-  
rology and Psychiatry

"The Part of Prevention in Pediatric Practice," J H  
Mason Knox, M D., Chief Bureau of Child Hygiene,  
Baltimore, Md (by invitation)

"Mental Hygiene of the Child and Its Relation to  
Mental Stability of Adult Life" Douglas A Thom,  
M D, Boston, Mass (by invitation)

Discussion opened by George S Amsden, M D, Al-  
bany

"Mental Hygiene of the Child in Its Relation to the  
Development of Character," Ira S Wile, M D, New  
York City

Discussion opened by William C Garvin, M D, Bing-  
hamton

"The Serum Treatment of Poliomyelitis," Wardner  
D Ayer, M D, Syracuse

### Wednesday, May 13th, 9 30 A M

Session for health officers, school medical inspectors and  
other public health workers

Principal Discussion Limited to 5 Minutes

"How can the County Laboratory Best Serve the  
Interests of Physicians and of the Public," Morris Mas-  
lon M D Glens Falls

"Organization of the Hornell Breast Feeding Demon-  
stration," Bertis R. Wakeman, M D, Hornell

"Morbidity and Mortality Among Breast Fed and  
Artificially Fed Babies," Elizabeth M Gardner, M D  
Albany (by invitation)

"The Washington County Public Health Clinic," Miss  
Virginia A. Kilrain Hudson Falls (by invitation)

"The Pre-tubercular Child as a Factor in the Control  
of Tuberculosis," Jonathan Pearson, M D, Baldwin

"The Newspaper as an Aid in Local Public Health  
Work," Leo F Schiff, M D, Plattsburg

### Wednesday, May 13th, 2 30 P M

Joint Session with Sections on Medicine and Pediatrics

### Symposium on "The Problem of the Chronic Cardiac Cripple"

"General Survey," James B Herrick, M D, Chicago,  
Ill (by invitation)

"Statistical Aspects," Louis I Dublin, Ph D, New  
York City (by invitation)

"A Program of Procedure," Homer F Swift, M D,  
New York City

"The Organization of a Cardiac Clinic," John Wyck-  
off, M D, New York City

Discussion opened by Haven Emerson, M D, New  
York City

Discussion from the Pediatric Viewpoint, De Witt H.  
Sherman, M D, Buffalo

### Thursday, May 14th.

### TUBERCULOSIS SESSION

Place of Meeting, Hotel Syracuse,

Part One—Morning

### DEMONSTRATION SESSION

#### Pathological

#### FRESH SPECIMENS

(a) Demonstration of gross and microscopic speci-  
mens of human tuberculosis

(b) Demonstration of gross and microscopic speci-  
mens of bovine tuberculosis

#### BACTERIOLOGICAL

(a) Cultures of pathogenic acid-fast bacilli

(b) Various preparations of tuberculin

(c) Methods of staining the tubercle bacilli, in  
urine, sputum and feces

#### X-RAY SESSION

(a) Technic of X-ray exposures of the chest

(b) Demonstration of stereoscopic films

(c) Interpretation of chest radiograms

(d) Pulmonary tuberculosis-moving pictures

(e) Demonstration charts of moving pictures

#### PHYSICAL DIAGNOSIS

(a) Demonstration of physical signs by the stetho-  
phone and other methods

#### HELIO THERAPY

Practical Demonstration

(a) Application of the mercury quartz lamp in  
treatment of laryngeal, intestinal lymphatic, bone and  
joint tuberculosis

(b) Skin manifestations of tuberculosis

(c) Tuberculosis of the Eye

(d) Tuberculosis of the Larynx

(e) Tuberculosis in pregnancy

(f) Tuberculosis in childhood

The work of the Milbank Memorial Fund in Syra-  
cuse, and the State Charities Aid Association

### Part Two

### SCIENTIFIC SESSION

#### Diagnosis

(a) History and Symptoms

(b) Physical signs

(c) X-ray Diagnosis

#### SURGICAL TREATMENT

(a) Pneumothorax

(b) Phrenectomy and Throacoplasty

#### TREATMENT BY HELIO THERAPY

Note The addresses will be limited to 15 minutes The  
discussions will be limited to 3 minutes

## DINNER TO PHYSICIANS WHO HAVE PRACTICED MEDICINE MORE THAN FIFTY YEARS

The committee of the Albany County Medical Society to arrange for a dinner for those members of the Society who have practiced medicine for fifty years or more report splendid progress in their plans

The Albany County Medical Society has the unusual honor of having in its membership eleven physicians who have actually practiced medicine for more than fifty years, among them, three who are ex-presidents of the Medical Society of the State of New York and several who have national reputation in medicine. Albert Vander Veer, Cyrus S. Merrill, Frederic C. Curtis, James P. Boyd and Herman Bedell are outstanding personalities.

It is planned to give this dinner at the Fort

Orange Club, on Wednesday, April 29th, in recognition of the worth and work of these, our associates.

The committee of arrangements believe that on such an occasion, unique in the annals of the Medical profession in any section of the United States, it would be fitting to honor these men in a manner which would do justice to their reputation and reflect credit on the members of the Society.

The Rockland County Medical Society is planning a dinner in honor of Dr. William R. Sitler, of Suffern, who graduated from the University of Pennsylvania fifty years ago, and is still in active practice, both as a family physician and as health officer.

## NEW YORK STATE SOCIETY OF INDUSTRIAL MEDICINE

The New York State Society of Industrial Medicine will hold its semi-annual meeting at the Ten Eyck Hotel, Albany, N. Y., on April 16th.

The meeting will be opened at 10 A. M. with a brief address of welcome by the Hon. W. S. Hackett, Mayor of Albany.

The scientific program will follow immediately and continue through the day. The speakers and their subjects are as follows:

"Disabilities of the Hand," H. H. Lyle, M. D., New York City.

"Injuries of the Genito-Urinary Tract," James Vander Veer, M. D., Albany.

"A Critical Study of Some Factors Influencing Recovery in Accident Cases," E. MacD. Stanton, M. D., Schenectady.

Discussion of each address will be opened by a well known specialist and followed by general discussion.

Noon recess and luncheon at the Ten Eyck Hotel from 12:30 to 2 P. M.

## THE PHYSICIANS' HOME BENEFIT

The Medical Profession of Greater New York and vicinity is advised of a method for securing support for The Physicians' Home and at the same time enjoying a popular opera at the Century Theatre.

"The Love Song" by Offenbach comprises a collection of musical productions by that author. The hero of the play represents Offenbach himself. It is one of the great successes of the season.

The Physicians' Home Committee has secured the Century Theatre for Monday, April 20th, and it offers tickets at agency prices.

Physicians who purchase two or more tickets for box seats, orchestra or dress circle will receive membership certificates for 1925 in The Physicians' Home. This organization takes

charge of physicians, who, through age or illness, require a helping hand. It gives them a pleasant home in the country as guests of the profession.

Tickets for the opera may be obtained by mail from the Secretary, Dr. Silas F. Hallock, 901 Lexington Avenue, New York. Those who send checks will receive tickets in reference to seats in the order of receipt of the checks. Please give us a prompt reply and please ask your friends in and out of the profession to enjoy this opera while at the same time lending a hand for a fine charity.

Box Seats, \$7.00  
Orchestra, front rows, \$7.00, back rows, \$6.00  
Dress Circle, front rows, \$6.00, back rows, \$5.00  
Balcony front rows, \$2.50 and \$2.00, back rows, \$1.50  
Second Balcony, \$1.00

## OPPORTUNITIES FOR GRADUATE MEDICAL STUDY IN NEW YORK

The Committee on Medical Education of The New York Academy of Medicine has prepared a series of synopses of approved opportunities for graduate medical study in New York City which will soon be published for distribution. The synopses cover dermatology and syphilology, obstetrics and gynecology, internal medicine, neurology and psychiatry, ophthalmology, otolaryngology, pediatrics, surgery, urology, and orthopedic surgery.

A Bureau of Clinical Information is maintained at the Academy of Medicine, 17 West 43rd Street, where detailed information is available regarding opportunities for graduate medical study in New York, and also in other cities of the United States and abroad. The Executive Secre-

tary in charge of the Bureau is prepared to answer inquiries concerning ordinary internships, special internships or residencies, graduate courses in medical schools and teaching hospitals, and extension courses. Much information in regard to graduate medical work in England and on the Continent is on file.

The Bureau publishes a Daily Bulletin of Surgical Clinics which will be mailed free to visiting doctors on request. A Weekly Bulletin of Medical Clinics also is published. A book of fixed clinics of Greater New York, with a transportation guide, has been prepared for the use of visitors whose stay in the City is limited, and is furnished without charge.

## SPECIAL MESSAGE OF GOVERNOR SMITH

State Department of Health  
Albany, N. Y., March 28, 1925

MY DEAR EDITOR

Now that the annual battle to uphold the Medical Practice Act is over and in spite of the defeat of the Karle-Dunmore bill, it seems to me that certain definite facts have come to light which have made the losing fight worth while.

1st That the medical profession of the State is better organized than ever before in the history of the State and is making such organization felt not only in the legislature but throughout the State.

2nd And to my mind most important of all, for the first time there has been placed on the written and spoken record the fact that the chiropractic and other cults claim the right by their various peculiar methods to treat infectious diseases and resent any interference by law with that right. This fact should be spread broadcast throughout the State.

May I take this opportunity to testify to the earnest and effectual work of Dr. Joseph Lawrence, representing the State Medical Society, and on the last day of the session of the legislature to that of Dr. Booth of Elmira?

I enclose a copy of the Governor's message to the legislature, of which the press this morning gave but casual mention. I think it is worthy of record as showing the Governor's attitude toward the Medical Practice Act.

MATTHIAS NICOLL, JR.,  
*Commissioner of Health*

State of New York, Executive Chamber  
Albany, March 27, 1925

TO THE SENATE

You have on the calendar in the Senate, Assembly Bill, 1854, entitled "An Act to amend the public health law, in relation to the practice of medicine." It has passed the Assembly by an overwhelmingly majority. It is in line with the recommendations that I have heretofore made to the effect that the State must be more vigorous in the prosecution for violation of the Medical Practice Act.

The bill seeks to give the State a control over the practice of medicine, which it is agreed by the State Department of Education, the State Department of Health, and more than ten thousand practicing physicians of the State we should have. I can think of no function in the government as important as the preservation of public health. The unlawful and illegal practice of medicine is a crime against the people and to permit it to go unpunished or even undetected bespeaks a failure on the part of the State to properly strengthen the arm of one of our greatest departments of government. It is inconceivable that there could be abroad in the State any influence seeking to stay the hands of public authority in the prevention of the illegal practice of medicine.

I earnestly hope that before you adjourn this bill will receive your most careful consideration.

(Signed) ALFRED E. SMITH

## REPORT OF COMMITTEE ON NURSE QUESTION

### To the President and Members of the Society

After careful consideration of the various factors entering into the so-called nurse situation as it exists today in Erie County, and throughout the State of New York as well, your Committee desires to submit this report, covering the following points

1 What, if any, are the just grounds for criticism of the present status of the registered nurse with relation to the public and to the physician?

2 What are the underlying causes of the unsatisfactory conditions that we find not only evident but increasingly prevalent?

3 What definite remedies can we recommend to relieve the situation?

### I—GROUNDS FOR CRITICISM

1 *Scarcity of Nurses* Evidence of the claim that there are insufficient nurses to supply the demands of the sick public is presented so frequently both by physicians and laymen requiring nursing service as to thoroughly substantiate the claim in the minds of the Committee. This more or less constant shortage becomes acute during epidemics or seasonal illness

2 *Nursing in Private Homes* Testimony of physicians and laymen is abundant evidence of the increasing unwillingness of a large number of Registered Nurses to accept calls to nurse in private homes

3 *The Twelve-Hour Schedule* Your Committee realizes that there are valid arguments advanced on both sides of the question of limiting the nurse's time on duty to twelve hours. Without entering into a discussion of the merits of this question your Committee is convinced that one result of this schedule is to work a great financial hardship on the sick public, the great majority of whom are unable to meet the expense involved.

Especially burdensome is this system on maternity patients. Your Committee believes that the great increase in expense for nursing in these cases tends to make it almost prohibitive for people of moderate means to accept parenthood, and so constitutes a serious menace to the birth rate among the very class in which a high birth rate is most desirable.

4 Your Committee finds evidence of an increasing tendency on the part of some Registered Nurses to exercise the functions of a physician rather than a nurse in their relations with patients. While we believe that this by no means holds as a criticism of any but a minority of nurses of today, we are impressed with the apparent growth of this attitude of mind on the part of many nurses

### II—UNDERLYING CAUSES OF CONDITIONS CRITICIZED

1 An increasingly large number of nurses are being drawn into special lines of work other than bedside care of the sick—such as Industrial dispensaries, public health nursing, institutional positions, etc.

2 Under the present system of training, emphasis is laid on the larger sphere of the professional woman. While your Committee would be the last to deprecate the expansion of any woman's sphere of usefulness, the practical fact remains that such aspirations on the part of nurses seem to result in a diminished enthusiasm for the performance of the real function of a nurse, viz, caring for the comfort of her patient and executing the orders of the physician.

3 The expanding curriculum further serves to educate nurses beyond the point of practical usefulness in their actual work, engendering in many the desire to exercise the function of one who treats the patient rather than one who cares for the ailing. In other words such nurses are not content, on the one hand, to play true rôles of the physician's representative on the case and, on the other hand, many of them are

misled into thinking that the general smattering of medical education which they receive renders them competent to practise medicine rather than nursing

4 The present high requirements as to preliminary education of a pupil nurse, viz., a high school course, together with a three years course of hospital training, makes for dissatisfaction with the financial returns on the investment of time and money necessary to secure such training

5 The preliminary high school course requirement serves to debar many young women of high character and ability such as formerly chose nursing as a calling from sheer love of the work. The number of applicants for training is thus greatly limited, with the resultant scarcity of women in the nursing ranks

### III—SUGGESTED REMEDIES

1 Your Committee's unhesitating recommends reducing the preliminary requirements of applicants for nurse training to a grammar school education—placing emphasis more on character, ability and enthusiasm of the applicant for this special field of work.

2 We would modify the curriculum in training schools so as to require two years of practical bedside training, limiting didactic instruction to the elements of anatomy, physiology, disease causation, modes of infection, practical asepsis, etc

3 We advocate granting a diploma at the end of the second year, graduating the pupil as a Qualified Nurse, with the privilege of registering and using the degree of R. Q. N.—Registered Qualified Nurse.

The idea of creating the class of Qualified Nurses is to clear the curriculum of useless advanced scientific specialties, to shorten the unnecessarily long period of training and to readjust the education to the necessities of medical and surgical practice.

4 We would arrange the curriculum for a third year of training for those who so elect—consisting of more advanced work in those studies necessary to prepare them for public health nursing, institutional work and other activities than actual bedside care of the sick. At the end of the third year, according to this plan, a diploma might be granted as Master Nurse, with the privilege of registering with the Regents and using the degree of R. M. N.—Registered Master Nurse.

To be eligible for this advanced degree the applicant must have had a High School Education. Her first two years of training would be the same as that of applicants for a diploma as Qualified Nurse, but her third year would be advanced technical, administrative or specialty courses, as the candidate for the degree might elect.

5 As a concrete suggestion of how this general plan might be carried out your committee submits the following tentative curriculum, giving in one column the hours now required in the various subjects taught, and in a second column the suggested changes to be made.

### SUGGESTED CHANGES IN NURSING SCHOOL CURRICULUM, WITH PRESENT PRESCRIBED HOURS

1st Semester	1st Year	
	Prescribed	Suggested
Anatomy and Physiology	48	36
Bacteriology	16	4
Personal Hygiene	8	6
Chemistry	16	4
Nutrition and Cookery	24	24
Hospital Housekeeping	8	8
Drugs and Solutions	16	6
Elementary Nursing	64	64
Historical, Ethical and Social Basis of Nursing		
Introduction to Private Nursing	8	3
	208 h. (12 h per week)	155 h. (Save 53 h (9 h per week)

### BRONX COUNTY MEDICAL SOCIETY

A regular meeting of the Bronx County Medical Society, held at Hollywood Gardens, 896 Prospect Avenue, on March 18, 1925, was called to order at 8 45 P M, the President, Dr Jacobs, in the Chair

Isaac Astrachan, Morris Blum, Thomas Levin, Samuel Lessinger, Morris Henry Oken, Gordon D Oppenheimer, Jacob Segal, were elected to membership, and Frederic W Bancroft, associate membership

Dr Weiztner introduced the following resolutions

"WHEREAS, The Bronx County Medical Society has sustained a severe loss in the death of its honored associate, Chester C Curtis, M D

"*Resolved*, That the Bronx County Medical Society record the sense of its loss in the death of Dr Curtis and that a minute thereof be placed on the records of the Society, and be it

"*Further Resolved*, That a copy of these resolutions be transmitted to the family of our departed member"

These resolutions were carried by a rising vote

Dr Podvin, who had been appointed by the President to represent the Society at the conference called by the Bronx Board of Trade, reported that a mass meeting will be held on March 27th, at Morris High School, when the future welfare of Bronx borough will be discussed

The President, Dr Jacobs, announced with regret the resignation of Dr Eichler as Chairman of The Bulletin Committee Dr Eichler has found it impossible to devote the time necessary for the proper performance of this work and has asked to be relieved The President further announced that he had appointed Dr Edward C Podvin as Dr Eichler's successor Dr Podvin appealed to the members for their cooperation

The Scientific Program then proceeded as follows

#### PRESENTATION OF CASE

"Carcinoma of Testicle Following Trauma (ten years post-operative)," J Lewis Amster

#### PAPERS

1 "Prevention of Cancer," James Ewing

2 "Essentials in the Diagnosis and Cure of Cancer," Herbert M Bergamini

3 "Practical Results of the Campaign Against Cancer," George A Soper, Ph D

Discussion by Drs William Stone, Burton J Lee, Isaac Levin, Henry Roth, J Lewis Amster and Adolph Rostenberg

Dr Podvin moved that a vote of thanks be extended to the readers of the papers of the evening This motion was unanimously carried

The meeting adjourned at 11 30 P M

I J LANDSMAN, *Secretary*

### CORTLAND COUNTY MEDICAL SOCIETY

The regular quarterly meeting of the Cortland County Medical Society was held at the High School Building, in the City of Cortland, on Friday, March 20, 1925

Professor Flora Rose, of Cornell, gave an interesting talk on food selections for infants and children

Dr Frank Howard Richardson, of Brooklyn, addressed the meeting on the subject of breast feeding

These papers were discussed by the members of the society

The society then took up the business of the evening, and upon receiving the report of the Censors voted to elect to membership in the society Dr Albert A Bailey, of Cortland, and Dr Hugh Frail, of Marathon

The meeting was then adjourned

A M LOOPE, *Secretary*

### MEDICAL SOCIETY OF THE COUNTY OF ERIE

#### REGULAR MEETING, MARCH 16, 1925

*Resolved*, That the Report of the Committee on Nurse Question which has been submitted to the Society at this meeting be adopted

*Resolved*, That the Committee be authorized to have said Report printed and a copy of same mailed to each member of the House of Delegates for the coming year Also a copy to every hospital in the State of New York Also a copy to a list of physicians and surgeons connected with various hospitals throughout the State, such list to be chosen by the Committee Also a copy to every member of this society (*See next page*)

*Resolved*, That the Delegates of this Society to the State Society be and hereby are instructed to use every effort to secure action by the next House of Delegates looking toward the introduction by the State Legislative Committee of a Bill embodying these or similar ideas regarding the training of nurses

*Resolved*, That the Delegates be also instructed to work for the establishing in the State Society of a Standing Committee on Nurse Training, whose duty it shall be to advise with the State Legislative Committee on all proposed legislation touching this question

periodic health examinations The medical profession, he said, has been so busy looking after the sick that it has had very little time to spend on prevention and general health Infant mortality in the State has been greatly reduced in the last ten years and Dr Jones is confident that equal results can be accomplished with adults by periodic health examinations

Dr William A Hagan, Professor of Bacteriology of the Cornell Veterinary College, gave a short but very instructive address on "Tularemia" which appears to be spreading over the country from the West The infection is an attenuated form of the once terrible bubonic plague, and is carried by rodents, particularly ground squirrels and rabbits

Recent investigation has shown its organism to have great infectivity, a single drop on the skin of a guinea-pig, without abrasion, will produce the disease It is highly communicable to man and produces a sickness of about three weeks and a slow convalescence extending over several weeks

Practically every laboratory worker who has handled the organism has been infected The disease is said to have been recently detected in the Adirondac region

Livingston Farrand, M D, President of Cornell University and member of the Tompkins County Medical Society, dealt with topics relating to the pending Medical Practice Act Among other things, he said, "One of the great prob-

lems confronting the medical profession is a conception of its responsibilities There is a tendency to aim for particular personal or group prestige and interest The surest way to attain prestige and success is to forget personal or group interest The interest of the community is the interest of the group The demand for the medical profession is greater today than it ever was The day is coming when the medical profession must take the initiative, with a judgment not primarily concerned with what the particular interests of the group may be

We have seen an immense improvement in the realization by the medical profession of its responsibility to lead and guide in this movement of public enlightenment The broadest possible point of view must be taken by physicians I am optimistic with regard to the future of the medical profession and its educational functions After all, the public health and vitality is what we are driving at

There is no symptom of a lessening demand for a highly trained medical profession On the contrary, there is every evidence of a constantly increased demand, which the world must see realized "

The program of the evening was interspersed with stunts and varied entertainment by members of the Savage Club and students of the Ithaca Conservatory of Music.

WILBER G FISH, *Secretary*

---

## GORGAS MEMORIAL

Perhaps one of the most interesting recent developments in the plans of the Gorgas Memorial Institute of Tropical Research and Preventive Medicine, a co-operative movement for better health, controlled by the medical profession, but actively backed by eminent lay members, is the widespread enthusiasm for, and cordial reception accorded Gorgas Memorial radio talks These are now being given in all the principal cities, notably over station WOR, Buffalo, and through the courtesy of the New York Health Speakers' Service, over WEAJ in New York

A Speakers' Bureau is now being organized from among the New York State Governing Committee members In brief, judging from the many letters received and other evidences of public response to these broadcasted Gorgas Memorial addresses, there is no question in the mind of those responsible for the Gorgas Memorial as to the need for authoritative health information directed to the "man on the street" through the channels to which he is accustomed, viz the daily newspaper, the general magazine, the radio, lectures from the platform and by moving picture films

On March 20th at 7 P M over WEAJ Dr George David Stewart, happily launched the radio program of the Gorgas Memorial for New York City Wednesday morning, March 25th, Dr William Francis Honan spoke for the Gorgas Memorial on "The Child's Best Heritage," this being the first radio address of a series planned by WEAJ to interest young mothers Subsequent addresses of this series are to be given every Wednesday morning at 11 10 over WEAJ by members of the Gorgas Memorial Speakers' Bureau Among the speakers scheduled are Dr Charles Mallory Williams, who will speak April 1st on the care of the infant with reference to skin disease and Dr Foster Kennedy, who is to present the cause of mental hygiene, April 22nd

We quote from Dr Stewart's radio presentation of the Gorgas Memorial

"Who was Gorgas and why is this institute named after him? William Crawford Gorgas began his professional life as a Lieutenant in the Medical Service of the United States Army He retired with the rank of Surgeon General, but between those periods he had served in Frontier Army Posts—had taken an eager scientific inter-

2nd Semester	Prescribed	Suggested
Elements Pathology	8	6
Advanced Nursing	32	24
Materia Medica and Therapeutics	16	8
Diet in Disease	8	6
Ethics	8	0 Given above
Massage	0	8
	72 h	52 h (Save 20 h.
	(5 h per week)	(3¼ h. per week)

2nd Year—Junior		
1st Semester		
Nursing in General—Medical Diseases	16	16
Nursing in General—Surgical Diseases	16	16
Nursing in General—Infant Feeding	16	8
	48 h	40 h (Save 8 h )

Gynecological Nursing	0	0
2nd Semester		
Nursing in Communicable Diseases	8	8
Operating Room Technique	8	8
Obstetrical Nursing	16	16
Eye, Ear, Nose and Throat Nursing	8	2
Public Sanitation	8	2
	48 h	36 h
	(3½ h per week)	(2½ h per week)

This saves about 97 hours in the first two years. To replace some of these unnecessary hours there could be added some of the practical 3rd year work, *e g*,

	Prescribed	Suggested
Emergency Nursing and First Aid	8	8
Occupational, Skin and Venereal Diseases	8	4
Hydrotherapy, etc.	8	8

#### 3rd Year—Senior

(Two or three of the courses of the third year could be added to the second year to meet special conditions in training a Registered Qualified Nurse.)

The pupil wishing to take a third year leading to the

degree of Registered Master Nurse might be allowed an elective course, choosing her subjects from some such list as the following, according to her individual leaning toward some special line of work.

- 1 Nervous and Mental Diseases
- 2 Occupational Therapy
- 3 Administration Problems
- 4 Laboratory Technique.
- 5 Anaesthesia
- 6 Modern Social Conditions
- 7 Field Work, Social Service Work, Public Welfare Work.
- 8 Tuberculosis Nursing
- 9 Nursing Mentally Defective Children
- 10 Gynecological Nursing
- 11 Obstetrical Nursing
- 12 Psychology, etc.

Finally, your committee wishes to disclaim any idea of personal criticism of any or all Registered Nurses now practising their noble profession. The criticisms herein contained are directed only at the present system of nurse-training, for which ill-judged system no responsibility or blame can attach to those who have been trained under its administration.

The whole matter can be reduced to very simple terms *What is the aim of nurse training?* Is it to train nurses, as the term implies,—that is, women whose first and chief mission is to care for the man woman or child who is sick and in need of her care? Or is the aim to impart in a most superficial manner a quasi medical education which is utterly insufficient to qualify its recipient for medical practice, but serves only to weary their brains with a mass of undigested medical facts?

Should not nurse-training strive mainly to develop the pupil's powers of intelligent observation, to inculcate a sense of responsibility for the execution of the physician's orders, and, last but not least, develop to the highest degree her skill in ministering to the sick?

Your committee believes that it should.

Respectfully submitted,

COMMITTEE ON NURSE QUESTION  
 GEORGE R. CRITCHLOW, M.D.  
 THEW WRIGHT, M.D.,  
 IRVING M. SNOW, M.D.,  
 DEWITT H. SHERMAN, M.D.,  
 JAMES A. GARDNER, M.D.,  
 EARL P. LOTHROP, M.D.

## TOMPKINS COUNTY MEDICAL SOCIETY

The Annual Dinner of the Medical Society of the County of Tompkins was held Wednesday evening March 18, 1925, with members and guests present to the number of 110.

When professional men foregather for a function of this type, their professionalism is characteristically relegated to the background. If there had been any hesitancy in such relegation at this time the toastmaster would have completed it with dispatch. He was listed in the program as Dr Rym Berry (Romeyn Berry, Graduate Manager, Cornell Athletic Association). "Dr" Berry's sparkling repertoire and sprightly stories were typically Berry-esque.

President John W. Judd opened the post-prandial program by introducing Mr Berry, and by presenting a floral token of appreciation to Dr Esther E. Parker, past president of the society and the only active woman practitioner in Ithaca.

Dr Owen E. Jones of Rochester, President of the State Society was the first speaker. He referred to past and present activities of the society with emphasis upon the Medical Practice Bill now before the State Legislature.

He said, "The Legislature has passed bills regulating admission and practice in nearly all other professions, but today almost any cult can practice medicine with no legal qualifications whatever. This condition is unusually strange, in that the health of the community or State is its greatest asset." He urged the use of the combined influence of medical societies toward the passage of the Medical Practice Bill, which would provide limitations of admission to practice.

"The medical profession in itself," he continued, "is the group best qualified from every standpoint to look after the public health."

Dr Jones also advised the Tompkins County Medical Society to get behind the movement for





# THE DAILY PRESS



Is New York State threatened with a recurrence of influenza? The newspapers are beginning to take notice of an outbreak of the disease in Chicago. The *Brooklyn Citizen*, March 13th, contains a statement ascribed to Dr Herman Burleson, Health Commissioner of Chicago, which sums up the situation. The doctor is quoted as saying

"Eight deaths were reported to this office for the thirteen hours period ending at 10 P M yesterday making a total of 279 deaths from respiratory diseases since March 1"

The *Brooklyn Times*, March 15th, throws more light on the distribution of influenza cases, and says

"It is evident, that the disease is not confined to the city on the shores of Lake Michigan. In Springfield, Vt, where the population is only seventy-five hundred, the Health Officer reports five hundred suffering. Manchester, N H, reports that between fifteen hundred and two thousand people are suffering from influenza."

Dr Bundesen, in the article quoted above, gives some sensible advice regarding the prevention of influenza, and says

"The present epidemic should be easy to combat if the public would help. The malady is highly contagious and if the people who feel the symptoms would go to bed and keep away from contacts we could stop the epidemic very soon. But sufferers continue to get around, expectorating, spreading the germs, with the result that scores and scores of people are infected daily."

Dr Bundesen has issued a bulletin offering free anti-pneumonia serum from the city laboratories to physicians for the duration of the epidemic.

We have a clipping which has appeared in three papers, the *Poughkeepsie Star*, March 17th, the *Elmira Advertiser*, March 17th, and the *New York Bulletin*, March 20th, two of which were run as editorial comment. The clipping is as follows

"Health officials never yet have succeeded in stopping an epidemic of influenza. The avoidance of 'flu' or its consequences is a personal problem for each individual.

"This is the time of year to be particularly on guard against 'flu' and pneumonia—as the two always go together—for in most vicinities their ravages usually reach the maximum toward the close of winter.

"Cleanliness, good physical condition and plenty of sleep are our best safeguards. Some-

thing besides germs is usually required to make us sick. Much depends on our general condition—our 'resistance'."

We are quoting the clipping in order to call attention to a defect in the manner of its presentation in the three papers. Neither paper gives the author or gives any clue to the author of the clipping.

We also call attention to the point which the three clippings emphasize, and that is the "resistance" of the patient. There are three great factors which affect the spread of epidemic diseases

- 1 The virulence, or vitality, or growing qualities of the germs which produce the disease. Some varieties of influenza germs are weak, and have difficulty in growing in the body, and others are vigorous and will grow if they have half a chance.

- 2 The general vigor and healthfulness of the body. Fatigue, for example, has considerable effect in lessening the ability of the body to kill influenza germs.

- 3 The presence of antitoxins against influenza in the body. Most people do not have the antitoxins until they have had influenza.

There is no practical way to cause the body to produce antitoxins against influenza.

A person may be ever so vigorous and healthy, and yet if he is exposed to a case, he is likely to come down with influenza unless he has had the disease before.

The most promising method of attacking an epidemic of influenza is that of preventing the spread of the germs from those who have influenza or other form of "colds."

This cannot be done by law or compulsion. It must come through education.

The basic fact to teach the people is that the excretions of the nose and throat are as dangerous and require as careful disposal as those of the bowels and bladder.

The campaign for the disposal of all forms of sewage has been going on for half a century, and the lesson has now been learned so well that diarrhoeas and other forms of intestinal infections are uncommon, and their presence arouses immediate protest.

A campaign of educating the people regarding the disposal of the excretions of the nose and throat will take a generation of time.

Why not start the campaign now?

The *Troy Record*, March 20th, has a short

est in yellow fever While on duty at one of his posts he had passed safely through an attack of yellow fever and thus became immune He had banished yellow fever from Havana where he was backed by the Military and Civil authorities, had banished the same disease from the Panama Canal Zone and made possible the building of the Canal, saving the lives (based on the mortality records of the French Company) of 60,000 men and affecting an economic saving of \$80,000,000 In this undertaking he was backed by the authorities in only a half hearted way and several times he was on the point of being recalled but his patient persistence won through

"Then when the World War broke out, Surgeon General Gorgas was responsible for the health of four million men and he watched the Army Medical Corps, of which he was the head, grow until in numbers, it surpassed the entire standing army before the war After the war was ended and General Gorgas had retired under the age limitation, the English Government asked him to go to Africa because General Gorgas believed he could rid the world of yellow fever and he could have done so, but in London he fell ill and died His work was finished

#### "WHAT HAS BEEN DONE

"A great deal has been done as you know by Health Boards, by Foundations and other organizations to prevent diseases but a great deal remains to be done Out of each 100,000 of the population each year tuberculosis takes 97, a few years ago it took 200 Heart disease takes 150, pneumonia 140, nephritis or kidney disease takes 89 and apoplexy claims about 90

"About 87 per cent of all deaths are due to infection and if cancer is considered a bacterial disease then 97 per cent of all deaths will be due to infections

"When the call of troops was made to get four million men fit to serve it was necessary to call between six or seven million men and remember these were all young men Now it doesn't seem fair that 34 per cent of the men under 30 were found suffering from disease or the defects of deformities produced by disease and it is just this condition of affairs that the Gorgas Memorial Institute is attempting to correct. Every good movement must have a sign or symbol under which it functions and what better than the name of the unselfish, practical altruistic Gorgas

"WHAT IS THE IDEA OF THE GORGAS MEMORIAL

"The idea of the Gorgas Memorial Institute is three-fold

"1 It wants to create in Panama as a memorial to Gorgas an Institute or school for research into tropical medicine Think of the immense

areas that will be added to the world's resources by these studies

"2 To inaugurate a personal health educational campaign that will bring every individual in this country to his doctor once or, better, twice a year, no matter how healthy he may be, just to find out that there are no knocks in the engine that it is running smoothly and without friction.

"3 If the doctor has not all the equipment necessary to make this examination the institute proposes to furnish him with what he needs It won't be enough for your doctor to look at your tongue, take your pulse and thump your chest once or twice so it may be necessary for the institute to educate (here any doctors listening in may turn off the loud speaker) the doctors to go over the heart and lungs, the stomach, kidneys, arteries, blood, blood pressure, glands, eyes, ears, nose, throat, feet, mental pose, etc

"The doctors themselves are back of all this A Committee of 100 Doctors for every one million population and each of them has gone into his jeans for \$100 contribution Figure that out. There can be no selfish motive in it, can there—to help to keep well is not going to put anything into the doctors' pockets, is it? In fact, the doctors will give about \$600,000 To carry out this plan five million dollars is necessary, only the income of which is to be used, one-fifth of it to go to the school of Tropical Medicine in Panama, four-fifths to this personal health educational campaign

"This personal health campaign is absolutely necessary There is no machinery at present available for compelling people to be examined, so they must be taught the necessity and value of such examinations in order that once a year, twice is much better, they will come, voluntarily even, demanding an examination

"Just what old age means and whether or not you can and want to add to yours—you can only add to the end—may be a question with some of you The psalmist's allotment of three score and ten or possibly four score years is a lugubrious one and runs thus, 'The days of our years are three score years and ten and if by reason of strength they be four score yet is their strength labor and sorrow' Now that is not what we want—not to add labor and sorrow The sum of human life has already been lengthened in the last half century But another half dozen years, perhaps more and happy years, may be added in the next quarter or half century if you will only go to your doctors twice a year and insist on getting a certificate that the delicate machinery having been overhauled has been, or will be made all right. That is the aim of the Gorgas Memorial"

# BOOK REVIEWS

**ESSENTIALS OF PRESCRIPTION WRITING** By CARY EGGLESTON, M.D. Third Edition, revised. 146 pages Phila and London, W B Saunders Co, 1924 Cloth, \$1.50

In these days of intensive medicine when students and practitioners alike are so keenly interested in the rapid changes that are taking place in our knowledge of diseases, their causes, and treatment, the art of correct prescription writing seems to have been entirely neglected. The recent graduate, though properly instructed, seldom gives much time to this subject and the busy doctor likewise considers other things more important with the result that both are in a dilemma when prescribing and are at a loss to know how and in what way to prescribe so that their receipts are pharmaceutically, chemically and therapeutically accurate. In addition, little attention is given to grammatical construction. There are many books on this subject that are valuable but most are too voluminous to be practical. This present volume of Eggleston's, in its third edition, is concise and covers the essentials exceedingly well. The chapters on Latin grammar, grammatical construction or prescriptions, practical writing of prescriptions, vehicles, and incompatibility, are well worth reading. To those who wish to improve themselves in this art this little book will answer admirably.

FREDERICK SCHROEDER.

**THE ROMANCE OF A LIVING TEMPLE, A STUDY OF THE HUMAN BODY** By FREDERICK M. ROSSITER, B.S., M.D., L.C.R.P., M.R.C.S., London, Professor Medicine, College of Medical Evangelists, Los Angeles, Cal. George Sully & Co, New York, 1924

This is a most elementary treatise on human physiology. By the use of very simple language and well selected comparisons the author has succeeded in presenting his subject in a way that will insure the sustained interest of the young readers for whom the book has been written.

FRANK E. MAILLON.

**GUY PATIN, AND THE MEDICAL PROFESSION IN PARIS IN THE XVIIITH CENTURY** By FRANCIS R. PACKARD, M.D. Author of *Life and Times of Ambroise Pare*. Seventeen illustrations, nine full page plates. Paul Hoeber, Inc., New York, 1924. Price, \$4.00

Guy Patin (1601-1672) was a member of the Faculté de Médecine de Paris, and for a time the dean.

His letters of which a number of collections and editions were published after his death, were written during the period 1630-1672. As one would expect they are concerned largely with medical matters in Paris and France, but as he was not writing for publication he did not hesitate to attack men like Cardinals Richelieu and Mazarin, and organizations like the Jesuits or the Apothecaries.

His comments on physicians are at times rather cynical. Writing March 14, 1657 he says "The great are unfortunate in their physicians. The chief number of the court physicians are ignorant or charlatans, and often both the one and other." And on another occasion "I will say, to the shame of my art if doctors were only paid for the good that they actually do, they would not gain so much, but we profit from the foolishness of women, from the weakness of sick men, and from the credulity of everybody."

The book, mainly a reprint of articles that have appeared in the *Annals of Medical History*, is well printed, well made, and contains a number of illustrations, which add to its interest and value.

We can heartily indorse a statement of the author in the introduction, "that the letters give us an invaluable

picture of the life of the times, not only from the medical point of view, but in all its aspects." The letters are largely the source of the book.

IRA TRACY

**IMMUNITY IN NATURAL INFECTIOUS DISEASE** By F. D'HERELLE. Authorized English Edition by George H. Smith, Ph.D. Octavo of 399 pages Baltimore, Williams & Wilkins Company, 1924. Cloth, \$5.00

The reviewer ventures to predict that d'Herelle's work will ultimately be regarded as one of the important contributions to immunology. The present volume is one of absorbing interest, requiring careful study and proving many stimulating ideas.

This second volume from the pen of d'Herelle consists of a resume of his first work 'The Bacteriophage' with considerable new matter in which he attempts a correlation of bacteriophagy with the other phenomena of immunology. In fact, he advances a new concept of the mechanism of immunity which supplements without displacing prior conceptions. Whether or not one agrees with d'Herelle, his ideas are stimulating and the inevitable discussion of them will be valuable.

Parts 1 and 2 consist of a full discussion of the reactions of living matter and of the role of the colloids therein, and presents the author's 'micellar concept of life'. Part 3 deals with the reactions against bacteria, bacteriophagy in vitro and in vivo and the bacteriophage as a prophylactic and therapeutic agent. Part 4 presents a most interesting discussion of the ultraviruses in disease and immunity and classifies the bacteriophage with these ultra forms of life.

The reviewer is impressed with several similarities in the work and minds of Pasteur and d'Herelle. Both sailed uncharted seas, both were obliged to invent a new technique, both were seekers of facts and believers in experiments. d'Herelle's work reveals a remarkable mind and the same vivid imagination possessed by Pasteur. There is even a similarity in their literary styles.

This is the most stimulating book the reviewer has read in a long time.

E. B. SMITH

**GENERAL SYSTEMATIC BACTERIOLOGY** History, Nomenclature, Groups of Bacteria. By R. E. BUCHANAN, Ph.D. Baltimore, Williams & Wilkins Company, 1925. Octavo of 597 pages. Cloth, \$6.00 (Monographs of Systematic Bacteriology.)

This is the first of a series of monographs published under the editorial direction of the Society of American Bacteriologists. Its purpose is to present the phylogeny and relationship of various groups of bacteria and a nomenclature upon which all can agree. The author gives all the important classifications from 1773 to 1922, various codes of nomenclature and finally an alphabetical list of bacteria with proper names and descriptions. This work by Buchanan and a previous one by Bergey are useful in bringing order to a branch of science where everyone has proposed his own classification.

E. B. SMITH.

**A TREATISE OF INFLUENZA**, with special reference to the Pandemic of 1918. By RAJENDRA KUMAR SEN, Medical Officer, Hurmatty Tea Co., Ltd., Assam. John Bale, Sons & Danielsson, Ltd., Oxford House London W. I. 1923

This treatise on influenza is well worth reading. The author a native of India, has made a careful study of the disease especially as it appeared in India in 1918, and in addition has read extensively on the subject. He gives a history of the various outbreaks and then logically presents the results of his personal experience.

comment on the relation of cross-word puzzles to mental health, and quotes a pamphlet issued by the Chicago Department of Health in which the puzzles are called the "Mental Daily Dozen"

The quotation reads

"In the pamphlet, 'Chicago's Health,' issued by the Chicago Health Department, crossword puzzles are termed the 'mental daily dozen' The pamphlet explains 'Health of mind is of as much consequence to happiness as is health of body A rational cycle of work, study, relaxation and amusement is essential to the health of mind To solve a crossword puzzle requires mental alertness, concentration and strict application to order and rules Moreover, it's great fun Activity is increased under the influence of pleasant feelings, giving a stronger heart beat, stirring the glands to better performance and invigorating the organs of the body' All of which is something for the cross-word skeptics to put in their pipes and smoke"

The health effects of another popular fad are discussed in the March 9th issue of the New York *Sun* by Dr Harris of the Brooklyn State Hospital, who said

"Radio may be one of the causes for the overstrained condition of persons today Emotional intensity, which is created by a number of elements which characterize our civilization, in some minds may be brought to too great a pitch They may then be snapped by static"

On the other hand, Dr Blaisdell, Assistant Superintendent of the Kings Park State Hospital, is quoted as saying

"We have installed radio in some of our wards with very great success People who have enough mind and enough attention to be interested in their surroundings find in radio a link which connects them with the world beyond the walls which must confine them

"Our people are chiefly interested in music They will tune in on orchestral selections much more often than they will on speeches Music is soothing and beneficial for the disordered mind

"The wards in which the receiving instruments have been installed have patients who have received occupational therapy and habit training so that no scientific statement can be made as to the exact effect of radio I am of the opinion that it is generally beneficial and that only in extreme cases does the static really shock the listener"

It is the opinion of the editor that the *Sun* reporter was short on news when he quoted the two doctors

The *Utica Press*, March 20th, has a half column article on the three principal measurements of advancement or backwardness of a community, and enumerates them as follows

- 1 Hours of labor
- 2 Requirements as to school attendance.
- 3 Death rate

The article discusses each as follows

"In this country half a century ago a day's work comprised at least twelve hours, and in some occupations more In those days it was impossible apparently to get the world's work done unless everybody worked a dozen hours each day

"Half a century ago, also, few could send their children to school after they were eight or ten years of age They might have the desire to do better by their children, but they could not afford it Now a child must go to school in this state until he is 16, which goes to show that the parents are more prosperous than formerly and have perhaps a higher appreciation of the value of education

"As to the death rate, it is much lower than formerly, and individuals live longer Dr William H Guilfooy, registrar of records in New York City Health Department, who began this week his 41st year of service, has seen the death rate in New York drop from 25 per 1,000 to 11.6 per 1,000 in his forty years in the department"

These yardsticks are as reliable as any of a dozen others that might be used

The Brooklyn *Eagle*, March 21st, describes a hearing on water pollution held in Riverhead on March 20th, by Dr Matthias Nicoll, Jr, State Commissioner of Health, during which the authorities of the villages that sewer into the coastal water agreed to install modern disposal plants Some of the critics of the Department of Health brought up the point that most of the pollution off shore came from the fleet of war vessels which frequent Gardiner's Bay The government could keep the fleet away from Gardiner's Island, and then the shopkeepers of Greenport would have a grievance

The City of New Rochelle has attempted to prevent water pollution by houseboats, according to the March 16th issue of the New Rochelle *Star*, which says

"As to the yachts and houseboats, of which the various civic bodies have complained because of the garbage, refuse and offal cast in their vicinity upon the waters of the bay, the Board of Health adopted rules providing that the boats must henceforth be provided with sanitary facilities, probably by the use of septic tanks or similar devices, to prevent further possible pollution In this connection, it may be noted that only last week the owner of a houseboat mentioned in the office of the building department that he is installing a septic tank and that most of his colleagues on the bay are doing likewise"

# BOOK REVIEWS

**ESSENTIALS OF PRESCRIPTION WRITING** By CARY EGGLESTON, M.D. Third Edition, revised 146 pages Phila and London, W B Saunders Co, 1924 Cloth, \$1.50

In these days of intensive medicine when students and practitioners alike are so keenly interested in the rapid changes that are taking place in our knowledge of diseases, their causes, and treatment, the art of correct prescription writing seems to have been entirely neglected. The recent graduate, though properly instructed, seldom gives much time to this subject and the busy doctor likewise considers other things more important with the result that both are in a dilemma when prescribing and are at a loss to know how and in what way to prescribe so that their recipe is pharmaceutically, chemically and therapeutically accurate. In addition, little attention is given to grammatical construction. There are many books on this subject that are valuable but most are too voluminous to be practical. This present volume of Eggleston's, in its third edition, is concise and covers the essentials exceedingly well. The chapters on Latin grammar, grammatical construction of prescriptions, practical writing of prescriptions, vehicles, and incompatibility, are well worth reading. To those who wish to improve themselves in this art this little book will answer admirably.

FREDERICK SCHROEDER.

**THE ROMANCE OF A LIVING TEMPLE, A STUDY OF THE HUMAN BODY** By FREDERICK M. ROSSITER, B.S., M.D., L.C.R.P., M.R.C.S., London, Professor Medicine, College of Medical Evangelists, Los Angeles, Cal George Sully & Co, New York, 1924

This is a most elementary treatise on human physiology. By the use of very simple language and well selected comparisons the author has succeeded in presenting his subject in a way that will insure the sustained interest of the young readers for whom the book has been written.

FRANK E. MALLON

**GUY PATIN, AND THE MEDICAL PROFESSION IN PARIS IN THE XVIIth CENTURY** By FRANCIS R. PACKARD, M.D. Author of *Life and Times of Ambroise Pare*. Seventeen illustrations, nine full page plates. Paul Hoeber, Inc., New York, 1924 Price, \$4.00

Guy Patin (1601-1672) was a member of the Faculté de Médecine de Paris, and for a time the dean.

His letters of which a number of collections and editions were published after his death, were written during the period 1630-1672. As one would expect they are concerned largely with medical matters in Paris and France, but as he was not writing for publication he did not hesitate to attack men like Cardinals Richelieu and Mazarin, and organizations like the Jesuits or the Apothecaries.

His comments on physicians are at times rather cynical. Writing March 14, 1657, he says "The great are unfortunate in their physicians. The chief number of the court physicians are ignorant or charlatans, and often both the one and other." And on another occasion "I will say, to the shame of my art if doctors were only paid for the good that they actually do, they would not gain so much, but we profit from the foolishness of women, from the weakness of sick men, and from the credulity of everybody."

The book, mainly a reprint of articles that have appeared in the *Annals of Medical History*, is well printed, well made, and contains a number of illustrations, which add to its interest and value.

We can heartily indorse a statement of the author in the introduction, "that the letters give us an invaluable

picture of the life of the times, not only from the medical point of view, but in all its aspects." The letters are largely the source of the book.

IRA TRACY

**IMMUNITY IN NATURAL INFECTIOUS DISEASE**. By F. d'HERELLE. Authorized English Edition by George H. Smith, Ph.D. Octavo of 399 pages Baltimore, Williams & Wilkins Company, 1924 Cloth, \$5.00

The reviewer ventures to predict that d'Herelle's work will ultimately be regarded as one of the important contributions to immunology. The present volume is one of absorbing interest, requiring careful study and provoking many stimulating ideas.

This second volume from the pen of d'Herelle consists of a resume of his first work "The Bacteriophage" with considerable new matter in which he attempts a correlation of bacteriophagy with the other phenomena of immunology. In fact, he advances a new concept of the mechanism of immunity which supplements without displacing prior conceptions. Whether or not one agrees with d'Herelle, his ideas are stimulating and the inevitable discussion of them will be valuable.

Parts 1 and 2 consist of a full discussion of the reactions of living matter and of the role of the colloids therein, and presents the author's "micellar concept of life." Part 3 deals with the reactions against bacteria, bacteriophagy in vitro and in vivo and the bacteriophage as a prophylactic and therapeutic agent. Part 4 presents a most interesting discussion of the ultraviruses in disease and immunity and classifies the bacteriophage with these ultra forms of life.

The reviewer is impressed with several similarities in the work and minds of Pasteur and d'Herelle. Both sailed uncharted seas, both were obliged to invent a new technique, both were seekers of facts and believers in experiments. d'Herelle's work reveals a remarkable mind and the same vivid imagination possessed by Pasteur. There is even a similarity in their literary styles.

This is the most stimulating book the reviewer has read in a long time.

E. B. SMITH

**GENERAL SYSTEMATIC BACTERIOLOGY** History, Nomenclature, Groups of Bacteria. By R. E. BUCHANAN, Ph.D. Baltimore, Williams & Wilkins Company, 1925 Octavo of 597 pages Cloth, \$6.00 (Monographs of Systematic Bacteriology)

This is the first of a series of monographs published under the editorial direction of the Society of American Bacteriologists. Its purpose is to present the phylogeny and relationship of various groups of bacteria and a nomenclature upon which all can agree. The author gives all the important classifications from 1773 to 1922, various codes of nomenclature and finally an alphabetical list of bacteria with proper names and descriptions. This work by Buchanan and a previous one by Bergey are useful in bringing order to a branch of science where everyone has proposed his own classification.

E. B. SMITH

**A TREATISE ON INFLUENZA**, with special reference to the Pandemic of 1918. By RAJENDRA KUMAR SEN, Medical Officer, Hurmatty Tea Co., Ltd., Assam. John Bale, Sons & Danielsson, Ltd., Oxford House London W. I. 1923

This treatise on influenza is well worth reading. The author a native of India, has made a careful study of the disease especially as it appeared in India in 1918, and in addition has read extensively on the subject. He gives a history of the various outbreaks and then logically presents the results of his personal experience.

and his wide reading. The book is accurate, concise, inclusive and thorough. The chapter on symptoms presents the clinical features of the disease more completely and fully than many other papers. Treatment has been well presented. No one can study this treatise without being benefited by it. HENRY M. MOSES

A WOMAN'S QUEST, THE LIFE OF MARIE E. ZAKRZEWSKA, M.D., edited by AGNES C. VIETOR, M.D., F.A.S.C. D. Appleton and Co., New York, 1924 \$3 00

This volume contains the life history of Marie Zakrzeska, one of the first women to receive a Medical degree in America.

She was born in Berlin of Polish parents. At the age of ten an eye affection made hospital care necessary. Her physician led her blindfolded on his visits through the wards and the patients called her "The little blind doctor." When her eyes recovered she asked the doctor to give her books on history to read. He gave her the History of Surgery and of Midwifery—two big volumes. Although but eleven years of age she read them through and determined then that she would be a doctor, although she had never heard of a woman becoming one. With this inkling of how this woman was led to enter upon the study of medicine we launch into a fascinating account of the life history of this pioneer woman physician. The story of her life is an example of the difficulties encountered and the prejudice met and overcome in large measure by all the women who first entered the Profession of Medicine. It is a most thrilling story of an eventful life with which is interwoven the evolution of the American Woman Physician written by one of her hospital internes, whom she chose before her death to write it and to whom she left her letters and manuscript for the purpose.

ELIZA M. MOSHER

EYE HAZARDS IN INDUSTRIAL OCCUPATIONS, LOUIS RESNICK and LEWIS H. CARRIS, published by The National Committee for the Prevention of Blindness, Inc., 130 East 22nd St., New York City, 1924. Price \$1.50 and \$2 50

This volume of 211 pages will be read with interest and profit by Ophthalmologists, as well as employers of labor, everywhere. The need for uniformity of statistics regarding industrial eye injuries is stressed and emphasis is placed upon making the wearing of goggles compulsory in plants where there is an eye hazard. As was to have been expected, the investigation reported upon, shows that the metal industries show a greater incidence of eye injuries than do any of the others. The necessity of proper guards for machinery and of proper illumination of industrial plants in the prevention of accidents is pointed out.

A chapter on the correction of defective vision bears testimony to the fact that, in plants where employees are regularly submitted to examination regarding their vision and defects corrected, the occurrence of industrial injuries is diminished.

Education, of the State as to its moral and economic obligations, of the employer as to the desirability of supplying adequate protection for the eyes of his employees, and education of the employee as to the necessity of using that protection when it is provided, these, it is pointed out offer the greatest possibilities for the elimination of unnecessary eye hazards in industry.

Occupational diseases affecting the eyes are considered at length. JOSEPH E. GOLDING.

ANATOMY OF THE HUMAN BODY By HENRY GRAY, F.R.S. Twenty-first Edition, thoroughly revised and re-edited by WARREN H. LEWIS, B.S., M.D. Octavo, 1417 pages, 1283 illustrations. Phila. and New York, Lea & Febiger, 1924. Cloth, \$10 00

The first edition of Gray's Anatomy appeared in 1858, no doubt in the first review the concise language and clearness of description were deemed worthy of comment. And this is just as true of the 21st edition which is now presented after an interval of six years and has again been revised and re-edited by Professor Lewis. There is some new material and many new illustrations including striking reproductions of photographs. A change in the order of presentation of the subject matter in each section is noted, the embryology now being given in advance of the microscopical anatomy. The use of the B.N.A. nomenclature in English together with the English synonym has been retained practically unchanged. The references to the literature at the end of each section are more numerous.

Considerable material has been added to the sections on General Embryology and Angiology and the reproductions of reconstructions of the developing aortic and pulmonary arches are noteworthy. The description of the architecture of the heart muscle has been enlarged and the sino-atrial node is now described in connection with the muscular structure of the sinus venosus and atrium and it is no longer described as connected up by Bundle of His fibres with the atrio-ventricular node, thus conforming to Tawara's original contribution.

The section on Splanchnology which includes the Ductless Glands and the Chromophil and Cortical Systems, has been brought up to date. In the anatomy of the Nervous System there are new figures but no great amount of alteration of the subject matter of the text is noted. The triangles of the neck are now included in the section on Surface Anatomy and Surface Markings and less importance is attached to them than in former editions, new material based upon cross sections of the extremities has been added to this section.

The influence of the language of Henry Gray upon the English speaking medical mind can never be estimated. What better introduction to the new world of medical science can there be for the first year student? We can continue to recommend Gray's Anatomy to them with as little hesitancy as in the past.

JAMES L. COBB.

THE ERRORS OF ACCOMMODATION AND REFRACTION OF THE EYE AND THEIR TREATMENT, A Handbook for Students By ERNEST CLARKE, M.D., F.R.C.S., Consulting Surgeon Central London Ophthalmic Hospital. Fifth Edition. William Wood and Co., New York, 1924. Price \$3 50

The matter and method of presentation of this admirable little book lives up to its title very well.

The explanations and descriptions are clear and very much to the point. The work is accurate and trustworthy in all respects.

The diagrams and plates generally are good, and particularly interesting is the one the author has reproduced describing the optics of retinoscopy.

It is gratifying to note that such a work has been so successfully used in teaching undergraduates in general medicine in the English schools. This is the more pleasing because it seems to the reviewer that Ophthalmology, and particularly refraction, is given more attention by the general practitioner than in this country where such a work could scarcely be used on account of the limited time assigned for the entire subject of Ophthalmology. It is hoped that our English brothers do not sacrifice the medical aspects for the sake of the optical studies in so important a subject to the man who needs a good general understanding of the eye and its diseases. JOHN N. EVANS

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 13

NEW YORK, N Y

APRIL 10, 1925

## THE DIAGNOSIS OF ACUTE SURGICAL DISEASES OF THE ABDOMEN \*

By HENRY ROTH, M.D., F.A.C.S.,

NEW YORK, N Y

THE responsibility of the physician is never as great as when he is confronted with an acute intraabdominal condition in which the question must be answered whether or not the patient requires an immediate operation. An exact diagnosis may be very difficult and in some of the rarer conditions may even be impossible. It is sufficient, however, if we can determine that we are dealing with a serious intraabdominal emergency which demands immediate operation. Owing to the very grave condition in which many of the patients are found, the risk of an operation is very great, and therefore our responsibility is so much greater. We are liable to adverse criticism whether we try to be conservative and advise an operation too late, or whether we occasionally resort to an operation which subsequently proves to have been unnecessary. In spite of the fact that this subject has been dealt with on many occasions, the mortality rate of acute intraabdominal conditions is still very high. This to a great extent is due to the fact that many of the patients are operated upon too late, or after too long a period of time has been allowed to elapse between the onset of the symptoms and the time of operation. This, undoubtedly, is due to the difficulties met with in diagnosis, and while it would seem as if everything worth while has been said, there is still very much which can be learned from a further consideration of the subject. With this in mind I will endeavor to discuss some of the most important factors in the diagnosis of the acute non-traumatic intraabdominal conditions. The diseases which belong under this heading are many and varied. Many of them occur as acute emergencies in connection with pre-existing chronic diseases, such as gastric and duodenal ulcers, gallstone disease, and tumors of the gastrointestinal tract and the female generative organs. In another group of cases the acute condition is due to some obstruction in the intestinal canal. In a smaller group the cause of the emergency

is bleeding into the peritoneal cavity, and in a still smaller class the emergency is due to torsion of structures with consequent circulatory disturbances.

In all of these conditions severe abdominal pain is the first and foremost symptom. This is soon followed by tenderness, rigidity and vomiting. The appearance of this combination of symptoms and signs is indicative of a serious intraabdominal condition. In attempting to make an exact diagnosis nothing will be of greater value than a carefully taken clinical history and its logical interpretation. In many instances the history alone may point to the correct diagnosis, but in every case the history should be supplemented with a careful physical examination. To discuss the significance and importance of all the various symptoms and signs as related to the diagnosis of all the various intraabdominal conditions requires more time than we have at our disposal. I will, therefore, limit my remarks to those conditions which are most frequently met with in our every day practice.

Experience has shown that of all the acute intraabdominal conditions, acute appendicitis is the most common disease. Acute cholecystitis comes next in frequency. Then follow cases of acute perforations of chronic duodenal and gastric ulcers, the various forms of acute intestinal obstruction, ruptured extrauterine pregnancy, and acute infections and torsions of the female generative organs. The more uncommon diseases which we have to bear in mind are acute pancreatitis, mesenteric thrombosis, mesenteric adenitis, pneumococcus peritonitis, acute tuberculous peritonitis and acute sigmoid diverticulitis. Owing to the fact that pain, tenderness, rigidity and vomiting are present in most of the acute intraabdominal diseases, an exact diagnosis is often very difficult, but by a process of elimination can usually be made in most instances, providing the various conditions are ever borne in mind. In this process of elimination many factors have to be considered. In most of the conditions there is some outstanding feature in the history or

\* Read before the Bronx County Medical Society November 19, 1924.

some outstanding symptom or sign which points more definitely to some one particular disease. It is this outstanding feature which directs our attention to the most likely condition which may be confronting us. The age and sex of the patient and the relative frequency of the various conditions occurring at different ages and in the two sexes are of great importance. For instance, if the patient is an infant under one year of age, the most likely condition causing the above symptoms will be an acute intussusception. If the child is over two years of age the most likely conditions which we have to consider are acute appendicitis, pneumococcus peritonitis and acute pyelitis, the latter being more common in female children. In a young man or young woman acute appendicitis is more apt to be present than acute cholecystitis or acute Meckel's diverticulitis, the latter condition being extremely rare. Acute cholecystitis is more likely to be present if the patient is a married woman, especially if she has borne children and is stout, and if the first attack occurs soon after childbirth. Acute sigmoid diverticulitis usually occurs in individuals past middle age who are very stout, whereas attacks of Dietl's crises are more common in younger women who are very thin. In very young girls an acute pelvic infection is less likely to be present than torsions of an ovarian cyst pedicle. Some menstrual irregularity in a woman during the child-bearing period should strongly suggest the possibility of a ruptured extrauterine pregnancy.

The character of the pain often helps in making a differential diagnosis. If the pain is of a paroxysmal character, renal, biliary and intestinal colic have to be considered rather than an acute infection or perforation.

If the patient is a married woman and especially if she has just given birth to a child, the colic is more apt to be of a biliary nature than due to an acute intestinal obstruction or to an obstruction in the ureter, especially if the pain radiates to the back or right shoulder. If the pain radiates towards the groins or genitals and especially if it is associated with some urinary symptoms, a diagnosis of renal colic is more apt to be right than one of biliary colic or intestinal obstruction. If with the above symptoms there is a history of a preceding abdominal operation, or of a preceding pelvic inflammation, acute intestinal obstruction due to strangulation by bands, or angulation due to adhesions, is the most likely condition present. In women, a strangulated femoral hernia is very often the cause of the acute obstruction, even though it appears only as a very small lump in the groin, not unlike an enlarged lymph node. Such a small lump in the groin in a patient with symptoms suggestive of an acute intestinal obstruction should always be looked upon as a strangulated femoral hernia until it is proven to be otherwise. If the patient is past

middle age, and especially if there is a history of preceding mild attacks of colic, the intestinal obstruction is very often due to an annular constriction of the colon, caused by a malignant neoplasm. This condition, however, is not infrequently seen even among young individuals. The presence of a hernia should also suggest the possibility of an acute torsion of the omentum as the cause of the symptoms. Nor should we forget that the above symptoms with a very painful lump, in the groin of a boy, may be indicative of an acute torsion of the spermatic cord.

A history of indigestion and pain after eating may be helpful in promptly recognizing an acute perforation of a chronic duodenal ulcer because of its greater frequency. If the patient gives a history suggestive of cholelithiasis, acute hemorrhagic pancreatitis must always be thought of, especially if the illness began with the manifestations of shock, and there is marked distention in the epigastric region. If the patient has a valvular lesion of the heart, the possibility of a mesenteric thrombosis must not be forgotten. During epidemics of influenza it is of the utmost importance to bear in mind that this condition is at times associated with abdominal pain, tenderness and vomiting. The presence of echymotic spots on the skin should immediately suggest the possibility of Henoch's purpura. A history of hemophilia should prevent the mistaking of a retroperitoneal blood clot for an appendiceal abscess. In our attempt to make an exact diagnosis, the comparative frequency of the various conditions should always be considered. Acute intussusception is the most common variety of intestinal obstruction occurring in infants and very young children. Intestinal obstruction caused by bands and by new growths occur much more frequently than obstructions caused by a volvulus of the sigmoid. Torsion of the omentum and of the spermatic cord are very rare, whereas torsion of an ovarian cyst pedicle is not quite so rare. Acute pelvic infections are more common than ruptured extrauterine pregnancies. Acute appendicitis and pneumococcus peritonitis are the most common acute intraabdominal conditions found in children.

In my experience almost seventy-five per cent of the operations done for acute intraabdominal conditions were for acute appendicitis. It will, therefore, be advisable to devote most of our attention to the diagnosis of this, still the most important of all acute intraabdominal diseases. It occurs at all periods of life, but is rare in infants. The clinical picture of the disease has been so often presented and is so well known that it would seem like a waste of time to say anything further about it. Yet many cases of acute appendicitis still go unrecognized for some time after the onset of pain, and on the other



hand, the diagnosis of acute appendicitis is often made when some other condition exists. This, undoubtedly, is due to the fact that some of the cases do not strictly conform to the classical type, or because the symptoms and signs are inaccurately interpreted. Acute appendicitis usually begins abruptly with severe pain in the abdomen. If pain is not the first symptom to appear, one should hesitate about making a diagnosis of acute appendicitis. Vomiting occurs in most of the cases soon after the appearance of the pain and is usually repeated. There is a rise in the pulse rate which is soon followed by some rise in the temperature. The temperature may or may not be preceded by a chill. When a chill occurs it usually signifies gangrene. There is usually an increase in the number of white blood cells. While I fully realize its value and always insist upon a complete white cell count as a part of a complete physical examination, I do not rely upon it to the exclusion of other symptoms or signs. If it is confirmatory of the other clinical signs it is considered for what it is worth, but it is rarely the deciding factor in the diagnosis. This attitude is due to the fact that a low blood count does not necessarily indicate the absence of pus any more than that a high leucocyte count always points to a serious infection. It is a very dangerous practice to delay diagnosis and operation for blood counts.

Tenderness and rigidity of the abdominal wall being the most significant of the physical signs, it is of great importance that all possible care be taken in eliciting these signs. Palpation should be gentle, because rough pressing and squeezing will cause pain and produce voluntary rigidity in any case. It is important that superficial hyperesthesia be not mistaken for real tenderness. Palpation should begin at a point remote from the suspected area. In suspected acute appendicitis, I always begin with palpation over the left iliac fossa. I then proceed upward on the left side, then palpate the epigastric and right hypochondriac regions, and lastly palpate over the right iliac fossa. The fingers can often be pressed in deeper and deeper during expiration, thus enabling the examining fingers to feel an exudate, if one is present. Rigidity is always most pronounced over the primary lesion. If the appendix is in the right iliac fossa, rigidity is most marked in this area. When the appendix is in the pelvis, the rigidity is usually most pronounced near and to the right of the median line, or just above the pubis. When marked rigidity is also found over the left iliac fossa, the pelvic fluid exudate has very likely overflowed the pelvic brim and is spreading into the left iliac fossa. If tenderness and rigidity are most marked in the right flank, the appendix is most likely behind or to the outer side of the ascending colon. When, as a result

of perforation or gangrene, peritonitis becomes diffuse, tenderness and rigidity spread toward the left side and gradually extend over the entire abdomen. The latter condition is greatly favored by the very prevalent practice of giving purgatives with the onset of the abdominal pain. Indeed, many surgeons ascribe the high mortality of acute appendicitis as much to the giving of purgatives as to delay in operating, because purgation favors perforation and gangrene and because by increasing peristalsis it spreads the infection.

The diagnosis of acute appendicitis is more difficult in children, especially in those under five years of age, because of their inability to describe their symptoms and because of the difficulty of making a satisfactory examination and also because of the frequency with which children complain of abdominal pain in connection with other diseases. This is especially the case in acute inflammatory conditions of the pleura and lungs, in which the pain is referred from the chest along branches of the lower intercostal nerves. It is of the utmost importance that pneumonia and pleurisy be excluded so as to avoid an unnecessary operation, with its grave risks from the anæsthetic. On the other hand, it is even more important that so serious a condition as acute appendicitis be not overlooked. In cases of pleurisy or pneumonia the tenderness is superficial and the palpating hand will meet with less and less resistance as the examination proceeds. The abdominal wall relaxes because there is no real tenderness present. Because of the delay in the appearance of physical signs, the most reliable method for the exclusion of pneumonia in these cases is an X-ray examination of the chest, which can be done without much delay, and with absolute freedom from all risk. A child with acute appendicitis usually cries constantly and is not apt to fall asleep for any length of time, whereas a child with pneumonia is often asleep for long periods of time, has a flushed face, a high temperature, higher leucocytosis and looks extremely ill.

Palpation in children must often be done under great difficulties, because children often resist all attempts at examination. It frequently has to be done during the very brief periods of rest from crying. I always attempt to win the child's confidence before I begin abdominal palpation, and try not to restrain its movements in any way, leaving the hands free, preferably alongside the body. I then proceed with palpation. If the child makes no attempt with its hands to guard its abdomen or to push away my examining hand, I feel quite confident that the child has no intraperitoneal inflammation. The failure on the part of the child to protect its abdomen against the examining hand is to my mind one of the most valuable signs indicative of the absence of an

acute intraperitoneal inflammation I have learned to rely upon this sign in children more than upon any other single sign or symptom. It has been more helpful than any other sign in determining the absence of acute appendicitis in children. Palpation should always be supplemented with a rectal examination, because of the valuable information which it may furnish in the absence of other reliable physical signs. Of the many conditions which may simulate acute appendicitis in children, pneumococcus peritonitis is the most important.

The diagnosis of pneumococcus peritonitis presents many difficulties. The condition usually occurs in young children, and in girls more frequently than in boys. Often there is a history of diarrhoea preceding the appearance of abdominal pain. In addition to pain there are present all the usual symptoms and signs of peritonitis, such as tenderness, rigidity and vomiting. There is a marked rise in the temperature, it may reach as high as  $105^{\circ}$  F, with a corresponding rise in the pulse rate. Leucocytosis is much higher than in acute appendicitis. There is marked prostration and toxemia, such as is seen in pneumonia. The constitutional symptoms as a rule overshadow the abdominal signs. Most of the cases occur independent of any lung involvement. If the patient survives the acute stage of the disease and the peritoneal exudate becomes encapsulated, an indefinite doughy tumor mass may be felt in some part of the abdomen. The mistake which is most likely to be made is that a pneumococcus peritonitis is mistaken for acute appendicitis. In differentiating acute pneumococcus peritonitis from other acute intraabdominal conditions, exploratory aspiration of the abdominal cavity with a specially constructed needle and examination of a smear from the aspirated fluid may furnish valuable information regarding the particular organism which is causing the infection.

The conditions which are most apt to simulate acute appendicitis in children besides pneumonia and pleurisy and pneumococcus peritonitis, are mesenteric adenitis, Henoch's purpura and acute throat infections, acute pastro-enteritis with or without acute acidosis, influenza with abdominal symptoms, acute pyelitis, infections of the iliac and inguinal lymph glands, acute Meckel's diverticulitis, stone in the bladder, ovarian cyst or tubular infections in little girls, and torsion of the spermatic cord in boys. Acute infections of the gall bladder and acute perforations of chronic gastric and duodenal ulcers are extremely rare in children. As a matter of fact, in children past infancy, acute appendicitis is the commonest acute intraabdominal condition requiring surgical treatment. Acute appendicitis in adults may be simulated by almost every one of the conditions mentioned above, and by many others, such as acute pancreatitis, acute sigmoid diverticulitis, biliary

renal or ureteral colic, acute hematogenous septic infarctions of the kidney, Dietl's crises, acute intestinal obstruction, torsion of the omentum, lead colic, the abdominal crises of locomotor ataxia, and even typhoid fever and malaria have been known to simulate acute appendicitis.

After acute appendicitis, acute infection of the gall bladder comes next in importance. Biliary colic occurs very often. Acute perforation of the gall bladder is extremely rare. As stated above, acute cholecystitis is very rare in children. The history often reveals the fact that the patient had typhoid fever at some time in the past. A woman may state that her first colic occurred soon after childbirth or during pregnancy. There may be a history of chronic indigestion, eructations of gas, flatulence and biliousness. A very valuable part of the history is the statement that many of the attacks of so-called indigestion have come on during the night, waking the patient from her sleep.

As in acute appendicitis, so also in acute cholecystitis, pain is the outstanding symptom. The pain of biliary colic starts abruptly in the upper part of the abdomen, shoots through to the back and radiates to the chest, or right scapular region. It is usually very severe and agonizing, and may induce collapse. It may stop as abruptly as it started, but usually recurs in paroxysms. It may last from a few minutes to many hours, and be followed by pain of less severity, localized to the right hypochondriac region. So-called biliary colic may occur even in cholecystitis without calculi. Tenderness is not as constant a symptom as pain. It is most marked in acute infection, and its maximum point of intensity corresponds to a point slightly to the left and below the junction of the right ninth rib and its cartilage. It may be present all over the right hypochondriac and epigastric regions. With pain and tenderness there is usually rigidity of the upper part of the right rectus muscle, the extent and degree depending upon the degree of inflammation. It may be diffuse in the earliest stages of infection, and then become more localized, and be most marked in the region of the gall-bladder. It is most pronounced in the severe forms of acute cholecystitis, with diffuse peritonitis. With the onset of acute cholecystitis the temperature may reach  $101^{\circ}$  or  $102^{\circ}$  F, in suppurating and gangrenous cholecystitis it may be preceded by a chill and reach as high as  $103^{\circ}$  to  $105^{\circ}$  F, although it may be but slightly above normal even though the gall bladder be filled with pus. There is a corresponding rise in the pulse rate and hyperleucocytosis. Nausea or vomiting is present with biliary colic, which it often relieves. Vomiting may be present at the onset of acute cholecystitis, and is then usually the result of reflex irritation. A swelling or tumor may be present if the gall bladder is markedly distended, and it may even

attain a very large size and extend down into the right iliac fossa. It is usually pear shaped, continuous with the edge of the liver, and moves with respiration. In very thin patients it may be visible and movable from side to side. In some cases of acute cholecystitis a tumor cannot be felt either because the swelling extends inward and backward under the liver, or because tenderness and rigidity interfere with satisfactory palpation. There may be a tongue-like projection of the liver, known as Riedel's lobe. In acute cholecystitis, jaundice is only present if the infection spreads to the common or to the hepatic ducts. When a complicating cholangitis is present, jaundice is very pronounced. When the common duct is completely and acutely obstructed by a stone, jaundice is very pronounced and constant. The temperature usually shows an abrupt rise to a high degree,  $105^{\circ}$  to  $107^{\circ}$  F, preceded by a chill, associated with profuse sweating, and followed by a marked drop to normal or subnormal. These exacerbations recur at varying intervals, and may continue for several weeks. With the rise in the temperature there is a corresponding rise in the pulse rate and leucocytosis, and other evidence of a general systemic infection. The gall bladder in these cases is usually contracted, therefore a palpable tumor is not present. The stools are clay colored and the urine contains bile pigment.

Biliary colic and acute cholecystitis may be simulated by acute appendicitis and also by the various conditions which have been mentioned as being likely to simulate acute appendicitis. Acute cholecystitis is especially apt to be simulated by acute appendicitis if the appendix or some part of it is situated high up under the liver, but in acute appendicitis the initial pain as a rule does not radiate to the back or to the right shoulder, tenderness and rigidity are at a lower level, while in acute cholecystitis they are most pronounced over the upper part of the right rectus muscle, even if the gall bladder is very much below its usual level. Acute appendicitis is always associated with a rise in the temperature, while in acute biliary colic, which does not go on to cholecystitis, there is no systemic disturbance. In fact, acute appendicitis, as a rule, is associated with more marked constitutional disturbances than acute cholecystitis, unless the latter be of the gangrenous or perforating variety. In renal colic which occasionally simulates biliary colic, tenderness is usually most pronounced in the costovertebral space. There is also pain on fist percussion, the so-called Murphy sign. With Dietl's crises a movable kidney may be palpable, and there may be some urinary symptom. In considering the possibility of the pain being due to the gastric crises of tabes, it is well to bear in mind that even a tabetic patient may have gall stones or acute appendicitis.

Acute cholecystitis may be simulated by acute pancreatitis. Both conditions occur in the same type of patients. In fact, acute pancreatitis usually occurs in patients who have gall bladder disease. It is, therefore, more common in women than in men, and in stout people more so than in the thin. The attack begins with excruciating pain in the upper part of the abdomen, radiating to the back. With the onset of pain the general condition of the patient becomes very bad, the pulse rate is rapid and feeble, the extremities are cold and the skin is clammy and cyanosed. There is very marked rigidity in the upper part of the abdomen, which develops promptly with the onset of pain. There is usually great distention, which is especially marked in the epigastric region. There is vomiting from the very beginning and hiccough is apt to occur as in all cases of peritonitis. The diagnosis is but rarely made before operation.

Acute perforation of a chronic duodenal or gastric ulcer may occur at any age and in either sex, although it is more common in men in the prime of life. In many of the cases there may be no history of any pre-existing symptoms. Sudden perforation into the free peritoneal cavity is one of the most serious surgical emergencies and, therefore, in the presence of the symptoms and signs of an acute perforative peritonitis, the possibility of an acute perforation of a chronic ulcer of the duodenum or stomach must always be considered. This is very important to bear in mind so as to avoid overlooking a condition which is so easily remedied by an early and appropriate operation. The diagnosis of this condition is made with much greater ease during the earliest hours after the perforation, and may be impossible if the patient is seen at a later stage, when symptoms of a diffuse or generalized peritonitis have developed. A diagnosis may be very difficult or impossible if the symptoms and signs are masked by the injudicious administration of morphine, which has the effect not only of distorting the clinical picture, but of causing seeming improvement in the general condition of the patient.

The outstanding symptoms and signs of perforation are pain, tenderness and rigidity of the abdominal wall. The rigidity is general and complete, but is usually most marked in the upper part of the abdomen in the region overlying the ulcer. It is board-like in character and in the beginning produces retraction of the abdominal wall. If the patient is seen a number of hours after the beginning of the illness, pain, tenderness and rigidity will be very marked in the region of the appendix, on account of the gravitation of septic material into the right iliac fossa. At this time there may be a diminution in liver dullness and on percussion the signs of fluid may be demonstrable in the right flank. Acute per-

foration of a duodenal or gastric ulcer may be simulated by any one of the acute intraabdominal conditions, and even by a beginning pneumonia or pleurisy of the diaphragmatic type. It has been mistaken most frequently for acute appendicitis. In fact, some of the earliest reported cases were only discovered during operations for supposed acute appendicitis. If seen early, acute perforation of an ulcer may be and is now very frequently diagnosed before operation. The initial pain of acute perforation is very much more severe than that of acute appendicitis. It begins more abruptly and the rigidity and tenderness are more pronounced in the upper abdomen, more so than in acute appendicitis. Furthermore, the rigidity in cases of acute appendicitis is not quite as marked or board-like in character, unless the appendiceal infection is exceptionally virulent. As a rule the symptoms and signs of diffuse peritonitis develop much more rapidly in acutely perforated ulcers than in acute appendicitis, because septic material escapes more quickly and in larger quantities through the perforation. Acute inflammation of a Meckel's diverticulum does not, as a rule, begin with such agonizing pain, nor is the rigidity so marked in the epigastric region. Furthermore, the condition is very rare as compared with acute perforation of duodenal or gastric ulcers.

Acute intussusception forms about one-third of all varieties of acute intestinal obstruction. Most of the patients are under twelve months of age. In infants it is attended by a characteristic chain of symptoms which should lead to an early diagnosis and prompt and appropriate treatment. The disease usually begins suddenly in previously perfectly healthy infants. The first and foremost symptom is pain, which is usually colicky in nature. The child screams and draws up its legs with each paroxysm. With the onset of pain there is a marked change in the general appearance of the little patient, characterized by the various manifestations of shock, such as an anxious expression of the face, pale skin, rapid and feeble pulse, cold perspiration, and shallow breathing. In fact, the patient presents the appearance of one who is very ill. This is of very great diagnostic value, because acute intussusception usually occurs in children who only a few hours before presented the picture of perfect health. Soon after the appearance of pain there is vomiting, which recurs, first at long and later at shorter intervals, and may become projectile in character. The vomitus is usually bile stained fluid. Several hours after the onset of pain there may be an escape of bloody mucus from the rectum. The child may have had a movement from the bowels which may have been blood stained, or may have absolute constipation, dating from the time of the first symptom. At times there

may be no escape of blood or bloody mucus from the rectum until a rectal examination is made, when on withdrawing the finger a bloody mucus discharge is seen. This group of symptoms is pathognomonic of the disease. In the beginning there is no abdominal distention, the abdominal walls are more likely to be relaxed than rigid, and during the paroxysms of pain there may be observed a tumor or fullness. On palpation a tumor may be felt and most frequently in the right side of the abdomen. Many times the tumor is palpable in the left side of the abdominal cavity. At times it cannot be felt at all, because it is hidden under the lower ribs. When not otherwise palpable, a tumor or fullness may be felt during the paroxysms of pain. In other cases it may be detected on bimanual examination with one finger in the rectum. In a few cases the examining finger in the rectum may detect the apex of the intussusception. In the beginning, there is no rise in the temperature, on the contrary, there may be a subnormal temperature. After a number of hours the vomiting and bloody discharge from the rectum becomes more frequent and the child appears to suffer from rectal tenesmus. The latter symptom is most marked in those cases in which the apex of the intussusception is in the rectum. If the disease is allowed to go on without recognizing its true nature, the symptoms of bowel gangrene and peritoneal sepsis develop. The temperature and pulse rate rise, the child becomes listless, shows general muscular relaxation, with sunken eyes, the extremities become cold and cyanosed, and the child appears absolutely indifferent to its surroundings. The abdomen becomes greatly distended with marked rigidity of the abdominal walls. Vomiting is almost continuous and the vomited material has a stercoraceous odor.

All other varieties of acute intestinal obstruction begin suddenly with pain which recurs in sharp paroxysms and which is due to the very violent peristalsis and distention of the bowel. In cases of acute obstruction secondary to carcinoma of the colon, there is usually a history of colicky pain for some time before the obstruction, but is usually felt in the umbilical region. In the cases of obstruction due to a neoplasm in the sigmoid colon, the maximum pain is in the lower part of the abdomen. The exact site of the obstruction can but rarely be determined before operation. In all suspected cases of acute intestinal obstruction the various hernial sites should be examined so as to determine whether or not the obstruction is due to a strangulated hernia. The most reliable sign in cases of intestinal obstruction is visible peristalsis. This is especially marked in those cases where the acute obstruction supervenes upon a slowly developing obstruction caused by a malignant growth in the colon. This

sign may sometimes be elicited by palpating the abdomen firmly and stimulating the bowel to peristalsis. When looking for it the patient should be observed in a good light. The loops of bowel are visible during the paroxysms of violent pain. They are especially marked if the small bowel had time to become hypertrophied and distended, or if the abdominal wall is very thin. The latter condition permits the wave-like movement of the coils of intestine to be seen without any difficulty. Inasmuch as this sign of intestinal obstruction only appears during a paroxysm of pain and disappears very quickly, it is necessary at times to watch the patient for some length of time before it appears. Owing to the great distention which is present in most of these cases, it may be impossible to feel a neoplasm of the colon, even if one is present. In cases of volvulus of the sigmoid the bowel may be palpable as a large tumor which is tympanic on percussion.

Soon after the appearance of pain there is vomiting, which at first is due to reflex irritation, and later on to obstruction to the normal flow of the intestinal contents. Continued vomiting of intestinal contents after repeated gastric lavage is almost conclusive evidence of intestinal obstruction.

The outstanding features of ruptured tubal pregnancy are sudden excruciating pain in the abdomen, followed by the symptoms and signs of an acute hemorrhage and preceded by a history of some irregularity in menstruation. The clinical picture of this condition is as a rule so typical that the diagnosis is readily made, especially if the history is taken carefully. There is usually a history of the patient having missed a menstrual period. Some time after this missed period, usually about a week or two after, the patient begins to have some vaginal bleeding, but not quite as much as with normal menstruation or with an abortion. In fact, the patient states that she spots rather than bleeds. Soon after the appearance of the bleeding the patient is suddenly seized with a most excruciating pain in the abdomen. Some of the patients give a history that while trying to move the bowels, they suddenly felt as if something had burst in the abdomen and that they fainted and fell to the floor. When picked up many of the patients are in a state of shock, with blanched lips and conjunctiva, and a very rapid, feeble pulse rate, marked restlessness and at times even air hunger. On vaginal examination there can usually be found tenderness and evidence of an exudate

in Douglas' pouch. Occasionally the enlarged tube can be felt. The early changes of pregnancy may be present in the breasts.

The differential diagnosis between ruptured ectopic pregnancy and acute infections of the adnexa and acute appendicitis often presents very great difficulties, especially if the appendix happens to lie within the pelvis. Vaginal examination is indispensable in these cases and usually reveals signs which aid in the diagnosis. With infections of the tubes there is marked tenderness in the pelvis. Severe pain is induced by pushing the cervix upward or trying to move it from side to side. The uterus is fixed and there may be evidence of an exudate in Douglas' pouch or there may be a tender tumor mass on one or both sides of the uterus.

In cases of torsion of some intraabdominal or pelvic tumor there is rarely such marked rigidity nor do the symptoms of peritonitis develop with such rapidity as in acute ulcers, perforations, or in acute appendicitis. Furthermore, a rapidly growing tumor can usually be felt in the lower part of the abdomen. The physical signs are most pronounced over the tumor. There may be a history pointing to the previous existence of a tumor.

In mesenteric thrombosis there may or may not be bleeding from the rectum or blood in the vomited material. Abdominal distention is pronounced very early in the disease. Acute mesenteric adenitis is comparatively rare and will but rarely be diagnosed correctly. Most of the cases are diagnosed as acute appendicitis before operation.

In tuberculous peritonitis there is likely to be marked abdominal distention owing to the ascites which is present in many of these cases. Indefinite irregular tumor masses can be felt in the abdomen, in some of these cases. The rolled up, thickened omentum is often felt as a distinct mass lying transversely in the upper abdomen.

In sigmoid diverticulitis the physical signs are the same as in acute appendicitis, excepting that they are low down on the left side of the abdomen.

In conclusion, it should be emphasized that a correct diagnosis in acute intraabdominal conditions can result only from a carefully taken history, accurate observations and a proper interpretation of the symptoms and signs. In the diagnosis of obscure cases a good clinical history is often more valuable than any other factor, because it sheds more light upon the cases than even a painstaking physical examination.

## FRACTURES OF THE HUMERUS\*

By HAROLD E. SANTEE, M.D.,

NEW YORK, N. Y.

When honored by an invitation from this association to read a paper on "Fractures of the Humerus," I was expressly told to "make it practical." This same request seems to be general at the present time and certainly any method for the treatment of fractures must be practical to obtain any kind of consideration. We all know of the present efforts of the American College of Surgeons to gradually work out a plan for the treatment of fractures which shall be based upon a thorough consideration of the pathology involved and shall draw from this consideration a plan of treatment which is more or less standardized for the various types of major fractures. The mere fact that men of ripe experience throughout the country are devoting time and thought to a review of such a subject as "Fractures" is indicative of a healthy attitude on the part of the profession and should be a source of hope to all of us. However, let us also hope that any method of standardization which may result will be elastic enough to permit of that degree of individualism in treatment which is the source of progress and advancement in any branch of our profession.

Since 1916 we have admitted to the Second (Cornell) Surgical Division at Bellevue Hospital, 170 fractures of the humerus. Of this number 83 were fractures about the upper end of the humerus, 66 of the shaft, 21 of the lower end. Only 10 have been under 20 years of age (our service admitting none under 12), so that any remarks I make are applicable to these fractures as they occur in adults. Of this total number of fractures, 17 were compound, two being crushing comminuted fractures which completely blocked the circulation and necessitated immediate amputation. The 15 remaining cases bring up that interesting question as to whether every compound fracture should be operated on. These cases were treated as follows:

Debrided, 10—Clean, 6, Infected, 4

Not Debrided, 5—Clean, 3, Infected 2

We realize that the above number is altogether too small to be the basis of any valuable deduction, nevertheless, when we add to this number our compound fractures of other bones in the body, we feel that we have a sufficient number on which to base reasonable judgment of this question. Our attitude at the present time is to consider the compounding of any major fracture an indication for immediate operation, such operative procedure

to include a careful toilet of the region surrounding the site of compounding, adequate exposure of the lacerated tract, a careful debridement of lacerated devitalized tissue and removal of blood clot, good hemostasis, continuous sponging or irrigation with Dakin's solution, removal of unattached bony fragments, reduction of the fracture to good anatomical alignment, and to conclude with either a primary closure, a delayed primary closure or a secondary closure after Carrel-Dakin treatment, depending upon the judgment of the surgeon in charge. We believe our results support this method. While recognizing exceptions to its advisability in every case, nevertheless we feel strongly that such a procedure cleanses a wound of infected material, removes the best culture medium for such infection and establishes at once a condition in the wound which makes for prompt, adequate drainage and treatment should such infection supervene. This last feature alone seems to make it well worth while, for it takes into consideration that human element in all of us which makes us hesitate day after day to interfere in that mildly infected type of compound fracture which ultimately runs on to a terminal osteomyelitis of the bony fragments, slow sequestration, and possibly non union or chronic osteomyelitis.

In reviewing these fractures of the humerus for presentation before this association I would divide them for discussion into three types—fractures about the upper end (83), the shaft (66), and the lower end (21).

In our cases, fracture about the upper end of the humerus is an injury of middle life and beyond. Our cases average well above 50 years of age. The causative violence is usually direct. The resulting fracture may involve the anatomical neck, the greater or lesser tuberosity or the surgical neck, with or without accompanying dislocation. We have found fractures of the anatomical neck (4) and lesser tuberosity (2) rare. Fracture of the greater tuberosity alone has occurred seven times, twice accompanied by anterior dislocation. In no case was the displacement marked after reduction of the dislocation. The subsequent disability, however, in abduction and rotation has been marked and prolonged, and we now accord this fracture the same care from the outset that we give to the apparently more major fractures about the shoulder.

Fractures of the surgical neck (70) are the most frequent of the fractures of the humerus

\* Read before the New York and New England Association of Railway Surgeons at its Annual Meeting, New York, October 25, 1924.

as we meet them A majority of these present a gross displacement with either a single line of fracture or combined with added fracture through the greater tuberosity The displacement resulting is as a rule typical and combines abduction and external rotation of the small upper fragment with inward and upward displacement of the shaft This displacement should be borne in mind in treatment as its presence modifies our treatment to some extent Associated with these bone displacements is an injury to the soft parts which from the standpoint of treatment must be accorded equal importance with the bone injury

Treatment—The disability anticipated in these fractures about the shoulder manifests itself in three ways, limitation in abduction and rotation and loss of strength I am informed by the Compensation Commission in New York that their average disability in these cases runs from one to two years Treatment to justify itself completely must recognize not only the injury to the bone and soft parts, but the potential disability The most advantageous position for these cases to convalesce in is that of abduction and external rotation While this position may be attained by a plaster spica or aeroplane splint, we feel that it is best accomplished by suspension, traction abduction and external rotation with the aid of the Balkan frame The attainment of wide abduction may necessarily have to be gradual (7 to 10 days) as wide abduction early in some of these cases results in angulation at the site of fracture, but once attained along with external rotation, it places the bones and soft parts in such position that two of the factors in disability are largely overcome at the outset Such position is maintained for from 25 to 30 days Hospitalization is a requisite, but this disadvantage is, I feel, more than overcome by the shortened period of disability Speed in recovery depends largely on the active co-operation of the patient himself in maintaining by graduated active exercise the above position Only by continued use will strength return Physiotherapy and massage are aids in convalescence, but the shortest disability is the reward of the actively co-operative patient

Fractures of the shaft of the humerus offer somewhat different problems from those near the end In our series of 66 the age incidence is lower, the etiological factor as far as can be ascertained showing slightly more by direct violence than indirect Angulation and overriding are the rule whether the line of fracture is oblique, spiral or transverse, but no typical position of the fragments seems characteristic The associated soft tissue injury involves adjacent joints to a lesser degree hence some pathological considerations present at the end of the bone are absent in the shaft Other

factors, however, have to be considered—namely, musculo-spiral paralysis and delayed or non-union In 66 cases, musculo-spiral paralysis has been encountered five times Observation as to its presence or absence on admission of the case should always be made It has been our custom to wait until union has occurred, then to operate if no improvement in nerve function has become apparent Our cases follow

1 Operation eight weeks—liberation of nerve from callus, excision ridge of bone Recovery

2 Operation forty days—nerve suture and bone suture Infection Failure

3 Operation ten weeks—musculo-spiral and median paralysis—fracture of humerus at junction of middle and lower third, fracture both bones of forearm, middle third Long operation—nerve suture of both Died just at end of operation Autopsy showed status lymphaticus

4 Musculo-spiral paralysis noted three days after admission Gradual improvement Spontaneous recovery

5 Fracture of humerus and both bones of forearm same side Also Potts fracture Retused operation Paralysis still present at three months

Any fracture of the shaft that permits of angulation after five weeks, I have classified as delayed or slow in union Six of these were present, five of these six were transverse fractures of the shaft Four were well united at the end of ten to twelve weeks Two continued as fibrous or non-union Both were cases of multiple fractures and very sick at the outset of their treatment One disappeared from observation One was operated on and showed a real inter-position of muscle tissue The bone ends were freshened, good alignment secured and held by kangaroo tendon No union resulted Seven months later she was operated on at another hospital and the kangaroo tendon was still clearly present An inlay graft was done and four months later no union was present It is interesting to consider possible causes for delayed or non-union other than purely mechanical causes, but the problem of bone metabolism still needs enlightenment We have carefully checked an appreciable number of fracture and osteomyelitic cases as to their phosphate and calcium blood content, but up to the present time have gained no therapeutic indications from it

Treatment—At present we treat all fractures of the humerus above the lower end in traction and suspension In fractures about the upper end we try to attain maximum abduction and external rotation largely because of the soft tissue injury and potential dis-

ability therefrom. In fractures of the shaft we use a position of 90 degrees abduction with forearm perpendicular to the bed. The suspending hammock for the arm itself is frequently reinforced on the inside with heavy felt. The outrigger for traction is always carried farther out from the side of the bed than in the high fractures so that when the patient moves in bed, he moves with the arc of a wider circle and thus minimizes any motion at the site of fracture. If union seems slow we try to hasten it by moderate manipulative irritation at the site of fracture. We believe traction suspension treatment to be the best treatment for fractures about the upper end of the humerus, we also believe it to be a very superior type of treatment for fractures of the shaft. It is comfortable to the patient, it reduces and aligns fractures, it gives maximum consideration to the maintenance of good circulation by encouraging movement in adjacent joints.

Fractures of the humerus at the lower end may well be a source of worry to all of us. Generalization is dangerous, but brevity at this time is imperative. In general we expect

good results in simple fractures of either condyle by treatment in acute flexion. In the supra-condylar fractures individualization is necessary and a choice must be made between the various right angled gutter splints, moulded plaster splints and such other retentive splints as appeal to the surgeon in charge. In those fractures which T and Y into the joint or present comminution along with these features the utmost ingenuity must be used to devise the proper splinting dressing. The maintenance of function in the joint by early motion must be the prime consideration. Too often however, early optimism must give way to discouragement as new bone continues to form from capsular or periosteal fragments and the initial result as to function becomes increasingly more limited. Possible ankylosis must always be borne in mind and the patient's occupation and choice must be a consideration in our own choice of treatment. No type of fracture better illustrates that axiom that applies to all fractures that even the most conscientious and well chosen treatment may result in dissatisfaction to patient and surgeon alike.

## SOME PRESENT-DAY TENDENCIES OF THE PRACTICE OF MEDICINE\*

By E C REIFENSTEIN, M.D.,

SYRACUSE N. Y.

**T**HIS Academy was formed in 1894. It has as its objects: (1) The cultivation and advancement of the science and art of medicine, (2) The promotion of public health, (3) The maintenance of the honor, character and interests of the medical profession.

The second object, the promotion of public health, is being successfully accomplished at the present time by our efficient Public Health Department, and therefore I shall not have anything to say with reference to it, but shall confine myself to the other two objects of the Society.

It is my purpose to review the present day tendencies of the practice of medicine as they are related to, and affect each member of the society individually. In so doing these tendencies must naturally influence to a certain degree the activities of the Academy.

At the start, it is well to point out certain evident lines of endeavor and to call attention to certain conditions, obstacles and handicaps of the practice of medicine.

It was not long ago when all that was considered necessary to practice medicine was a few years study with some reputable physician. Very

careful attention at that time was paid to the bedside instruction obtained. Then medical colleges and universities took up this important task, and ever since there has been a gradual increase in the requirements and standards so as to better prepare young men and women for the very important life work—The Practice of Medicine.

During this period there have been great strides made in the science of medicine so that the science today is more a science than ever before. Great discoveries in the laboratory as related to bacteriology, pathology, physiology and chemistry have given to the fortunate students of this period knowledge which has served as a working basis of inestimable value. During this time great emphasis has been laid, and rightly so, upon the necessity of acquiring these new facts as brought out from the laboratories.

Various methods of imparting this knowledge have been carefully studied and improved upon. Different methods of studying clinical medicine in the ward and at the bedside have been considered, with gradual improvement in the character of the instructions given, so that the prospective practitioner as he passes through the medical school acquires many facts related to the science both in laboratory and in the ward.

\* Delivered before the Syracuse Academy of Medicine, January 15, 1924.



Some days the entire time is spent in the ward discussing some phase or problem as it relates to the known facts in the different departments of medicine. This method of instruction is extremely important and valuable, but there is still missing an important part of the instruction before it can be said with positiveness that a person is fit to practice medicine.

The science of medicine as studied experimentally in the laboratory and in the wards, with great benefit to mankind, should be encouraged. It requires a special type of mind, and the need of this very important line of endeavor is so great that all of us should urge young men, whenever we see them so inclined to take up this field of work. Under the present plan of education, after one has passed through the medical school and has had the opportunity of thorough preparation in the science of medicine, the student then serves one or more years in some hospital. During this period he has occasion to see many of the facts as related to the science demonstrated in patients, and he gradually increases his knowledge from the various phenomena which are exhibited. Finally, he leaves the hospital full of hope and confidence and with great expectations, that now he is ready to practice medicine.

In a short time he comes to the realization of a very important fact, that there is something definitely missing in his armamentarium, and that there is evidently another side to the practice of medicine, of which he has heard but little or at least to which very little attention has been called, and this is the Art of the Practice of Medicine.

The late Dr. Elsner, when he started his lectures, would give the following definition of the practice of medicine:

"It is the science and art of medicine, and the greater of these is the art."

All of you who knew him well can subscribe to this statement.

When one attempts to describe what constitutes the art he finds himself utterly incapable of expressing all its various phases. The art should be cultivated. Attention should be called to it early in the medical student's life instead of leaving him to acquire it in various ways after graduation.

It is not my purpose to minimize in any way the efforts made to impart the knowledge related to the science. I believe that this is very thoroughly done at present so that it is not so much the science that is at fault or insufficient, which enables so many cults to spring up, but it is the lack of thorough appreciation of the art of the practice of medicine.

The known facts of medicine are available to all of us. The mere possession of this knowledge is not sufficient to practice medicine. A few

examples to illustrate the distinction between the science and the art may not be amiss. Take for instance a patient who requires catheterization. There are certain symptoms and signs discovered which indicate that the patient has a distended bladder. Two practitioners arrive at the same conclusion. One will immediately, after sterilization, pass a catheter and relieve the bladder. The second will observe the rules of asepsis, but will first, before passing the catheter, use a small percentage of local anæsthetic, and without any discomfort to the patient, accomplish the same result. Those of you who have ever had this experience, will soon discover the difference between the physician who has art and the one who is filled with science without any art.

Similarly one may observe in cystoscopic examination how in some instances great care and gentleness is practiced, in other instances this very distressing examination is done with very little regard, apparently, for the sensibilities of the patient. In the latter type it is "just a cystoscopic examination", in the other it is the patient suffering. This distinction, to my mind, illustrates clearly the advantage of the cultivation of the art.

I recently read a criticism of doctors which I will take the liberty to quote: "Why do doctors so often make mistakes? Because they are not sufficiently individual in their diagnosis or their treatment. They class a sick man under some given department of their nosology whereas every invalid is really a special case, a unique example. How is it possible that so coarse a method of sifting should produce judicious therapeutics? Every illness is a factor invariably complex—the individual, that is to say, who is suffering from it, so that the result is a special problem demanding a special solution, the more so the greater the remoteness of the patient from childhood or from country life. The principal grievance which I have against these doctors is that they neglect the real problem, which is to seize the unity of the individual who claims their care. Their methods of investigation are too elementary. A doctor who does not read you to the bottom is ignorant of the essentials."

It is well for us to take this criticism to heart and ponder over the same. We will do well if we begin within ourselves to correct certain tendencies of practice which we have been compelled to follow, either because we have allowed the public to lead us along with these tendencies or because we have not ourselves seen the light of modern medicine and its possibilities. There is a large percentage of individuals who class our practitioners as mere dispensers of drugs, in fact it was the custom, and is yet the custom in many instances, for a physician to carry a stock of drugs almost equal to that carried by the corner drug store. What is the result? The individual is sick, he thinks in terms of drugs

for immediate relief. He, with his self-made diagnosis, seeks a physician. The physician, not on his guard, or unwilling to spend the time, takes this diagnosis and then considers that his chief function is the distribution of two or three packages or bottles of medicine, and the individual considers the transaction closed. He pays dearly for this transaction in a sense, and the physician who has spent years in study, who knows medicine, has not even had a chance to exercise the knowledge or his art.

How frequently we hear the diagnosis of the "grippe," or "rheumatism," or "sluggish liver," or "nervousness," all of which truly express an actual ignorance of the state of the individual. It is an easy way to label an individual who is sick with one of these terms, and many times a short cut to a diagnosis.

I do not blame the medical profession alone for this state of affairs, the public is also at fault because it has been educated for many years to expect this kind of service from our profession. It is up to us to educate the public to the idea that we are no longer "purveyors" of medicine but rather that our chief function is to diagnose the sick individual and then to apply certain therapeutic agents, whether mental healing, drugs, massage, mechanotherapy, surgery, electricity or any other remedy which shall relieve suffering.

What group of men is better trained to diagnose the complaint of an individual than that of our profession? A little more attention to the art is very helpful. I am certain that when all of the profession pay attention to diagnosis and also to the application of this art, better therapeutic results will be obtained and our profession more highly respected.

It may be well to call attention to certain other phases of the art, particularly the art of history taking. This is a tedious job sometimes, but with experience it does not take very long to acquire the essential points. The history need not be a long and extensive one, in fact, some of the best histories I have ever read were so condensed as to be easily placed upon a small card. Some physicians state that they have not the time to write a history, which perhaps is true under present practice, but I am confident that if this plan was universally followed the physician would be more highly respected, and that the work would be more evenly divided, and that all physicians would have time to do this very important part of the work.

A criticism frequently made is that doctors are not usually very specific as to how their directions should be carried out. They are given verbally to the patient sick in bed, and then half an hour after the physician has departed the patient is at sea as to what directions were given. A few minutes time with pencil and paper would help

the patient beyond question, and incidentally would elevate the standing of the physician in that family. In many instances the diagnosis can be made alone from the history, but never is the service of the physician properly rendered until he has examined the patient. Here again we hear serious criticisms of our profession. Patient after patient makes the rounds of physicians without ever receiving even a superficial examination. The examination of the patient is an art, cultivated by practice. Each individual is a law unto himself, and only by having the opportunity to observe the normal with its many variations is one able to evaluate certain deviations. Therefore, the lack of knowledge of the variations of the normal, in many instances, has been responsible for serious errors in judgment. There is one thing that our profession is best qualified to do, and that is to make a complete physical examination. It is a hopeful sign that more attention is being given to this part of our practice. Insurance companies are calling attention to the necessity for a complete physical examination at periodic intervals. Here is a great opportunity for us. Of course, there is an art in the application of physical examination. Inspection is an art. Invaluable information can be obtained by careful inspection. Sometimes the diagnosis is established from the evidence obtained from inspection. The proper light as an aid is not fully appreciated. The art of palpation so that our finger tips have eyes, together with the careful and painstaking methods of percussion and auscultation are only acquired by continual practice. It should be the earnest endeavor of every physician to try to improve himself in this very important and very necessary part of his service to the suffering individual. Far better is it to make one hundred physical examinations with normal findings than to miss the one who has an incipient lesion, the discovery of which would lead to the proper cure by its early recognition.

Now that the history has been taken and an examination made, in many cases a diagnosis is arrived at. At least confidence in the physician has been inspired, so that additional data referable to the history is frequently freely given by the patient at this time, and this data relates to fear. Many patients will give a rather clear cut history at times of a serious illness which after careful physical examination is not substantiated. Then one will try to discover where the fault lies, and another cross-examination of the patient will bring forth the information that the underlying cause of the complaint is a morbid fear of some definite organic and serious ailment. The reassurance to the individual that he is normal as far as the physical examination is concerned, is the greatest medicine that the individual can possibly have. The relief from symptoms starts almost at the moment that such information has been given.

There are many individuals who are constantly seeking such advice. They value it higher than any other remedial agent. There is no question at all but there are cases which start with fear as the basis of the trouble which are so changed by the unnecessary administration of drugs that it becomes difficult to estimate which is the cause and which is the effect. This fact may explain the success of many of the cults now in existence and from which many sufferers seek relief. In order to elicit fear from the patient it is necessary that one have his confidence.

Nothing inspires greater confidence than the earnest, conscientious, and sympathetic physician who is desirous of doing all that is in his power to do to relieve the unfortunate individual.

To appreciate the value of confidence or faith in removing fear it seems to me that the physician first must have within himself faith that he is a part of a profession which is especially favored by the Divine Master because He was the first great physician. The physician must be familiar with the teachings as given by Christ. There is a wonderful opportunity for our profession to embrace some of His teachings and to practice some of His teachings. Cultivate the spirit of brotherly love towards all mankind, especially towards the members of the profession, "with charity to all and malice towards none."

I recently read a quotation which impressed me most strongly in this respect. "To me, the ideal doctor would be a man endowed with the profound knowledge of life and of the soul, intuitively divining any suffering or disorder of whatever kind, and restoring peace by his mere presence. Such a doctor is possible, but the greater number of them lack the higher and inner life. They know nothing of the transcendent laboratories of nature, they seem to me superficial, profane, strangers to the divine faith, destitute of intuition and sympathy. The model doctor should be at once a genius, a saint and a man of God."

This is unusual, but a very high ideal as to the status of the physician. Many physicians fail to appreciate the importance of fear. They consider that the removal of some pathological organ, such as an appendix, or a gall bladder, or tonsils will relieve the unfortunate sufferer. The patient is told "now that the cause has been removed, go and get well," with no specific directions as to how to live so as to adjust his nervous system to the strain incident to the every day life, with no attention to diet or to the regulation of habits.

The surgeon, who today is considered to be a therapeutic agent, it would seem, is, in many instances responsible for sending such patients out when he has the greatest opportunity of helping many and incidentally preventing many so-called "secondary" operations, by giving very timely advice instead of, as many do, considering

the case closed as soon as the sutures are removed.

This is a serious criticism of our profession and it is not always necessary that these cases should be referred to an internist, but that the surgeon as well as the rest of the profession should be familiar with the rules as to the regulation of the activities of the body.

With full appreciation of the importance of diagnosis as the first aid in the relief of the sick individual, State Medicine has gradually increased its field of usefulness as an aid to physicians by supplying laboratory facilities and also state consultants. Fear has been expressed by some physicians that the state was taking away from them some work which they ought to have. To my mind the work the state is doing is an asset and a help. One part which she cannot take but which she is desirous of encouraging is the art of diagnosis and practice.

In the same way various groups of physicians throughout the country, realizing the great importance of diagnosis, have attempted to improve the quality and the character of diagnosis given to certain individuals. There is no doubt that a certain percentage of patients require the opinion of more than one man before the final diagnosis can be arrived at, but again, by far the greater percentage of individuals who suffer can be correctly diagnosed by their regular physician, provided attention to the science and art of medicine is given by him.

Another serious criticism which reflects upon the high standing of our profession is that which one occasionally hears from laymen, in that they will not reveal to the doctor all they know about themselves because they think the doctors cannot keep a secret. They are afraid to repose their secrets with men, when for instance, at a public place they hear their secrets become common property. It is well to state that this is not a general practice, but an occasional occurrence of this kind does irreparable damage to our profession, and we all, in consequence, suffer for it. It is not amiss to remind you of the sacred oath which you took at your graduation.

"Whatever in connection with my professional practice or not in connection with it I see or hear in the life of men which ought not to be spoken of abroad I will not divulge as reckoning that all such be kept secret."

It is true that the laymen consider that we are discussing names of patients when they hear us discussing cases in public, and perhaps the public has been a little unjust to us in this respect, but the mere fact that the criticism is abroad is enough for us all to be especially guarded as to what we discuss in public places.

Another serious handicap in practice is as follows. Cases are seen where one is desirous of having proper massage or electricity given. At present this work is done by individuals who in

many instances are not familiar in any sense with the various changing moods of the patient. The same rule is applied to each patient who needs massage regardless of the particular needs of the sick individuals. This academy would do well, it would seem to me, to consider the advisability of having certain individuals registered with the secretary, and if he became too busy, a paid assistant secretary might well function in this capacity, so that whenever a physician appreciates the necessity of massage, he can refer to the secretary for information as to the list of those who are competent to give this form of treatment. In the same manner the medical profession should encourage co-operation with the clergy. There are many sick unfortunate individuals who are sick mentally. The combined efforts of the clergyman or priest whose work is closely identified with ours, and a physician, will many times be able to help the unfortunate sufferer and enable him to lose his morbid fears. I have great confidence in the wonderful aid which certain clergymen can give us.

In like manner I have found it a handicap in certain instances, when I have felt a patient needed complete rest and have secured their co-operation to go to a hospital for rest, to then find that the hospital was even more noisy and full of confusion than the home. Hospitals as

they are planned at the present time, seem to be primarily planned to meet surgical requirements. Little attention is given to the needs of patients who suffer from many of the other disorders, relieved either by rest in bed, proper diet, massage, baths or mechanotherapy. Large hospitals in other cities are so equipped, but unfortunately, here in Syracuse, we who wish to use this means of practice find the existing conditions to be a serious handicap. It may be to the advantage of the Academy, through its Hospital Committee, thoroughly to consider this important necessity in improving the medical practice as it is at present in Syracuse. As was mentioned above, I feel that this Academy should aim for higher things, that it should carefully consider having a paid assistant secretary. In order to do this its income should be increased. There are many other places where a paid secretary could be of service to the members of this Society. In addition, it would seem to me wise for the Academy in its thirtieth year to consider most seriously some permanent meeting place where the activities of this Society might be enlarged upon.

It is my hope, therefore, that by improving the general character of the practice of medicine in Syracuse, the Syracuse Academy of Medicine will maintain such a place as to be second to none in this country.

## THE VALUE OF THE EDUCATIONAL CAMPAIGN IN PROMOTING THE EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS\*

By HARRY GOLEMBE, A B, M D

LIBERTY, N Y

**E**DUCATIONAL campaigns in medicine during the past two decades seem to have been the method of choice in reaching the lay public in the battle against disease. This is very well evidenced by the splendid work done by the National Tuberculosis Association, *The Journal of the Outdoor Life* (a lay journal for the tuberculous patient), the campaign of publicity conducted by the American Cancer Association, and now the new national lay journal, *Hygeia*, published by the American Medical Association.

There is hardly a state in the Union where various health and nursing bureaus have not been formed to carry the gospel of good health out to the people. Pre-natal clinics, district nurses, and even health demonstrations on a large scale such as are being carried out in Framingham and in Syracuse under the Milbank Foundation are scattered throughout the breadth of the land. With the advent of the radio, health talks are being broadcast by various city and state departments of health.

Can anyone doubt the value and importance of this work or think long as to why it has developed in so short a time to such tremendous proportions? Physicians and workers interested in public health problems have long realized the great role played by the educational campaign in combating disease and they are using every conceivable method in reaching the lay public directly.

This, to my mind, is only one-half of the work. That it has been well done no one can deny. The other half of the work that has not been well done and which all educational campaigns seem to have left out entirely, or at the most to have given but a small insignificant place, is the education of the medical public itself.

My own observations have been practically confined to the field of tuberculosis, where perhaps more has been done along these lines than in any other branch of medicine. Certainly a great deal of good has been accomplished by the systematized campaigns among the general public carried out under the auspices of the National Tuberculosis Association. Here the opportunity of reaching the general medical public and broad-

\* Read at the Annual Meeting of the Third District Branch of the Medical Society of the State of New York, at Loomis, October 9, 1924.

casting advice as to diagnosis, management, and treatment of tuberculosis has surely been a good one. Sanatoria are scattered all over the country, but it is only the exceptional one, such as the Adirondack Cottage Sanatorium (Trudeau) or the Colorado School of Tuberculosis at Colorado Springs that is making any special effort to teach tuberculosis to the general practitioner. Unfortunately these schools are small and have attracted only those physicians who are desirous of specializing in tuberculosis. The average general practitioner still remains as ignorant of tuberculosis as he has been in the past. This is still an open field for a great deal of good work in the fight against the inroads of the tubercle bacillus. It is one that demands vigorous and concentrated efforts, for the average physician hates to admit his shortcomings, especially when it pertains to such a common disease as tuberculosis.

During the past year I have had ample opportunity to observe a large group of patients sent to a health resort for pulmonary tuberculosis. These cases have been, in the main, under the care of the average general practitioner. It is my purpose to analyze these cases and arrange them under various groups so as to bring out the value of early diagnosis on prognosis, the importance of early sputum and X-ray examinations. I will not attempt to teach the general practitioner the proper method of examining a chest in order to make an early diagnosis. This has been well done in the past by means of brilliant papers written by leaders in the tuberculosis movement. In light of my experience this has certainly proven to be the wrong method of attack in reaching the average medical man. You cannot teach a man who is not interested in tuberculosis *per se* how to distinguish various types of rales, differences in physical findings, and other fine points no matter in how flowery a language you write your descriptions. That is a phase of the tuberculosis problem that we must tackle in the medical schools where the teaching of tuberculosis has been badly neglected. It is the very exceptional school that gives its undergraduates a thorough training in the diagnosis and treatment of tuberculosis. But we can teach the general man "to play the game safe", we can teach him by means of an educational program to think of tuberculosis early in the presence of such symptoms as cough, expectoration, fever, sweats, malaise, hemoptysis, hoarseness, loss of weight, pleurisy, ischio-rectal abscess, and even in so called "stomach trouble", we can teach him to be just as cautious in the presence of possible tuberculosis as he has learned to be with other diseases in the modern practice of medicine. For example, let us see what has been accomplished in diphtheria since the discovery of the diphtheria bacillus and diphtheria antitoxin and in the management of fractures since the X-ray

has assumed its proper place in the practice of medicine. No man, no matter how keen a diagnostician he considers himself, will treat a child or even an adult with a sore throat without taking a throat culture at the first examination, and not infrequently, even if he is absolutely certain that diphtheria is not present, he will go as far as giving a prophylactic dose of diphtheria antitoxin. Yet how many of these same men will treat a case having a persistent cough for many, many months without even thinking of doing such a simple thing as having the sputum examined or a radioscopic study of the chest made. If one of his sore throat patients, in whom he had neglected to be cautious, died of diphtheria, just think of the hue and cry that would be justifiably raised, let alone the possibility of giving up practice and a suit for malpractice. While on the other hand if one of his chronic coughers in whom he has been just as neglectful is suddenly pronounced a hopeless consumptive after many months of observation, nobody looks upon it as extraordinary and malpractice is not even considered. The same analogy can be drawn to the modern management of fractures since the advent of the X-ray.

If this study will help in awakening the general practitioner to the importance of early diagnosis, the importance of sputum analysis, and the importance of X-ray examination, then its purpose will certainly have been accomplished.

The cases that I have selected for this study are all private patients and have been under my care during the past year. I have included only those in whom a definite diagnosis of pulmonary tuberculosis was made and I may at some later date, in a separate study, discuss those cases sent here for tuberculosis who proved to have some other pulmonary lesion.

In Chart One I have tabulated the cases according to the stage, activity and prognosis on the first examination. This chart proves most instructive and enlightening. Of a total of 145 cases, 108 or 74.5 per cent proved to be cases of far advanced pulmonary tuberculosis and in practically the same number, 70.4 per cent, the original prognosis was doubtful, unfavorable or hopeless. These figures certainly speak for themselves. They tell us that an overwhelming majority of this group of patients were given an opportunity to carry out proper measures leading towards ultimate recovery only too late. In comparing these figures with chart number two we see another very significant fact, namely, that a diagnosis of pulmonary tuberculosis was not made until at least six months had elapsed from the time tuberculosis first exhibited itself as evidenced by the history in over 63 per cent of the cases. And were we to include in this group those in whom a diagnosis was not made at all before coming to the mountains, we again have

the very striking figure of 73.8 per cent. In other words only one patient in four was fortunate enough to have a diagnosis of pulmonary tuberculosis made within a reasonable time, inside of three months, thus giving that patient a better and a quicker opportunity to carry out the necessary measures leading to ultimate recovery. These two sets of figures certainly parallel one another. Can anyone long question why only one patient in four is not far advanced and has a good prognosis for ultimate recovery when three-quarters of the patients are kept at their ordinary work for at least six months before a diagnosis of their true condition is made and proper treatment instituted? Many explanations for such a state of affairs presented themselves to me in going over these cases. I will discuss each one of them separately and endeavor to show their importance and how publicity and education carried out by such organizations as the National Tuberculosis Association, various county tuberculosis societies and possibly state health departments among the general medical public, will prove beneficial in hastening the early diagnosis of tuberculosis.

1 *Sputum Analysis*—When Koch discovered the tubercle bacillus he gave to medicine a means whereby tuberculosis could be diagnosed with absolute certainty. It is almost an axiom that the presence of tubercle bacilli in the sputum is proof conclusive of pulmonary tuberculosis. Although this fact has been known for over forty years, is it not surprising and appalling that in over 90 per cent of this group of cases the physician in charge neglected to have a sputum analysis made within three months of the onset of symptoms? It is more surprising when one is told that most of these patients came from New York City where Department of Health stations for the collection of specimens for examination are scattered all over the city and such examinations are made without charge. Does not this fact alone open up room for a good deal of improvement? Publicity carried out along this direction alone will play a big part in promoting early diagnosis. The general practitioner should make it a rule, as he does with throat cultures in sore throats, to have sputum analyzed in all cases having symptoms or signs pointing to pulmonary disease regardless of whether or not he believes it to be tuberculosis.

2 *Röntgenological Examination of Chest*—The discovery of the X-ray gave to the study of tuberculosis a sign which is almost second to none in the diagnosis of chest pathology. A positive diagnosis of pulmonary tuberculosis by means of an X-ray plate is practically equal in importance to the finding of tubercle bacilli in the sputum. And yet in only ten of this group of cases, or less than 7 per cent, was this well recognized method of diagnosis resorted to within three

months of the onset of the disease. Radioscopic units are now at hand wherever physicians are located. For the poorer patients most out-patient departments are either equipped with machines or have connections whereby radiological study can be made at minimum cost to the patient. With such a sure method of diagnosis available to all physicians there is no excuse for great delay in making a proper and early diagnosis of pulmonary tuberculosis.

3 *Hemoptysis*—Hemoptysis occurred as a first symptom of tuberculosis in fifteen patients of this group. Despite this a diagnosis of pulmonary tuberculosis was not made in ten of these cases within six months of the onset of this very important symptom. Tonsilectomies were done (in vain) in four cases in order to stop the hemorrhage. Clinical experience has taught us that a very safe rule to follow is to treat all cases of hemoptysis, at least in young adults and those in whom cardio-vascular disease can be ruled out, on the basis of pulmonary tuberculosis until otherwise proven. Workers in tuberculosis have always looked upon hemoptysis as a blessing in disguise when coming as a first symptom. For if any one symptom of tuberculosis frightens both physician and patient alike into immediate action and causes them to institute proper rest therapy at once, that symptom is hemoptysis. Regardless of the physical findings, hemoptysis should be considered as due to tuberculosis, with the exception as mentioned above, and other rare conditions such as hereditary hemoptysis referred to by Libman and Ottenberg,<sup>1</sup> until exhaustive study and watching of the case proves the opposite. Operative interference such as tonsilectomy is gross mistreatment in the vast majority of cases of hemoptysis and is therefore inexcusable.

4 *Pleurisy with Effusion*—Acute pleurisy with effusion occurred in nine cases of this group at least one year before a diagnosis of pulmonary tuberculosis was made. The fact that a majority of all cases of pleurisy with effusion are due to tuberculosis is of such great importance that it should be made known to all practitioners. Osler<sup>2</sup> quotes many authorities who have followed their cases for a number of years subsequent to the original diagnosis of pleurisy with effusion in confirmation of this point. Is it not a significant fact that all of these nine patients when first seen by me were far advanced cases of tuberculosis? Can anyone doubt that some of these patients would have been helped to ultimate recovery had they received the benefit of the doubt at the time they were ill with pleurisy and had follow-up treatment on the basis of pulmonary tuberculosis been immediately instituted? In my own sanatorium experience and also in

private practice it was just those patients who were properly advised at the time of their pleurisy and given correct rest therapy on the basis of pulmonary tuberculosis who made good recoveries and were able to return to gainful occupations. Certainly their chances for remaining so are far better than those who were not treated along these lines. General practitioners should be impressed with the fact that pleurisy with effusion is not just "plain simple pleurisy," but that it is in all likelihood only a manifestation of pulmonary tuberculosis which demands the same kind of treatment as does "ordinary" pulmonary tuberculosis.

**5 Ischio-rectal Abscess**—Careful history taking disclosed the fact that an ischio-rectal abscess occurred as the first sign of tuberculosis in seven patients. Not one of these patients connected this with their tuberculosis and apparently the physician under whose care they were at the time never thought of it either. Ischio-rectal abscess occurs as a complication of tuberculosis in a great many patients. In addition to the seven patients mentioned above, twenty-one other patients of this group developed an ischio-rectal abscess sometime in the course of their pulmonary tuberculosis. This manifestation of tuberculosis is probably the one that is least known to the average general practitioner and publicity of this fact among medical men should certainly prove of great value. In this connection I am reminded that Dr. Maurice Fishberg used to teach his students, that in the presence of an ischio-rectal abscess or an anal fistula, the chest should always be examined for pulmonary tuberculosis regardless of whether or not the patient has symptoms pointing to pulmonary disease.

**Comment** I have attempted in this paper by means of a clinical report to bring out the value of the educational campaign in promoting the early diagnosis of tuberculosis. By analyzing a large number of cases and arranging them into various groups, I have shown how a better understanding of the facts disclosed by this study would undoubtedly have helped a greater percentage of this group of patients to ultimate recovery.

To those of us who are doing tuberculosis work the facts as illustrated by this group of patients are only too well known. The problem is to bring the benefit of this knowledge home to the general practitioner. The only solution that I can see at present is the carrying out of an intensive educational campaign among the medical public as is being done by the U. S. Public Health Service in its cooperative work with State Departments of Health in their fight against the spread and for the proper management of syphilis and gonorrhea. We cannot ask busy practitioners to return to school to learn all over again

the physical diagnosis of the chest in tuberculosis, nor to study again the many manifestations of pulmonary tuberculosis, but we can by means of bulletins, case reports, clinics, lectures, and health demonstrations directly among the medical public, teach them to "play the game safe" and to resort to other methods of diagnosis such as sputum analysis and X-ray examination earlier in the course of the patient's illness. Tuberculosis is just as important a disease from the public health standpoint as are gonorrhea and syphilis, and there is no reason for neglecting to do for tuberculosis what is being done for these two diseases. The value of the rest regime in tuberculosis has been proven beyond question, but statistics have shown us that the more lasting results are obtained in the less advanced cases. Let us profit by this experience and do our utmost to bring home the importance of early diagnosis to the general practitioner by every means at our command. If necessary let us teach him to be overcautious. For to err on the safe side will certainly not be harmful to the patient, while to err where "safety first" might have proven beneficial to the patient, is almost inexcusable.

# REFERENCES

- 1 Libman, E. and Ottenberg, R. Hereditary Hemoptysis. *Journal of A. M. A.*, 1923, Vol. LXXXI, p. 2030
- 2 Osler. Principle and Practice of Medicine, 8th edition, p. 655

# CHART ONE

## EXTENT OF TUBERCULOSIS, ACTIVITY, AND PROGNOSIS ON FIRST EXAMINATION

		No. of Patients	Per Cent
1 Stage	Minimal	10	6.9
	Moderately Advanced.	27	18.6
	Far Advanced	103	74.5
	Total number of cases	145	
2 Activity	Slight or none	11	7.5
	Moderate	56	38.6
	Marked	78	53.9
	Total number of cases	145	
3 Prognosis	Excellent	10	6.9
	Favorable	33	22.7
	Doubtful	54	37.3
	Unfavorable	27	18.6
	Hopeless	21	14.5
	Total number of cases	145	

# CHART TWO

## LENGTH OF TIME AFTER ONSET OF PULMONARY TUBERCULOSIS BEFORE DIAGNOSIS WAS MADE

	No. of Patients	Per Cent
1 Within three months	38	26.2
2 Within six months	55	37.9
3 Within nine months	37	25.6
4 Diagnosis first made in Liberty	15	10.3
Total number cases	145	

the very striking figure of 73.8 per cent. In other words only one patient in four was fortunate enough to have a diagnosis of pulmonary tuberculosis made within a reasonable time, inside of three months, thus giving that patient a better and a quicker opportunity to carry out the necessary measures leading to ultimate recovery. These two sets of figures certainly parallel one another. Can anyone long question why only one patient in four is not far advanced and has a good prognosis for ultimate recovery when three-quarters of the patients are kept at their ordinary work for at least six months before a diagnosis of their true condition is made and proper treatment instituted? Many explanations for such a state of affairs presented themselves to me in going over these cases. I will discuss each one of them separately and endeavor to show their importance and how publicity and education carried out by such organizations as the National Tuberculosis Association, various county tuberculosis societies and possibly state health departments among the general medical public, will prove beneficial in hastening the early diagnosis of tuberculosis.

1 *Sputum Analysis*—When Koch discovered the tubercle bacillus he gave to medicine a means whereby tuberculosis could be diagnosed with absolute certainty. It is almost an axiom that the presence of tubercle bacilli in the sputum is proof conclusive of pulmonary tuberculosis. Although this fact has been known for over forty years, is it not surprising and appalling that in over 90 per cent of this group of cases the physician in charge neglected to have a sputum analysis made within three months of the onset of symptoms? It is more surprising when one is told that most of these patients came from New York City where Department of Health stations for the collection of specimens for examination are scattered all over the city and such examinations are made without charge. Does not this fact alone open up room for a good deal of improvement? Publicity carried out along this direction alone will play a big part in promoting early diagnosis. The general practitioner should make it a rule, as he does with throat cultures in sore throats, to have sputum analyzed in all cases having symptoms or signs pointing to pulmonary disease regardless of whether or not he believes it to be tuberculosis.

2 *Röntgenological Examination of Chest*—The discovery of the X-ray gave to the study of tuberculosis a sign which is almost second to none in the diagnosis of chest pathology. A positive diagnosis of pulmonary tuberculosis by means of an X-ray plate is practically equal in importance to the finding of tubercle bacilli in the sputum. And yet in only ten of this group of cases, or less than 7 per cent, was this well recognized method of diagnosis resorted to within three

months of the onset of the disease. Radioscopic units are now at hand wherever physicians are located. For the poorer patients most out-patient departments are either equipped with machines or have connections whereby radiological study can be made at minimum cost to the patient. With such a sure method of diagnosis available to all physicians there is no excuse for great delay in making a proper and early diagnosis of pulmonary tuberculosis.

3 *Hemoptysis*—Hemoptysis occurred as a first symptom of tuberculosis in fifteen patients of this group. Despite this a diagnosis of pulmonary tuberculosis was not made in ten of these cases within six months of the onset of this very important symptom. Tonsilectomies were done (in vain) in four cases in order to stop the hemorrhage. Clinical experience has taught us that a very safe rule to follow is to treat all cases of hemoptysis, at least in young adults and those in whom cardio-vascular disease can be ruled out, on the basis of pulmonary tuberculosis until otherwise proven. Workers in tuberculosis have always looked upon hemoptysis as a blessing in disguise when coming as a first symptom. For if any one symptom of tuberculosis frightens both physician and patient alike into immediate action and causes them to institute proper rest therapy at once, that symptom is hemoptysis. Regardless of the physical findings, hemoptysis should be considered as due to tuberculosis, with the exception as mentioned above, and other rare conditions such as hereditary hemoptysis referred to by Libman and Ottenberg,<sup>1</sup> until exhaustive study and watching of the case proves the opposite. Operative interference such as tonsilectomy is gross mistreatment in the vast majority of cases of hemoptysis and is therefore inexcusable.

4 *Pleurisy with Effusion*—Acute pleurisy with effusion occurred in nine cases of this group at least one year before a diagnosis of pulmonary tuberculosis was made. The fact that a majority of all cases of pleurisy with effusion are due to tuberculosis is of such great importance that it should be made known to all practitioners. Osler<sup>2</sup> quotes many authorities who have followed their cases for a number of years subsequent to the original diagnosis of pleurisy with effusion in confirmation of this point. Is it not a significant fact that all of these nine patients when first seen by me were far advanced cases of tuberculosis? Can anyone doubt that some of these patients would have been helped to ultimate recovery had they received the benefit of the doubt at the time they were ill with pleurisy and had follow-up treatment on the basis of pulmonary tuberculosis been immediately instituted? In my own sanatorium experience and also in



duration, deflection of septum to left with adhesion to middle turbinate. Submucous resection of septum and separation of adhesion, followed by complete relief from headache.

Mr G M, age 23. Bilious attacks off and on all his life. For fifteen years has had unilateral headache, growing gradually worse until now it occurs daily. It comes on at eleven o'clock and increases in severity until bedtime. He is frequently obliged to give up his work in the afternoon and go to bed. Headache is worse in the summer time. Pain is felt over the left side of the bridge of the nose, over the left supra-orbital region, and in the left temple. It is rarely accompanied by vomiting.

*Examination*—Nasal mucosa and turbinates normal. Septum deflected to the left, deviation beginning half-inch above the floor of the nose and extending above the left middle turbinate, which is firmly adherent to it.

*Operation*—A submucous resection was done, removing the septum to a point above the middle turbinate and back almost to the naso-pharynx. The middle turbinate was then separated from the septum. From the time of operation to the present, the patient has not had a single headache.

*Case 3*—Dull pain over left eyebrow. Long adhesion between inferior turbinate and septum. *Operation*. Cure of pain.

Mrs H S, 25 years of age. Good family history. Tonsils were removed one month ago for recurrent quinsy. For five or six years she has suffered from a dull supra-orbital pain, sharply localized, coming on every morning and lasting one or two hours.

*Operation*—A long adhesion between left inferior turbinate and septum was removed by a submucous resection of septum. No headache since operation.

#### B VACUUM HEADACHES

To Sluder of St. Louis is due the credit for first accurately describing this condition, as well as the syndrome of nasal ganglion neuroses.

Vacuum frontal headache is difficult to diagnose. The patient has a low grade constant headache which is made worse by using the eyes for near work, such as reading, and which glasses or eye treatment do not relieve. The pain is usually worse in the morning. In this type of case, we find a tender point at the upper and inner angle of the orbit (Ewing's sign). The pain experienced on using the eyes is due to traction exerted by the pulley of the superior oblique muscle upon the sensitive floor of the frontal sinus.

Certain anatomical peculiarities may be factors in the production of vacuum frontal headaches, such as:

(1) Narrowing of the middle meatus due to thickening or deflection of nasal septum.

(2) Obstruction of the hiatus semilunaris (outlet of frontal sinus) by hyperplasia and enlargement of the bulla in front, or the processus uncinatus behind. This oedema of the middle meatus and hiatus semilunaris often follows the ordinary head cold.

Treatment consists in removing the underlying cause by the resection of the middle turbinate or hyperplastic tissue about the outlet of the frontal sinus, with or without a submucous resection of the septum. The relief afforded is usually prompt and gratifying.

#### C NASAL (MECKEL'S) GANGLION NEUROSES

The sphenopalatine ganglion, also known as Meckel's or the nasal ganglion, is situated in the sphenomaxillary fossa, close to the sphenopalatine foramen, in close proximity to the sphenoidal cavity. The symptoms of neuroses of this ganglion so closely resemble those of hyperplastic sphenoiditis that it is unnecessary to describe its symptom complex separately. In ganglion neuroses, the intra-nasal application of strong cocaine solution directly to the mucous membrane over the ganglion stops the pain temporarily, while in hyperplastic sphenoiditis this procedure fails to give relief.

II The inflammatory conditions producing headache may be divided into two main groups:

- (a) Hyperplastic ethmoiditis and sphenoiditis
- (b) Suppurative inflammation of the sinuses, either acute or chronic

#### A HYPERPLASTIC SPHENOIDITIS

Hyperplastic sphenoiditis occurs usually in conjunction with hyperplastic ethmoiditis. The symptom complex is somewhat as follows. The patient complains of a coryza, and, after a short interval, he experiences pain at the root of the nose, in the eye-ball region, upper jaw and teeth. This pain may extend backward to the ear and mastoid and downward into the shoulder, arm and fingers. Sluder has observed salivation, a perverted sense of taste (metallic) and scintillans. These headaches have been termed "lower half headaches." Examination of the sphenoidal region is difficult. The mucous membrane of the ethmoids and sphenoid is changed both in color and consistency. Usually it is necessary to rely upon the characteristic history and symptom complex in making a diagnosis rather than upon the appearance of the structures intranasally.

The following case, recently operated at the New York Eye and Ear Infirmary, illustrates this condition.

*Case 4*—Right sided parietal and occipital headache of three months' duration, caused by hyperplastic ethmoiditis and sphenoiditis with deflected nasal septum. Intranasal excision of ethmoids and sphenoid, submucous resection of septum. Relief of headache.

Mr H S, 37 years old. Has always had

## HEADACHE OF NASAL ORIGIN

By GERARD HUTCHISON COX, M.D., F.A.C.S.,

GLEN COVE, N. Y.

ONE of the complaints the practitioner of medicine is most frequently called upon to treat and one of the conditions most difficult to diagnose is headache. Headaches arise from many causes. Some of them are toxic or infectious, involving many organs, but probably most of them come from pathologic conditions of the nose and its accessory sinuses.

The proximity of the nasal sinuses to the cranial cavity and the fact that the same nerve, the trigeminus, supplies both the mucous membrane of the sinuses and the dura mater, explain the frequency of headache as a symptom of sinus disease and other nasal abnormalities.

The innervation of the nose for common sensation is derived from the ophthalmic and superior maxillary divisions of the trigeminal nerve. The lateral wall of the nasal fossa is supplied from several sources, including the upper posterior nasal branches from Meckel's ganglion, and the lower posterior nasal branches from the larger palatine nerve behind, and, in front, the external division of the nasal nerve and the nasal branch of the anterior superior dental, which also distributes twigs to the floor of the fossæ. The septum receives its chief supply from the naso-palatine nerve, supplemented by branches from Meckel's ganglion behind, and by the internal division of the nasal nerve in front. The mucous membrane lining the antrum receives filaments from the infraorbital nerve by means of its superior dental branches. The frontal sinus is supplied by twigs from the supra-orbital and the nasal nerves, the ethmoidal air cells, by minute branches from the nasal, and the sphenoid sinus, by filaments from the sphenopalatine ganglion.

We see, therefore, why in the case of frontal sinus disease, pain is referred to a point in the forehead over the anterior wall of the sinus, corresponding to the distribution of the supra-orbital nerve. In the same way, in case of the maxillary antrum, which, as we have just seen, is supplied by twigs from the intraorbital nerve, we can account for the pain being felt in the cheek and in the teeth. Hajek has suggested that there is set up a kind of neuritis of the nerve in question. However, when we try to explain why pain from disease of the sphenoidal sinus is usually experienced in the occiput, we fail to find any reason why sensory impulses coming from this particular sinus to Meckel's ganglion should be experienced as pain in the occipital region. The paths of the afferent nerve fibres in this locality have not yet been accurately worked out.

The affections of the nose and paranasal sinuses causing headache may be divided into

### I Non-inflammatory conditions

### II Inflammatory conditions

1 Cases of nasal headache due to non-inflammatory causes, where there is no suppurative inflammation of the accessory sinuses, are subdivided into

- (a) Pure pressure cases
- (b) So-called vacuum headache
- (c) Nasal ganglion neuroses

(a) In the pure pressure cases, due to terminal nerve pressure, we have hypertrophy of the middle turbinate bone, which impinges against the septum, which may or may not be deflected. Again in this group there may be adhesions between the inferior turbinate and septum, or between the inferior and middle turbinates and the septum, or the turbinate may be of practically normal size, but may be pressed upon by a markedly deflected septum. These pressures are responsible for a large number of headaches. This group may be subdivided again into

(a) Pain in individuals not constitutionally prone to headaches, and

(b) Pain in cases with the so-called neuro-pathic temperament. These latter patients have a low reserve of nervous endurance and readily succumb to slight continuous peripheral irritation.

### PURE PRESSURE CASES

Case 1 Almost constant left-sided supra-orbital headache since childhood. Marked deflection of nasal septum to left, pressing against middle turbinate. Submucous resection. Complete cure of headache.

Mrs. H., age 38, gives a history of an injury to the nose in childhood. She has had headache since childhood, growing worse in the last ten years. Pain is complained of almost constantly, and is felt above the left brow and in the left temple. The pain is dull with occasional severe exacerbations, when it becomes acute and is then accompanied by vomiting.

*Examination*—The nasal septum shows an acute angular deviation to the right, close to the floor of the nose. There is a corresponding sulcus on the left side with a slight deviation to the left, completely obliterating the view of the middle turbinate on that side. There is compensatory hypertrophy of the left inferior and of the right middle turbinate. Adrenalin applied to the left side of the nose gives temporary relief.

*Operation*—A submucous resection was performed, removing the deformed parts of the septum.

Six months later the patient reports that she has been absolutely free from headache since operation.

Case 2—Unilateral headache of fifteen years'

drowsy and forgetful, and slept most of the time

A radiograph, taken in the anteroposterior direction, shows a dark spot in the left sinus. This was thought to be due to diseased and thickened mucosa.

Examination of the nose showed that both middle turbinates had been removed, and the ethmoids and sphenoids of both sides opened. A radical operation, by the external route, was decided upon and performed under general anesthesia. The mucosa lining the frontal sinus was thickened, diseased and polypoidal. The same condition was present in the ethmoid cells, which were completely exenterated. The patient was immediately relieved of his pain.

*Resumé*—These cases represent fairly well the different types of headache due to lesions within the nose and sinuses. In the first three cases the headache was due to pressure. Mere septal turbinate contact is not sufficient to give rise to pain when the individuals are not constitutionally prone to headache. To cause pain there must be considerable pressure. As a rule the pain is fairly well localized over the affected side or sides. It is felt in the orbit, the nasal bridge, and often in the temple. It is always aggravated by any nasal irritation, and is often temporarily relieved by the application of adrenalin or cocaine to the affected region within the nose.

I have pointed out the difficulties in diagnosing vacuum frontal sinus headache, and have emphasized the diagnostic points in this condition, viz. a low grade frontal headache, worse in the morning, which is increased by reading, and which is accompanied by a tender spot at the upper and inner angle of the orbit (Ewing's sign).

Case 4 illustrates headaches caused by hyperplastic ethmoiditis and sphenoiditis, with a few physical signs in the nose, but diagnosed by the general nasal picture, the characteristic history and X-ray findings.

The other cases illustrate common types of

headache caused by acute and chronic sinusitis, of the suppurative variety.

It has been found that localization of pain in certain regions of the head is not typical for the affection of the different sinuses. For example, pain in the forehead may be caused by inflammation of the frontal, ethmoidal, maxillary, or even the sphenoidal sinus. On the other hand, the characteristic pain of sphenoidal disease is felt in the occiput or behind the bulb—as one writer has expressed it—or over the vertex. In maxillary sinusitis the usual point for the pain is over the anterior surface of the antrum, as well as in the teeth of the corresponding side of the upper jaw. Frontal sinusitis generally produces pain in the forehead, especially over the course of the supra-orbital nerve. In many cases of frontal sinus inflammation the pain is characterized by periodicity. At a certain time in the morning, usually ten or eleven o'clock, furious pains are felt over the affected sinus which persist for hours—perhaps until one, two, or even four o'clock in the afternoon—and then suddenly disappear. For the remainder of the afternoon and during the entire night the patient remains free from pain. On the following day the pain recurs at exactly the same hour.

#### CONCLUSIONS

1 Headaches are frequently caused by conditions existing in the nose or nasal sinuses.

2 These conditions may be either inflammatory or non-inflammatory, and in either case the headache may be relieved by proper treatment of the nose or sinuses.

3 Every case of persistent or recurrent headache warrants a careful physical examination of the nose with a nasal speculum, nasal probe, and transillumination of the sinuses, supplemented, if necessary, by exploratory puncture of the antrum, and radiography.

4 Headaches of nasal origin usually respond rapidly to removal of the causative pathologic condition.

nasal obstruction Several years ago began to have occipital and parietal headaches, right side For past three months headaches have been worse and are present constantly Eyes were examined at the Eye and Ear Infirmary four weeks ago and glasses given, without relief X-ray showed extensive deep frontals, not very clear Some thickening in ethmoids and antra, particularly on the right side Nasal septum was very thick and to the left, low down Sphenoid region well developed and only fairly clear

Operation under local anæsthesia Submucous resection of septum Exenteration of right ethmoids and sphenoid Frontal sinus opened intranasally Mucous membrane of the ethmoids was thickened and swollen and seemed to show beginning polypoidal changes Cure of headache

### B SUPPURATIVE SINUSITIS

*Case 5*—Pain over right supra-orbital region due to acute frontal sinusitis, following grip Simulates supra-orbital neuralgia Treatment, irrigation Relief of pain

Anna T, 21 years old, contracted influenza three weeks ago One week ago complained of pain over right supra-orbital region, which was severe and almost constant

*Examination*—The middle turbinate of the right side is large and puffy, and a discharge of yellowish pus is seen coming down between it and the external nasal wall Treatment—adrenalin and irrigations—completely relieved the pain in 24 hours

*Case 6*—Right supra-orbital headache, pain over right maxillary antrum and in teeth of upper jaw, together with right-sided exophthalmos caused by acute frontal and maxillary sinusitis following influenza Intranasal operation Relief

Mrs G H H, age 25 Eleven days ago had influenza with sore throat, fever, and pain in the limbs Five days later, dull pain developed over right maxillary antrum, which was present almost constantly The teeth of the right side of the upper jaw ached There was also tenderness of the right side of the roof of the mouth Two days later she experienced intense pain over the right eyebrow, temple, and ear The pain over the antrum of Highmore abated somewhat after a few days, but the frontal headache was severe enough to necessitate a dose of morphine

When first seen, the temperature registered 101.5°, by mouth

*Examination*—Slight swelling of the cheek over right maxillary antrum, and moderate right exophthalmos Nose narrow Low deflection of septum into right nostril with corresponding sulcus in left Right middle turbinate is somewhat hypertrophied, slightly polypoid, and adherent to septum anteriorly Pus between turbinate and external wall

*Operation*—The anterior portion of right middle turbinate was removed and the right

maxillary antrum pierced with a trochar Irrigation of antrum washed considerable pus Result the exophthalmos and antral pain disappeared in 24 hours The temperature became normal two days later, and the supra-orbital pain was completely gone five days after operation

*Case 7*—Headache and pain over left antrum and cheek of two months' duration caused by chronic maxillary sinusitis, left side First treated by intranasal puncture and washings Later by radical (Caldwell-Luc) operation Relief of headache and pain

Mrs R U, 45 years old, complained of pain in left antrum for six days, and soreness of one of the teeth of upper jaw Pus was seen coming down under the left middle turbinate bone Transillumination showed a dark antrum and ethmoids Punctured antrum under inferior turbinate and obtained about half an ounce of thick, foul-smelling, yellow pus This patient was treated at intervals over a period of two months with antral washings The pus failed to clear up entirely and she failed to obtain complete relief from pain An X-ray was then taken, which showed marked thickening of the ethmoid region and mucosa lining antrum Radical Caldwell-Luc operation was then performed on the antrum The mucous membrane lining the antrum was one-quarter of an inch thick and polypoidal in character and the cavity contained considerable pus After thorough curettage, a large counter opening was made into the nose through the inferior meatus and the wound in the canine fossa closed Cure of antral suppuration and relief of headache

*Case 8*—Adult male suffering with headache from chronic ethmoiditis and frontal sinusitis Operated intranasally in Europe without relief Cured by radical external frontal sinus and ethmoid operation

C J, a robust man of 39 years, came to the clinic with a history of bilateral mucopurulent nasal discharge and headache since childhood During the past three years he had had repeated intranasal operations for the cure of his nasal trouble in several of the large European cities His pain has always been over the frontal sinus, with one exception, when he had a bad attack of pain in the occipital region, relieved by intranasal opening of the sphenoid His last operation was performed eleven months ago in Hamburg Since then he has been free from pain over the right frontal, but his left-sided trouble has continued When first seen, a little over a year ago, he sought relief from periodic attacks of dull supra-orbital pain, left side These attacks usually lasted about two weeks Then there was a free discharge of muco-pus, followed by relief He was having one of these attacks when he came under observation, and stated that the supra-orbital pain began every morning about 9 A M and lasted until 3 P M He was very

## PROBLEMS OF TUBERCULOSIS

What would you like to know about tuberculosis or the methods employed in combatting it? No problem in medicine has received more careful and searching study than has been given to tuberculosis during the last generation, both by the medical profession alone and in conjunction with influential lay groups. Our information concerning the etiology of the disease, its development and prognosis are almost as complete as they can be made, but, nevertheless, a physician never comes upon a case of tuberculosis without encountering some perplexing symptom complex. It may have to do with early diagnosis, a patient may give a history of loss of weight and a cough, but bacilli cannot be found in the sputum, although specimens have repeatedly been examined. It may be a swollen joint where the patient gives a history that would suggest the possibility of congenital syphilis. It may be a chronic cough where it has been impossible to find rales. Possibly the physician must decide whether, in a particular case, he shall permit the patient with tuberculosis to attempt to bear a child. Certain cases give rise to particular problems concerning therapeutics.

It is a realization of the need for specific consideration of particular problems in connection

with tuberculosis that has prompted the Scientific Committee to prepare a program consisting of demonstrations and exhibits for Thursday, May 14th, as a part of the program of the annual meeting. The Committee's aim in preparing the program has been to collect material that would have a specific value to the physician in aiding him to solve problems similar to the ones suggested above. Neither accuracy nor thoroughness will be sacrificed for expediency in the demonstration, but each demonstrator will endeavor to make his contribution practicable for the practicing physician who does not consider himself a specialist in tuberculosis.

No physician in the State can afford to miss the annual meeting this year, and he should by all means come prepared to stay for the Thursday program. Those physicians living within a radius of one hundred miles of Syracuse, who may not be able to spare the time for the entire meeting, will easily find it possible to come back on Thursday.

The Committee hopes to complete its program in detail during the coming week and will publish it in the next issue of the Journal.

J S L

---

## SCIENTIFIC NURSING

Much advice is given to physicians that they should treat the patient as well as the disease. There are certain scientific essentials to be followed in the treatment of cases of sickness, and after the doctor has prescribed what he thinks the patient needs, he will give due consideration to what the patient wishes to have done. Some physicians whose services are widely sought, get a greater amount of fame from pleasing the patient than from their ability in scientific medicine, but every really successful physician has ability along both scientific and diplomatic lines.

We wonder if these two methods of approaching a patient are emphasized to nurses to the extent that they are to physicians?

We wonder if physicians give much thought to the human side of the nurse or her diplomacy, in her relation to the patient?

A nurse has a double relation to a patient. She is both a scientific advisor, and also a maid-in-waiting of a high class. A "practical" nurse is one who is strong in her maid-in-waiting duties and short in her scientific attainments.

Probably one of the greatest criticisms of a highly trained nurse is that her science excels her diplomacy and that she does not care to be a

maid-in-waiting. How many patients do we hear say about a hospital, "They get you well there, but they don't care about your feelings!"

There are conditions in which almost the only qualification that is required of a nurse is diplomacy—as, for example, the pre-operative care of a healthy person who is resting in bed for a few days waiting for an operation.

There are other conditions in which scientific attainments only are required of a nurse—as, for example, in an operating room, and during the post operative hours when the patient is either unconscious or too sick and weak to notice anything.

There are also conditions in which both scientific knowledge and diplomacy are required, as, for example, during the first week of convalescence after a major operation.

There are two ways in which a nurse can carry out a physician's orders. First, she may follow them literally and scientifically, and second, she may use some degree of diplomacy and independent judgment in adapting the physician's orders to the particular human being who is the patient. Suppose a hypodermic of morphine is to be given every four hours, catheterization is to be done at twelve o'clock, and the patient is to



# EDITORIALS



The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

**Editor-in-Chief**—NATHAN B VAN ETEN, M.D., New York  
**Associate Editor**—ORRIN SAGE WIGHTMAN, M.D., New York  
**Executive Editor**—FRANK OVERTON, M.D. Patchogue

### COMMITTEE ON PUBLICATION

E. ELIOT HARRIS, M.D., *Chairman* New York  
ORRIN SAGE WIGHTMAN, M.D. New York  
EDWARD LIVINGSTON HUNT, M.D. New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

**President**—OWEN E. JONES, M.D. Rochester  
**First Vice President**—GEORGE A. LEITNER, M.D. Piermont  
**Second Vice President**—LUZERN COVILLE, M.D. Ithaca  
**Speaker**—E. ELIOT HARRIS, M.D. New York  
**Vice-Speaker**—GEORGE M. FISHER, M.D. Utica  
**Secretary**—EDWARD LIVINGSTON HUNT, M.D. New York  
**Assistant Secretary**—WILBUR WARD, M.D. New York  
**Treasurer**—CHARLES GORDON HEYD, M.D. New York

### CHAIRMAN, STANDING COMMITTEES

**Arrangements**—FREDERICK H. FLAHERTY, M.D. Syracuse  
**Public Health and Medical Education**  
JOSHUA M. VAN COTT, M.D., Brooklyn  
**Scientific Work**—ANDREW MACFARLANE, M.D. Albany  
**Medical Economics**—HENRY LYLE WINTER, M.D. Cornwall  
**Legislation**—JAMES N. VANDER VEER, M.D. Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex President and the Councilors of the District Branches.

**First District**—EDWARD C. RUSHMORE, M.D. Tuxedo Park  
**Second District**—FRANK H. LASHER, M.D. Brooklyn  
**Third District**—ARTHUR J. BEDELL, M.D. Albany  
**Fourth District**—CHARLES C. TREMBLEY, M.D. Saratoga Lake  
**Fifth District**—NELSON O. BROOKS, M.D. Oneida  
**Sixth District**—GEORGE H. FOX, M.D. Binghamton  
**Seventh District**—WILLIAM I. DEAN, M.D. Rochester  
**Eighth District**—HARRY R. TRICK, M.D. Buffalo

### COUNSEL

GEORGE W. WHITESIDE, Esq., 27 William St. New York  
Telephone, Broad 1744

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St. New York

### EXECUTIVE OFFICER

JOSEPH S. LAWRENCE, M.D. 51 Chapel Street, Albany

### SECTION OFFICERS

#### Medicine

**Chairman**—ROBERT L. LEVY, M.D. New York  
**Secretary**—L. WHITTINGTON GORHAM, M.D. Albany

#### Surgery

**Chairman**—MARSHALL CLINTON, M.D. Buffalo  
**Secretary**—EDWARD S. VAN DUYN, M.D. Syracuse

#### Obstetrics and Gynecology

**Chairman**—HAROLD C. BAILEY, M.D. New York  
**Secretary**—NATHAN P. SEARS, M.D. Syracuse

#### Pediatrics

**Chairman**—JOSEPH C. PALMER, M.D. Syracuse  
**Vice-Chairman**—ROGER H. DENNETT, M.D. New York  
**Secretary**—ARTHUR W. BENSON, M.D. Troy

#### Eye, Ear, Nose and Throat

**Chairman**—ARTHUR G. BENNETT, M.D. Buffalo  
**Secretary**—EUGENE E. HINMAN, M.D. Albany

#### Public Health, Hygiene and Sanitation

**Chairman**—PAUL B. BROOKS, M.D. Albany  
**Secretary**—ARTHUR D. JACQUES, M.D. Lynbrook

#### Neurology and Psychiatry

**Chairman**—EUGENE N. BOUDREAU, M.D. Syracuse  
**Secretary**—CLARENCE O. CHERNEY, M.D. Utica

For a list of the officers of the county medical societies, see this issue, advertising page \

## MEETINGS OF COUNTY MEDICAL SOCIETIES

The Medical Societies of the several counties are integral parts of the Medical Society of the State of New York, and their activities have an importance which equals that of the State Society. In fact the State Society reflects the activities of the local societies. If the County Societies are active, the members take a deep interest in the State Society.

The leaders of the State Medical Society feel that there is a mutual obligation upon the State and the County Societies that each shall support the other. The State Society is providing assistance to the County Societies along two lines,

first, publicity through the STATE JOURNAL OF MEDICINE, and second, the advice and assistance of the State Executive Officer.

We are gratified with the many evidences of progress in organized medicine in the several counties. We are receiving a greater number of reports on the meetings than ever before, and the reports show an increasing interest in civic medicine.

We suggest that our readers turn to page 630 and read the report of the meeting of the Livingston County Medical Society.

much of the unkind criticism of the trained nurse in the practice of her calling

During 1924, 5,246 pupil nurses attended nurse training schools approved by the Department of Education, an increase of nearly thirty-one per cent in ten years. The number of occupied hospital beds was 17,103, representing an increase of twenty-nine per cent in the same period. (Reports of Schools of Nursing, Univ of State of N Y 1925.) Pupil nurses are admitted to approved training schools on a preliminary education of one year of successful high school work or its equivalent, and yet of 767 pupil nurses who left the training schools in a single year for various reasons, 428, or fifty-six per cent, did so because of mental incompetency or instability. Annual pupil withdrawals of fifteen per cent from approved New York State training schools compare favorably with the general statement covering the entire United States that nearly one-half of the pupil nurses leave training before the course is completed. That girls with a better educational background are entering nurse training schools is shown by the statistics of the last four years, when about one-half the pupils had upwards of two years high school education on admission. A fragmentary survey indicates that from one-fifth to four-fifths of pupil nurses intend to pursue private duty nursing for at least one year after graduation. During 1924, 2,538 registered nurse certificates were issued by the Department of Education, an increase of about 100 per cent in a ten-year period.

After twenty-two years of existence of the registration law, of the 143 nurse-training schools approved by the Regents, only twenty-two complete the required standard training within the walls of the school. The State law only requires a minimum of two years of training. The course of two years is divided into four months of theory, eighteen months of practice, and two months of vacation, it is so proportioned that six months are devoted to surgical, five months to medical, three months to obstetrical, three months to pediatric, and one month to nutritional procedures. When put into hours the two years' course requires a total of about 6,520 hours, of which 6,000 hours are spent on practical, and 520 hours on theoretical work. The courses offered by the

143 training schools differ widely and vary greatly from standardized uniformity, a situation quite parallel to that which pertained in medical education prior to 1890.

It is as obvious that hospitals must have a nursing service as it is that they are instituted primarily for the care of the sick and conducted upon eleemosynary principles, on the other hand nurse-training schools now are educational institutions. Hospitals are maintained largely by gifts and endowments, and notwithstanding the economic return from hands and feet, it hardly is the province of the hospital to maintain from such funds educational institutions whose expenditures are mounting for salaries, laboratories, and maintenance.

For several weighty reasons, it would seem that the time has about arrived to place the responsibility for nurse education elsewhere than on the hospital. The State is conducting vocational schools in ever increasing variety. It certainly should have the management funds, and equipment properly to carry on nurse training as any other vocational education. The institution of a high school course<sup>1</sup> in nurse training to extend over a period of from five to six years, of which from one to two should be spent in practical bedside training in an approved hospital with proper adjustment of equivalents so as to permit students to be received from outside of New York State, would seem to offer a workable scheme whereby uniformity of subjects taught and of teachers' qualifications readily could be secured. Hospital funds, equipment, and responsibility would be greatly relieved, a greater number of highly trained nurses would be available, the student turnover in the hospital would be practically nil, and the graduation of the nurse take place at a proper age, and after a course of training uninterrupted from age or educational disqualifications. In New York State more than seven hundred institutions with upwards of 40,000 beds care for the sick and the convalescent. They are widely scattered throughout the State and require nursing service of all degrees. They would furnish abundant clinical material available for early as well as late teaching and experience.

A T L

<sup>1</sup> Nurse Training as an Educational Project.—A. T. Lytle  
New York State Journal of Medicine March 14 1924

## BILLS SIGNED BY GOVERNOR SMITH

### LAW OF 1925

227	S 671	Cole	Physically handicapped persons	367	A 1321	Lattin	Health Law, vital statistics
275	S 681	Cole	Dead bodies may be incinerated	368	A 536	Lattin	Health law, vaccine
365	A 1539	Lattin	Health law, pharmacy	369	A 1027	Lattin	Health law, cadavers

be kept quiet. If the patient is restless and in pain at 11:30, shall the nurse give the hypodermic and do the catheterization at that hour, or wait a half-hour longer? If she deviates one iota from literal orders, what will the physician say to her?

To what degree is the hospital physician responsible for the cast-iron, hard-boiled attitude of some nurses which leads them to carry out orders to the letter?

But some nurses who are skilled scientifically lack plain, ordinary tact. Suppose such a nurse adjusts the pillows and the patient still finds them uncomfortable, shall the nurse insist that they *are* comfortable, for does she not know how to adjust pillows and to make beds? Let any male physician answer this question: "Can you put a hat on any man's head to his satisfaction, or wipe his face?" He will invariably wish to change the position of his hat and to give his face another dab with the towel. A nurse *must* use diplomacy as well as scientific judgment. In fact, the two are one.

Why are the nurses who have great scientific skill found in large hospitals more often than in private practice? We have a suspicion that one reason is that their science exceeds their diplomacy. The hospital doctor is likely to be entirely satisfied if his orders are carried out. If his patient is in a hospital, he judges the nurse by the record sheet which she keeps, and he

gives little heed to her diplomacy, but if the patient is in a private home, he is compelled to hear about the courtesy, patience, and diplomacy of the nurse.

The excellent custom of excluding friends from the sick room of a hospital has its objectionable feature in that it deprives the physician of the principal means of judging whether or not the nurse is pleasing the patient.

It may be excusable for a nurse to refuse to notice the whims of a ward patient where other patients also need attention, but how about a private case who has a special nurse by day and another for the night at six dollars each? It would seem that at that price both scientific efficiency and diplomacy could be secured in full measure.

A physician who fails in courtesy and tact gets a quick call-down, or it may be that the patients and their friends will tolerate him during the few minutes of his visit. But a patient is with the nurse hour after hour, and depends on her for peace of mind and contentment.

Physicians give all manner of advice to their assistants and deliver post-graduate lectures on tactful ways of pleasing patients. Would it not be well to give some post-graduate talks to nurses on how to be diplomatic and tactful with their patients?

F O

## NURSE EDUCATION

There are people, especially physicians, who still consider nursing a trade and not a profession, they consider the quality and desirability of the nurse's service to be determined by the character of the hospital in which her training occurred. The law registering nurses, placed on the statute books of New York State in 1903, established a minimum standard for schools of nursing, and by placing its administration under that of other professional schools of the Department of Education gave to nurse training the status of a profession. The characteristics of nurse training which classify it as a profession, as one educator puts it, are a great amount of individual responsibility, the derivation of its materials from science and scholarship, the possession of a definite technique which may be communicated by educational means, and a service rendered primarily with a view to public service and not to profit.

The first law protected only the title of Registered Nurse (R N), as only graduates of schools registered by the Regents could take the licensing examination. As the public did not differentiate the titles Graduate, Certified, or Trained nurse from that of Registered nurse, the law did not protect it from graduates

of quack nurse-training schools, so in 1920 the law was so amended as to make it illegal to use the title trained, graduate, certified, or registered nurse unless the user was a graduate of a school approved by the State Department of Education and was licensed by the Board of Regents to practice as a Registered Nurse. No hospital is compelled by this law to have its training school approved by the Department of Education, such approval rests exclusively with the hospital. As the law could not be made retroactive, and as hundreds of nurses had graduated from approved hospitals or had been actively engaged in nursing for many years, before the law became effective, all such nurses as so desired were permitted on application to be licensed to use the just mentioned titles. On November 1, 1924, 18,879 individuals were listed by the Department of Education as Registered Nurses and permitted by law to use any of the other titles. A very large number of these Registered Nurses never have attended any hospital training school, a number are graduates of correspondence schools, the sheep are still herded with the goats. To the necessity for this unfortunate situation must be ascribed





# State Department of Health



## SUDDEN DEATHS AFTER DIPHTHERIA

The Department recently received a report from a district state health officer of the circumstances in regard to the sudden death of a boy who had diphtheria six weeks previously. This child, two years of age, had apparently recovered, but was left with some paralysis. While he was attempting to climb on a piano, he dropped dead.

Such fatalities are not at all infrequent. The Division of Communicable Diseases has reviewed the special diphtheria death reports submitted since January 1, 1924, and has found sixteen other cases of sudden deaths from cardiac involvement following diphtheria. Five of these occurred more than three weeks after the onset of the disease. In seven cases the reports indicate that the patients were not kept in bed and that this was an immediate factor in the cause of death.

The longest time between onset and death was forty-four days. This interval was given for two adults, aged 38 and 64. The ages in the entire list ranged from 17 months to 64 years.

Two patients left their beds merely for toilet purposes and immediately afterwards collapsed and died. In another case it was stated that "the patient was nearly well, got out of bed and died before the doctor could get there." In another, "death occurred after the child had been playing with another child tossing a ball."

In nine other cases in which there was no statement as to whether or not the deaths were sudden, it was reported that the patients were allowed to sit up or get out of bed, often against the physician's instructions.

According to Holt and Howland (*Disease of Infancy and Childhood*, Eighth Edition, p. 1008), "patients should invariably be kept in bed for at least a week after the throat has cleared, and much longer if any tendency to

cardiac weakness is seen. The pulse should be carefully watched, and irregularity, intermission, diastolic, or a weak first sound of the heart, should make one apprehensive. An abnormally slow pulse is generally more serious than one which is rapid. In such circumstances the patient should be kept recumbent and absolutely quiet, since fatal syncope may be the result of a violation of these rules." Ker (*Infectious Diseases*, Second Edition, p. 446), states that "it is of the utmost importance that, from the moment diphtheria is definitely diagnosed, the patient be rightly kept in the *recumbent posture*. Sitting up should not be allowed on any pretext whatever, and even the slightest exertion, such as reaching to a bedside table, should be strictly forbidden.

If the attack is a very slight one, the patient may be gradually propped up in bed from the middle of the third week, and, if no harm results, allowed to get up for an hour or two early in the fourth. In really severe cases, however, it is safer to keep him in bed for at least six weeks, the tendency for the later forms of paralysis to appear about the sixth week making such a precaution advisable. Adults should not resume work or children return to school for some weeks later, and a complete change of air is often of great advantage."

It is evident that greater care is needed in this matter. Not only should physicians keep careful watch of the pulse and heart, but also every possible effort should be made to impress on parents the likelihood of the serious consequences which may follow even slight exertions by the patient. This is, of course, especially necessary if antitoxin has been given later than the first day of the disease, or if there is any indication that an insufficient amount was given on the first day.

## SUPPOSED TYPHUS FEVER PROVES TO BE DRUG RASH

The Department recently received a report of a case of typhus fever in a small village. Upon investigation it was found that on or about February 20 this patient had developed symptoms of gripe with quite severe frontal headache. The patient had purchased a package of headache tablets and doubled the advised dose, taking the contents of the entire package within a few hours "in order to hurry his recovery." Not content with this, he also took several headache tablets of another variety "as a matter of precaution."

It is hardly surprising that after this vigorous attempt at self-medication the man developed a soft thready pulse, cyanosis of the lips and a scattered rash which made its appearance a day or so after the ingestion of these drugs, but which subsided within a couple of days without leaving any discoloration.

Following the later developments of the case, the attending physician was quite willing to change the original diagnosis.



# LEGAL



By GEORGE W. WHITESIDE, Esq.  
Counsel Medical Society of the State of New York

## CLAIMED BREACH OF CONTRACT TO CURE

In this matter the plaintiff, suffering from a genito-urinary condition charged that the defendant physician was guilty of fraud and deceit and sought to recover the amount which he had paid to the defendant for attention and treatment. He further claimed that the defendant physician agreed to treat him for the condition, until such time as he was cured, for the amount which he had paid.

The patient had made three visits to the physician, at which visits extensive diagnostic examinations were made and laboratory analyses were had of the urine specimens, the laboratory charges being paid by the defendant. After the three diagnostic visits the physician gave the plaintiff electrical treatment, charging him a stated price for the same and advising the plaintiff that the succeeding visits would be at the same price.

The defendant was a specialist in genito-urinary conditions and upon the plaintiff's call advised the plaintiff that he would undertake, for \$50 00, to make a complete and exhaustive diagnosis of the plaintiff's condition, that the diag-

nosis would consist of three visits—on the first visit a thorough physical examination and specimens of pus for microscopic analysis—on the second further physical examination and the taking of a seven-glass urine test for laboratory analysis—and on the third visit an internal examination of the urinary canal by means of a telescopic instrument—and that from these examinations and the laboratory reports on the pus and urine the best treatment for the plaintiff's condition would be determined by the defendant, the plaintiff to be charged a reasonable fee for such treatments.

At the time of trial the plaintiff abandoned the complaint of fraud and deceit and charged that the defendant undertook to treat him until cured for \$50 00 and testified to this effect. The defendant offered his testimony in proof of the arrangement that the payment of \$50 00 was to cover the three diagnostic visits and laboratory analyses. The jury, however, determined the issue in favor of the plaintiff and the judgment was affirmed by the appellate court.

## DEATH—ETHER ANAESTHESIA AT DELIVERY

An action was brought to recover for the death of the plaintiff's decedent, it being charged that the defendant, as a physician, was employed to attend the decedent at child birth, and that because of his carelessness and negligence in the administration of the anaesthesia, the decedent died of ether poisoning.

The defendant, a general practitioner, was called to attend the decedent at which time she was in labor and being attended by a midwife. She was about thirty-eight years of age. Upon examination the defendant found that she was about to be delivered of a full-term dead foetus, her labor being difficult and painful. The defendant sterilized his instruments and gloves and prepared the parts of the patient, and also prepared with sterile towels a table upon which the patient was placed. After preparation of the patient and himself the physician handed the can of ether to the midwife, directing her to let fall one drop at a time on a gauze mask which had been prepared for the purpose of administering the anaesthesia. The physician watched the midwife let the ether drop steadily

for about five minutes, at which time the patient was fully anaesthetized. He then inserted his forceps in the vagina, getting hold of the head of the foetus. At this moment the physician noticed that the patient had become cyanosed. He immediately withdrew the forceps, suspended the application of the ether and resorted to massage and artificial respiration. He also administered two hypodermic injections of caffeine and sodium benzoate. The heart action gradually grew weaker and the breathing ceased. An injection of strychnine-nitrate was also administered. The patient did not revive and died in about fifteen minutes after the first application of ether. The cause of death was stated as shock from ether anaesthesia while doing a high-forceps delivery of a full-term dead foetus, and the contributory cause status lymphaticus, no autopsy being performed.

The plaintiff failed to prosecute the action. A motion was made to dismiss the same for lack of prosecution which motion was granted, favorably terminating the action in favor of the doctor.

The New York Academy of Medicine is composed of physicians of professional standing in general practice, the specialties, and public health. It has taken a leading part in the broader aspects of civic affairs, and its reports carry weight and influence. Nearly all its members also belong to the County Medical Society.

*The County Medical Society*—The Medical Society of the County of New York has 3,334 members, or about 61 per cent of the physicians of the County. This proportion is about the same as that for all of Greater New York. The Kings County Medical Society enrolls about 60 per cent of the physicians of the County, while 72 per cent of the physicians outside of Greater New York are members of County medical societies. Still, the number of physicians in New York County is so great that nearly one-third of the members of the Medical Society of the State of New York live in New York County.

The New York County Medical Society holds eight meetings a year, or one each month except during the summer. The Society holds its meetings in the building of the Academy of Medicine at 17 West 43rd Street, and maintains its offices there.

*Committee Activities*—The great number of members of the New York County Medical Society precludes the possibility of conducting the affairs of the Society by discussions in open meetings. The activities of the Society are, therefore, carried on principally by committees, just as they are in other County societies—for it is only a few members in any County society who have the time, the inclination, and the qualifications to devote to medical civics. The internal affairs of the Society are administered by the Comitia Minora, and its external activities are directed principally by the Committee on Civic Policy which has been organized in recent years to coordinate the activities of the Society, and which reports on these activities to the Comitia Minora for action. This Committee is composed of eight members in addition to its chairman, Dr. Frederick E. Sondern, and has under its direction several special committees on each of which one of its members acts. These special committees are those on Hospitals and Dispensaries, on Nursing, on Roentgenological Laboratories, on Clinical and Pathological Laboratories and on Press and Publicity. They do an enormous amount of detailed work, much of which is not made public, but the reports are made to the Committee on Civic Policy and to the Comitia Minora. The important nature of the work that is done quietly and efficiently by these committees is indicated by a few examples.

The Committee on Roentgenological Laboratories has done an enormous amount of work in the investigation and control of inept X-ray operators in beauty parlors and the offices of chiropractors.

The Committee on Pathological Laboratories

has undertaken the control of commercial laboratories in which unqualified persons pretend to make expert examinations of blood, urine, and other specimens on whose results health and life may depend.

The Committee on Press and Publicity is endeavoring to stop the broadcasting of alleged health talks by charlatans.

The Legal Department of the Society has followed up complaints against illegal practitioners, and has assisted in driving many out of business by working with the Department of Health and District Attorney's office.

The amount of work handled by the committees and Comitia Minora each year is enormous, the Comitia Minora often sitting until midnight. If it were proper to disclose the details of the work of the Society, the Secretary, Dr. Daniel S. Dougherty, could tell interesting stories of the detection and prosecution of illegal practitioners, and of measures for uplifting the standards of ethics and medical practice.

The correspondence and details of the Secretary and Treasurer's office are of such importance that they require two full-time secretaries and several part-time clerks.

The Milk Commission conducts one of the most important of the routine activities of the Society, that relating to certified milk. The Commission consists of twelve leading pediatricians and laboratory workers who have charge of the inspection and control of dairies and the certification of their milk. The details of the work are done in the laboratory of the Department of Health under the direction of Dr. W. H. Park, but the funds for the work are provided by the dairymen. The Commission renders real service of advice and certification to the milk producers, for which they are willing to pay a fee, which makes the work entirely self-supporting.

The Committee on Legislation has been extremely active not only during the sessions of the Legislature, but throughout the year, with the result that the New York County Legislators have supported the Medical Practice bill and other legislation raising the standards of professional work.

A special committee on Periodic Health Examination was appointed during the past year and its work is a real contribution to the movement. One feature of its activity has been a symposium of sixteen lectures by experts in the various specialties, each in his own line, setting forth the salient features for which an examiner should look when he examines a patient. The lectures tell an examiner how to make an examination, so far as any verbal or written instruction can do so. Abstracts of many of the lectures have been published in this Journal.

*The Medical Week*—The Medical Society of New York County supports its own publication called the *New York Medical Week*. Each issue



# MEDICAL SURVEY



## MEDICAL SURVEY, NUMBER 8—NEW YORK COUNTY

**EDITOR'S NOTE** The information on which this Survey is based was obtained with the co-operation of Dr Samuel J Kopetzky, President of the Medical Society of the County of New York, Dr Daniel S Dougherty, Secretary of the Society, and Dr Frederic E Sondern, Chairman of the Committee on Civic Policy, and by Dr Linsly R Williams, Director of the New York Academy of Medicine

*Medical Circles of Influence*—New York City is divided into five counties whose boundaries are the same as those of the Boroughs of the City. Each county has its own County Medical Society, and the physicians have their own medical affiliations. The counties have many of the characteristics of separate cities.

The reasons for the medical individuality of the several counties of Greater New York are historic, geographic, and economic. The huge unwieldy size of the city also promotes the individuality of its component parts.

While New York County formerly constituted the entire City of New York, it now comprises only one-third of the population of the city and one-fifteenth of its area. Yet the county is a great medical center for not only purely medical organizations, but also for lay organizations whose activities are allied to those of medicine. It is but natural that the County should contain physicians whose eminence and influence are comparable to those of its great financiers and lawyers. There are also a very great number of physicians whose practice is confined to a limited class and section, such, for example, as the Italians in their quarter of the city, or the negroes in their locality.

It is characteristic of a great city that its people tend to form rather limited circles of affiliation which often seem narrow to outsiders who have not experienced the hugeness of every phase of life in the city. A physician in New York County is compelled to associate with a restricted circle of confreres which, nevertheless, may be larger than the entire body of the medical profession in most other cities. New York physicians of eminence often deplore the physical impossibility of their forming wide medical associations with general practitioners, and when they attend a meeting of a rural county society, they express their jealousy of their country brethren, all of whom call one another by their first names. It is not intention, but force of circumstances that compels the physicians of New York to group themselves into rather restricted circles.

New York County is the center of medical organizations, both professional and lay, whose activities are nation wide, and which do active work in the city also. The hospitals of New York County, the department of Health, the Tuberculosis Association, and other organizations operate on such a vast scale and have so many ramifications that a complete medical survey of the County would be well nigh impossible. We will, therefore, confine our description of medicine in New York County to an outline description of its two representative organizations—the County Medical Society, and the New York Academy of Medicine. These two societies are organized and conducted along the same lines as those of similar organizations in other parts of New York State.

*Number of Physicians*—New York County has an area of about 22 square miles. Its population is 2,400,000, as estimated by the Department of Health of Greater New York.

New York County has 5,556 physicians, according to the medical directory of the Medical Society of the State of New York. This gives a proportion of one physician to every 432 of population. The proportion in Kings County is one doctor to every 835 of population, in Bronx County, one in 1,220, and in Richmond County, one to 1,300. The proportion in New York State, outside of Greater New York, is one doctor to 770 of population.

Since the average number of persons per physician in New York County is 432, or only one-half or one-third the proportion in other parts of New York State, one wonders whether or not the physicians of the County are as prosperous as those elsewhere. The financial rewards to some physicians are very great, especially to specialists to whom cases are referred from far and near. It is doubtful that the average income of the New York County doctor is greater than that of his rural confrere. The average four hundred and thirty-two of population of New York City has no more money and pays no more to a doctor than the same number of persons up-State.

*Medical Organizations*—The Medical Society of the County of New York represents the profession of the County, and a membership in it is open to every ethical practitioner in the County. It is an integral part of the Medical Society of the State of New York, and the benefits that it confers upon its members are the same as those that accrue to the members of other county medical societies.

# NEWS NOTES

## ENDOCRINOLOGY IN PERIODIC HEALTH EXAMINATIONS

By WALTER TIMME, M.D., New York

Abstract of the twelfth lecture in the symposium on Periodic Health Examinations conducted by the Medical Society of the County of New York given January 22, 1925

THE topic of my lecture is the internal glandular system in its relation to constitutional development

About sixty per cent of the cases in which there is either an excess or a deficiency in the functions of the pituitary and other glands of internal secretion may be traced back to very early periods of life, and even to one's ancestors. The abnormalities may not recur in the type in which they originally appeared, but in tables of inheritance the various types may succeed one another without any definite order, and subject to many metamorphoses.

About sixty per cent of cases of endocrine excess or deficiency belong to one type called the *Status hypoplasticus*. In this constitutional type the cardio-vascular system is undersized and inadequate, as are also the pituitary, thyroid and adrenal glands. On the other hand, some glands are enlarged, especially those containing lymphoid tissue, such as the thymus, lymph nodes, spleen, and liver. The blood of a person who has a hypoplastic type of body will show a low polymorphonuclear count, low coagulation curve, low blood sugar, and a low alkaline reserve.

Persons of the hypoplastic type will not show a high poly blood count when infection occurs. A surgeon is likely to go wrong if he depends on a high polymorphonuclear count as an indication for operating on one of these cases.

Patients of this type have a low blood sugar content—70 or 75 mg per 100cc. Since muscular activity depends on the percentage of blood sugar that reaches the muscles, these patients have a great tendency to fatigue.

The long coagulation time of the blood—10 to 20 minutes,—leads to bleeding and purpura. A very slight bruise will cause purpura in the skin of these persons. The tendency to bleed may lead to secondary hemorrhages of important organs such as the brain after slight injuries, or even after moderate hyperemia.

The low alkaline reserve of the blood leads to periodic symptoms of acidosis.

Patients with the hypoplastic state have extremely loose joints. This looseness is exceedingly troublesome when it affects points which are normally snug and tight, such as the sacro-iliac. Loose sacro-iliac points produce low back-ache for which the only relief is a tight band

which will hold the joint firmly in place, as a substitute for the ligament.

Looseness of the joints of the foot leads to flat foot and its accompanying pain and disability.

What becomes of these patients? Many die young of sudden fright, or of slight infection, or of a mild narcosis such as a few whiffs of chloroform. The cause of death is likely to be unknown, for their physicians have not realized that there was anything seriously wrong with their constitutions. The practical application to periodic health examinations is obvious.

If these patients survive to adult life, what has happened to allow of this? There is a balance among the glands by which one may overcome the deficiency of another. If, for example, the pituitary enlarges the patient has an increase of blood sugar, if the thyroid enlarges, he has a more rapid assemblage of sugar and a shorter coagulation curve. Thus is what happens to the cases which reach an approximately normal adult state, but the compensation is often only partial, and these persons remain handicapped for life.

Compensation may be sufficient until an extra strain is put on the body. An example is the influence of puberty on a boy in whom the pituitary, while previously somewhat inadequate, becomes markedly so when puberty demands an extra supply of the secretion of the gland. Relative hypopituitarism results and the boy then becomes lethargic and fat.

By examining a case early in life by an ordinary physical examination, the hypoplastic state may be readily detected and remedied.

On the other hand, suppose the thyroid has been called on for over-activity during childhood. When puberty calls for added activity, the gland cannot respond and there develops the symptoms of relative hypo-thyroidism—with enlargement of the neck, called goitre, sluggishness, increase in weight, mental retardation, dryness of the skin,—all of which go with low oxidation. If the early signs of this condition had been recognized and corrected in infancy, there would have been no hypo-thyroidism later on.

The symptoms of hypo-adrenalism are vague, excepting those of inordinate fatigue and low blood pressure, but these symptoms also accompany disturbances of the thyroid and pituitary.

contains about sixteen pages of editorial comments, news notes and announcements. The periodical is almost a necessity in informing the great number of members of the County Society regarding its activities and in maintaining their interest in the organization. It is a live, high class medical publication and a model which other County medical societies could follow with profit. Its success has been due largely to Dr. Samuel J. Kopetzky, who is now President of the County Society.

The activities of the Medical Society of the County of New York have not been spectacular in any sense, but have consisted in the quiet performance of numberless details of civic duties which have the same relation to the medical profession and the public that the high class practice of medicine has to an individual patient.

*The New York Academy of Medicine*—If the activities of the County Medical Society may be compared with those of a physician in general practice, those of the Academy of Medicine are like the work of a medical consultant. The work of the County Society is intimate and personal, the work of the Academy is impersonal and scientific.

*Property and Endowments*—The New York Academy of Medicine now has 1,750 members or "Fellows," and 75 Associate Fellows. It was founded in 1847 for the purpose of promoting the science and art of medicine, the maintenance of a medical library, and the promotion of public health. It has consistently carried out these purposes to such a degree that its Fellows and their friends have endowed it with approximately nine hundred thousand dollars. The income of a fund of a million and a quarter dollars has been allotted to the Academy by the Rockefeller Foundation for the extension of its library and educational activities, and the entire principal will be turned over to the endowment fund when the Academy has inaugurated its new activities satisfactorily. The funds at its disposal enable it to carry on scientific work unhindered by adverse opinions of various medical groups.

The Academy has title to its own building at 17 West 43rd Street, which has five meeting rooms, houses the library, and provides offices for the Medical Society of the County of New York and the Medical Society of the State of New York. It is expected that in 1927 the Academy will occupy a new building at 103rd Street and Fifth Avenue, provided by the gift of a half million dollars by the Carnegie Corporation.

*Promotion of Medical Science and Art*—The first of the objects of the Academy, that of promoting the science and art of medicine is carried on by means of scientific meetings and a Bureau of Clinical Information.

Two scientific meetings are held monthly for the presentation of scientific papers and discussion of them by the Fellows. With the growth of medicine and the increase in the number of specialties twelve sections have been formed, each with a membership of from one hundred to three hundred and fifty. Each section meets monthly. All meetings of the Academy and its sections are open to the medical profession generally and to medical students.

The Academy Committee on Medical Education conducts a Bureau of Clinical Information which prepares daily lists of operations and clinics, and meetings in Greater New York. It posts the lists on the bulletin board of the Academy, and mails them to numbers of physicians outside of the city. The Committee also collates information regarding the post-graduate courses of instruction that are available. It is recognized as the authoritative source of information regarding what courses of instruction are available to a physician seeking clinical knowledge.

*The Bulletin*—The Academy has begun the publication of a thirty-six page bulletin which is designed to carry news of its activities, and some original scientific articles. The publication takes the place of the transactions which were published from 1860 to 1901. The first number was issued late in March, and will be followed by monthly issues.

*The Library*—The Academy maintains a public medical library of 140,000 volumes. This library is the second in size in the United States, and is exceeded in size by only the Library of the Surgeon General in Washington. It is open to physicians generally at certain hours.

The quarters of the Library are crowded, and the space does not permit of efficient service by the librarians. It is proposed to give the readers modern library service and assistance when the new quarters are occupied.

*Public Health*—The Academy has always taken a deep interest in the promotion of the larger phases of public health. Its committees have studied the needs of hospitals and dispensaries, and it has recently published a book on the hospital situation in the city.

An intensive study of child health has been made, and will be published during the year.

Studies have been made regarding the adequate care of chronic patients, and the need of better treatment in convalescent homes.

The training of nurses and nurse anesthetists has also been considered.

This is only a partial list of the lines of work undertaken by the Academy. It is proposed to amplify the scope of the activities when the funds become available and the work is organized.

by the Society and favorable action requested by the Board of Supervisors, and

WHEREAS The Livingston County Board of Supervisors completely ignored the wishes of the Physicians of the County as represented by the Livingston County Medical Society by designating a Laboratory that is inconvenient and had not met the requirements of the State Department of Health,

Therefore, be it Resolved, That the Livingston County Medical Society in regular meeting at Geneseo on March 24th puts itself on record as being opposed to the action taken by the Board

of Supervisors in regard to the County Laboratory contract, as let, wherein they completely ignored the request of the Society

Dr C Fiero, Chairman Committee on revision of the County Fee Bill, reported progress in making suitable revisions and promised to furnish the Secretary with a complete revision so that copies might be sent to all members prior to the next meeting, at which time any corrections could be made and its adoption assured

The Society adjourned at 11 45 P M after one of the most interesting and instructive meetings held within recent years

L A DAMON, *Secretary*

## BULLETIN OF THE NEW YORK ACADEMY OF MEDICINE

The New York Academy of Medicine has resumed the publication of its *Bulletin* after it had been suspended for twenty-four years The *Bulletin* was first issued in 1860, and was continued up to 1901, either as separate pamphlets or as transactions It is now called the second series, and Volume One, Number One, and a copy has just reached us

The new *Bulletin* has thirty-six pages, each about half the size of a page of this JOURNAL It contains a history of the former series, and a financial report of the Academy It prints the inaugural address of the President, Dr Samuel

A. Brown, which recites the story of the home of the Academy It carries a description of the collection of the first editions of the poems of Dr O W Holmes, and of artistic portraits of distinguished physicians, both of which collections have been presented to the Academy by Dr Charles L Dana Ten pages are devoted to two scientific articles on pneumonia Announcements of meetings and lists of committees are published

The *Bulletin* is a part of the educational system of the Academy, and is well designed to inform the reader about the activities of the organization

F O

## EXHIBIT OF ANATOMICAL BOOKS

Physicians who have a liking for medical history and art will be interested in an exhibition of early anatomical books in the Grolier Club, 47 East 60th Street, New York City Here are shown many works which have a high artistic as well as scientific value The reason seems to be that in the time of Vesalius the painters who went to the chemists to buy their pigments met the

physicians who came to buy pills and potions, and the two dissected bodies together—the painters for art and the physicians for science. It was only natural that the painters should give even the skeletons a lifelike pose, and should depict every part of the body in action

The exhibit is open every day from 10 o'clock until 6, and admission is free

F O

When the pituitary begins to compensate, its increasing size causes it to press upon the sides of the bony cage in which it lies, and headaches develop. The headaches come on periodically, after exertion or fatigue, and after acts of mental concentration. The headaches may continue for many years until the pressure causes a sufficient enlargement of the pituitary fossa, when the pain ceases. The fossa may be seen by

means of X-ray pictures, and in a series in such cases it may be seen to enlarge. Some of these cases have eye troubles owing to the location of the pituitary beside the optic and oculo motor nerves, and so the headaches are sometimes thought to arise from the eyes.

The conditions that have been described are only a few of the more common ones which are attributable to the early status hypoplasticus.

### LIVINGSTON COUNTY MEDICAL SOCIETY

A regular meeting of the Livingston County Medical Society was held at the Big Tree Inn, Geneseo, at 6 P. M., March 24, 1925. The President, Dr. H. A. Patterson, presided, and there were 18 members and 12 guests present.

Dr. D. C. Wilson of Clifton Springs gave a paper on "Carcinoma with Spinal Metastasis." He reported 21 cases of spinal carcinoma secondary to malignancy in various other parts of the body. A lantern slide X-ray of each case was shown demonstrating the lesion present. The paper aroused considerable discussion among the members concerning differential diagnosis between this condition and Pott's disease and other affections of the back.

Dr. F. H. Richardson of Brooklyn gave a talk on "Infant Feeding," and made an eloquent plea for breast feeding. His statistics showed that it was possible for 97 per cent of all mothers to nurse their children if given the proper instruction and encouragement by the family physician. He described methods of milking the breasts in order to stimulate further production, and gave various methods of complementary feeding while the breasts were being stimulated. A general discussion followed the paper.

Dr. A. Pfeiffer, Head of the Division of Venereal Diseases of the State Department of Health, next demonstrated a collection of wax models showing the various skin manifestations of syphilis.

Dr. B. R. Wakeman, District State Health Officer, addressed the Society on the subject of Children's Health Clinics. His proposal that this work be taken over by the Society and that at the clinics in the various towns of the county, the members themselves act as examiners, did not meet with approval. The general feeling, as brought out by the discussion, was against such clinics and no action in regard to the matter was taken.

A motion requesting the State Department of Health to assist in instructing the Public Health Nurses throughout the county regarding infant feeding methods as previously outlined by Dr. Richardson, made by Dr. Driesbach and seconded by Dr. Burt, was passed.

The Secretary read a letter from Genesee County Society inviting the members to join in a Tri-County meeting to be held in Batavia in

April. A vote showed a majority in favor of accepting the invitation.

The Society voted to accept an invitation from Dr. Shanahan to hold its next meeting at the Craig Colony on the first Tuesday in May.

Dr. Wakeman extended to all members a cordial invitation to attend the next meeting of the Steuben County Society, which will be held in Hornell on May 18th, and promised to send a program to each member in advance of the meeting.

The following physicians were elected to membership: Drs. Glendolyn Cowper Schwing, Nunda, Harold E. Schwing, Nunda, Paul Levi, Sonyea.

A resolution relative to the death of Dr. Barton F. Andrews was submitted by the Committee, Dr. F. J. Bowen, and Harold A. Patterson, and was adopted.

Dr. W. E. Lauderdale, Chairman of the Laboratory Committee, gave a report of the activities of the Committee. Every effort had been made to secure the adopting of the Craig Colony Laboratory, but the Board of Supervisors had ignored the requests and had made a contract with the Laboratory of the Jackson Hotel and Health Resort. There was much discussion of the subject and the consensus of opinion was that the Society had been treated unfairly and that its disapproval of the actions of the Board of Supervisors should be properly registered. Dr. W. E. Lauderdale and the Secretary were appointed to draft such a resolution, a copy of which was to be sent to the Board of Supervisors, to the State Department of Health, and if possible published in all the County newspapers. The following resolution was submitted:

WHEREAS The Livingston County Medical Society respectfully petitioned the Livingston County Board of Supervisors to establish a County Laboratory that would meet with the State Department of Health requirements and would thereby secure the customary \$1,200.00 aside from the State as provided for in Chapter 638, Laws of 1923, of the State of New York, and

WHEREAS The Laboratory of the Craig Colony being available for this purpose and meeting all the requirements of the State, was approved





# THE DAILY PRESS



We have received an unusually large number of medical clippings during the past week—a great many of them record health lectures and exhibits. Health talks always make readable news, even if the hearers cannot remember all the points that are made.

A considerable number of clippings relate to health centers and their activities especially in tuberculosis and child welfare. Schuck testing and the administration of toxin-antitoxin are described in several papers.

Vaccination talks and clinics are frequently described, and every newspaper commends the procedure. While one or two New York papers condemn vaccination, our clippings show that the up-State papers support it.

A crusade against spitting in public places is noted in the *Syracuse Post-Standard*, March 25th. We have commented on the need of emphasizing the infectious nature of the excretions of the nose and throat. The *Syracuse* lectures are along the right lines.

The *Saratoga Saratogian*, March 23d, contains half a column account of the movement to vaccinate the school children of the city. The account says that parents are requested not to come with the children who are to be vaccinated for both doctors and nurses will be present at the centers where the vaccination will be done.

The account quotes the Health Officer, Dr. Moriarta, as follows:

"At present we have no cases of smallpox in Saratoga Springs. However, from surrounding cities and villages come reports of many cases from which persons carrying this disease may come to our city and live in our midst, thus becoming an active menace to ourselves and the children of this city. Skidmore College has thought it of sufficient importance to enforce vaccination of all students.

"To decline vaccination is to place personal inclination above public good and is against every principle of citizenship. Smallpox can be prevented by vaccination and by vaccination only."

The *Buffalo Express*, March 25th, contains the following account of a Children's Health Demonstration in Buffalo:

"A children's health demonstration, to cover a period of five years in the section of the city where the greatest infant mortality exists, has been begun under the general auspices of the Buffalo Council of Social Agencies. The area to be served comprises the baby clinic at No. 404 Seneca Street and a new baby clinic at No. 378 Elk Street, in general covering the first sec-

ond and third wards of the city. Physicians and district nurses are in charge.

"Other agencies co-operating in this effort to bring about a reduction in infant mortality are the Buffalo City Hospital, Junior League, Buffalo Home Bureau, Charity Organization Society, Erie County Board of Child Welfare, International Institute Buffalo Foundation, Bureau of Public Welfare, Department of Charities and Corrections of Erie County, members of the medical profession, members of the clergy and the public schools. It is hoped not only to reduce infant mortality, but also to improve health conditions generally in this section of Buffalo. The Buffalo City Hospital will maintain morbidity and mortality records for all patients treated at central or branch dispensaries, in the home or in private hospitals at public expense.

"Cases of sickness other than accident, first aid or trivial ailments are not to be treated at these demonstration clinics, but are to be referred to the proper clinics or to private practitioners where the patient can pay the prevailing rates."

We fail to note any mention of physicians or medical society in this account. When will the leaders of lay health organizations learn to consult physicians and medical organizations in their plans?

In contrast with Buffalo the physicians of Troy are being consulted in a health movement in this city, according to the following account in the *Troy Budget* of March 22d:

"In the movement to promote and popularize health preservation through annual physical examination, the Rensselaer County Medical Association and the Rensselaer County Tuberculosis Association are co-operating with the National and State Associations in trying to interest the people of Rensselaer County in this subject.

"With its usual sympathy in movements of this kind, Proctor's Theatre is lending its aid, and tomorrow, Tuesday and Wednesday will project the film, bearing the title of 'Working for Dear Life.' The film has been produced by the Metropolitan Association and is being used throughout the United States. More than two million people have already seen it.

"During the past year the Rensselaer County Medical Association has ascertained as far as possible the number of people who are having annual physical examinations in Troy and the county. For the population of our country the number who are giving the prevention side of health work attention is very small. We have adopted the national slogan, 'Have a physical examination in your birthday.' This means go

## GORGAS MEMORIAL

Pursuant with its plan to secure active cooperation between the public and the medical profession the Gorgas Memorial is now holding meetings, open forums, large and small convocations of influential men and women in cities and towns throughout the United States. This is also in line with a \$5,000,000 Endowment Fund appeal now before the public. Staten Island, New York, reports such an enthusiastic reception in that community of the Gorgas Idea that we believe it is worth noting in these columns.

On March 22nd, Sunday afternoon, over one hundred Staten Islanders assembled at the home of Mrs. William G. Wilcox to hear about this health movement which aims to prolong life approximately twelve years and make those years of maturity the best of all, that is healthy, productive years.

We quote from notes taken at that meeting.

"Mrs. William G. Wilcox called the meeting to order and told informally and delightfully about the Gorgas Idea.

"Dr. Edward Sherrard Rimer of New York City was the first speaker. Dr. Rimer said that two of the reasons he was personally interested in the Gorgas Memorial were because he was so fortunate as also to belong to the Society of Bellevue Alumni of which General Gorgas was so distinguished a member. Also Dr. Rimer as a former quarantine officer of Staten Island had formerly himself to combat yellow fever.

"Dr. Rimer made an exceedingly interesting address.

"Briefly, he said that all physicians are interested in preventive medicine. He outlined the life of Dr. Gorgas, showing how it had pivoted around yellow fever.

"Most interesting was Dr. Rimer's description of a Staten Island yellow fever epidemic some years ago. He related that ships coming in from foreign ports brought yellow fever cases and in spite of every precaution then known to medical officers the dread disease spread all over the Island. So enraged were the Staten Islanders at one time when there were 108 cases of yellow fever in St. George (the section where the ferry comes in from New York and also where the quarantine buildings were) that a group of them got together and set fire to the hospital. This deed was reviled in every newspaper in the land, but eventually the courts set free the citizens who had perpetrated it (many of them very prominent socially and financially) on the ground that no special community should be made to suffer for the good of the whole country.

"The irony of the situation was, as Dr. Rimer put it, that 'all this didn't keep the yellow fever mosquito from wandering around' and yellow fever was as rampant as ever!

"Dr. Alva H. Doty, as Health Officer, was at that time very much interested in following the

work of General Gorgas in Havana and Panama. (Dr. Doty is now an enthusiastic member of the Gorgas Memorial New York State Governing Committee). Working on the mosquito theory of yellow fever that Gorgas so marvelously demonstrated, Dr. Doty and his helpers were able eventually to banish yellow fever from Staten Island and an almost worse plague—malaria.

"Quotations of statistics from Health Department Bulletins illustrated the extent of deaths from preventable diseases, and Dr. Rimer pointed out how the Gorgas Memorial expected to remedy this. 'In the United States,' declared Dr. Rimer, 'there are three million persons sick today, of whom one million are wage earners. The financial loss from preventable illness and death amounts to at least one and one-half billions of dollars annually. At least one hundred million dollars of the money lost each year on account of illness could be saved and a quarter of a million deaths could be prevented.'

"Dr. William Bryan, known and beloved by every family in Staten Island, next spoke.

"Two years before, in 1923, Dr. Bryan stated that he had had the honor to be present at the laying of the corner stone of the Gorgas Memorial Institute in Panama. This Institute is the \$750,000 gift of the Republic of Panama for research along the lines of tropical disease. Dr. Richard P. Strong of Harvard is Director of this phase of the Gorgas Memorial. 'Most impressive,' said Dr. Bryan, 'was the ceremony I witnessed when the corner stone of this great Institute was put in place.'

Dr. Bryan, who had been of the party of Dr. Franklin Martin of Chicago on this occasion, spoke of his long association with Dr. Martin, how he loved and admired him personally and how fortunate the Gorgas Memorial was in having such a man as Chairman of its national Board of Directors.

Dr. Bryan told graphically of the difference in Panama as he had seen that country before and after Gorgas's day—Panama under native control and Panama under the control of sanitary laws. Dr. Bryan considered Panama a splendid example of what knowledge and education along health lines can mean. 'The Gorgas Memorial,' stated Dr. Bryan, 'has as its object to spread a more advanced knowledge of what relates to health.'

"'Medicine over the radio, health talks at meetings such as this one at Mrs. Wilcox's home, lectures, easily read pamphlets for wide distribution, the great press and by films in the motion picture theatres—and in schools—are some of the means to be employed by the Gorgas Memorial in promoting better health,' continued Dr. Bryan. 'The medical profession,' he drily remarked, 'is, you will note the only profession that is working to knock the props from under it



# BOOKS RECEIVED



Acknowledgment of all books received will be made in this column and this will be deemed by us a full equivalent to those sending them. A selection from these columns will be made for review as dictated by their merits, or in the interest of our readers.

**PRACTICAL HISTOLOGY** By HENRY ERDMANN RADASCH, M.Sc., M.D. Second Edition Revised and Enlarged 12mo of 621 pages, with 333 illustrations Phila., P. Blakiston's Son and Co., 1924 Cloth, \$5 00

**TOXICOLOGY OR THE EFFECTS OF POISONS** By FRANK P UNDERHILL, Ph.D. 12mo of 292 pages Phila., P. Blakiston's Son and Co., 1924 Cloth, \$2.25

**LANG'S GERMAN-ENGLISH DICTIONARY OF TERMS USED IN MEDICINE AND THE ALLIED SCIENCES** Edited and Revised by MILTON K. MEYERS, M.D. Third Edition, enlarged. Octavo of 613 pages Phila., P. Blakiston's Son & Co., 1924 Cloth, \$7 00

**THE ESSENTIALS OF PHYSIOLOGY INCLUDING THE PHARMACODYNAMICS OF THE IMPORTANT TYPICAL DRUGS** By GEORGE BACHMANN, M.S., M.D., and A. RICHARD BLISS, Jr., A.M., Ph.D., M.D. Octavo of 343 pages with 178 illustrations Philadelphia, P. Blakiston's Son and Company, 1924 Cloth, \$3 50

**A TEXT-BOOK OF PRACTICAL THERAPEUTICS** With Especial Reference to the Application of Remedial Measures to Disease and Their Employment Upon a Rational Basis By HOBART AMORY HARE, B.Sc., M.D., LL.D. Nineteenth Edition, enlarged, thoroughly revised, largely rewritten Octavo, 1061 pages, 144 engravings, 8 plates Phila., Lea and Febiger, 1925 Cloth, \$7 00

**ELEMENTARY MORPHOLOGY AND PHYSIOLOGY FOR MEDICAL STUDENTS** A Guide for the First Year and a Stepping-stone to the Second By J. H. WOODGER, B.Sc. Octavo of 528 pages, illustrated. New York, Oxford University Press, American Branch, 1924 Cloth, \$4.20

**SURGICAL CLINICS OF NORTH AMERICA.** Volume 4, Number 6, December, 1924 (Lahey Clinic Number) Published every other month by the W. B. Saunders Co., Phila. and London Per Clinic Year (6 issues) Cloth, \$16 00 net, paper, \$12 00 net.

**THE PHYSIOLOGY OF MIND** An Interpretation Based on Biological, Morphological, Physical and Chemical Considerations By FRANCIS X. DERCUM, A.M., M.D., Ph.D. Second edition, reset Octavo of 287 pages Phila. and London, W. B. Saunders Co., 1925 Cloth, \$3 50

**PRINCIPLES OF SURGERY FOR NURSES** By M. S. WOLFF, M.A., B.Sc. M.R.C.S. (Eng.), L.R.C.P. (Lond.) Octavo of 350 pages, illustrated. Phila. and London, W. B. Saunders Co., 1925 Cloth, \$3 00

**MEDICAL CLINICS OF NORTH AMERICA.** Volume 8, Number 4, January, 1925 (Mayo Clinic Number) Published every other month by the W. B. Saunders Co., Phila. and London Per Clinic Year (6 issues) Cloth, \$16 00 net, paper, \$12 00 net.

**TEXT-BOOK OF HUMAN PHYSIOLOGY INCLUDING A SECTION ON PHYSIOLOGIC APPARATUS** By ALBERT P. BRUBAKER, A.M., M.D., LL.D. Eighth edition, revised and enlarged Octavo of 853 pages with 367 illustrations. Phila., P. Blakiston's Son and Co., 1925 Cloth, \$5 00

**ORGANIC MEDICAMENTS AND THEIR PREPARATION** By ERNEST FOURNEAU Authorized translation by W. A. SILVESTER, M.Sc. Octavo of 262 pages with 22 illustrations Phila. P. Blakiston's Son & Co., 1925 Cloth, \$4.25

**MEDICINE AN HISTORICAL OUTLINE.** By M. G. SEELIG, M.D. 12mo of 207 pages Baltimore, Williams and Wilkins Co., 1925 Cloth, \$2.25

**PREPARATION OF SCIENTIFIC AND TECHNICAL PAPERS** By SAM F. TRELEASE and EMMA SAREPTA YULE. 12mo of 113 pages Baltimore, Williams and Wilkins Co., 1925 Cloth, \$1 50

**THE DETERMINATION OF HYDROGEN IONS** An elementary treatise on the hydrogen electrode, indicator and supplementary methods with an indexed bibliography on applications By W. MANSFIELD CLARK, M.A., Ph.D. Second Edition Octavo of 480 pages Baltimore, Williams and Wilkins Co., 1925 Cloth, \$5 00

**THE INHERITANCE OF MENTAL DISEASES** By ABRAHAM MEYERSON Octavo of 336 pages Baltimore, Williams and Wilkins Co., 1925 Cloth, \$5 00

**SERUM DIAGNOSIS OF SYPHILIS BY PRECIPITATION** Governing Principles, Procedure and Clinical Application of the Kahn Precipitation Test. By R. L. KAHN, M.S., D.Sc. Octavo of 237 pages Baltimore, Williams and Wilkins Co., 1925 Cloth, \$3 00

**CLINICAL PSYCHOLOGY** By LOUIS E. BISCH, M.D., Ph.D. Octavo of 346 pages, with illustrations Baltimore, Williams and Wilkins Co., 1925 Cloth, \$3 00

**ELEMENTS OF PHYSICAL BIOLOGY** By ALFRED J. LOTKA, M.A., D.Sc. Octavo of 460 pages, illustrated Baltimore, Williams and Wilkins Co., 1925 Cloth, \$5 00

**LES ARYTHMIES EN CLINIQUE** PAR A. CLERC, PROFESSEUR AGREGÉ A LA FACULTE DE MEDECINE MEDECIN DE L'HOPITAL LARIBOISIERE. Preface du Pr H. VAQUEZ Masson et Cie, Editeurs Paris 1925 34 fr

**FROM INFANCY TO CHILDHOOD** The Child from two to six years By RICHARD M. SMITH, M.D., Assistant Professor Child Hygiene, Harvard University The Atlantic Monthly Press, Boston 1925

**DISEASES AND DEFORMITIES OF THE FOOT** By JOHN JOSEPH NUTT, B.L., M.D., F.A.C.S., Professor Orthopedic Surgery, Polyclinic Medical School and Hospital, Surgeon-in-Chief, New York State Orthopedic Hospital for Children. Second Edition, completely revised E. B. Treat & Co., New York, 1925 Price, \$4 00

**THE PRACTICAL MEDICINE SERIES**, comprising eight volumes on the year's progress in medicine and surgery Under the General Editorial Charge of CHARLES L. MIX, A.M., M.D. Volume V, Gynecology and Obstetrics Series 1924 The Year Book Publishers, Chicago Price, \$2 00

**LA REACTION DE FIXATION DANS LA TUBERCULOSE** PAR ARCHILLE URBAIN Preface De A. BESREDKA, Professeur A l'Institut Pasteur Masson et C, Editeurs Libraires De L'Academie De Medecine, 120 Boulevard Saint-Germain, Paris, 1925

**ENERGETIQUE CLINIQUE PHYSIOPATHOLOGIE—THERAPEUTIQUE.** A. MARTINET Le Sympathique, Le Vague, Les Reflexes, De La Vie Organo-Vegetative Publie Par Les Soins Du Dr Martingay Masson et C, Editeurs, Libraires De L'Academie De Medecine, 120 Boulevard Saint-Germain, Paris 1925

to your own family physician and enlist his aid in preserving your present health or correcting any undesirable conditions which may exist "

The New York Sunday *Times* of March 22d, contains an article on Motor Camps. It had investigated camps in various parts of the country, and described one in Michigan maintained at an annual cost of \$3,000 to the public treasury, the theory being that the campers would spend money in the town. The reporter had canvassed the campers, 167 in number, and found that the total amount that they had spent that day was nine dollars, and that less than 5 per cent of them expected to patronize a hotel during a lengthy trip.

The article states that a fee is now being charged for some camps, and says

"The recently organized International Association of Tourists' Camps was formed to direct in an advisory capacity the general management and equipment of motor camps in the United States and Canada. One of its prime objects is to abolish the free municipal camping system, substituting better equipped camps at which a nominal fee will be charged.

"Competition by various communities for the expectant trade from motor visitors, which it is now discovered seldom materialized, had the result that many desirable comforts were obtained for nothing.

"Many of these places," explained President McManus at the recent organization of the association, "are equipped with electric lights, water sanitation, tables under shelter, fireplaces, fuel for cooking, police protection, and in many instances local evening papers are supplied and shower baths provided, all gratis to campers, but at the expense of taxpayers."

"The large free tourist camp at Denver, which has been used by thousands of motorists, was recently changed to a pay-as-you-enter camp and hundreds of other western camps will adopt that policy this year."

Motor camps are a potential source of danger to health, and our experience is that the sanitary attitude of any set of campers will bear watching.

The New York *Herald-Tribune*, March 26th, contains the following account of the arrest of a chiropractor.

"Joseph Miller, a chiropractor of 49 Seventh Street, was held in \$500 bail for trial in Special Sessions yesterday, on a charge of practicing

medicine without a license. He was alleged to have treated John Sankovski, 316 Sixth Street, diagnosing pulmonary tuberculosis as acidity of the stomach.

"Sankovski was a registered patient with the Board of Health. Dr. Samuel H. Paley, of the Health Department, said he and other doctors had examined Sankovski and were arranging to send him, at the city's expense, to a dry climate. Dr. Paley added that on a recent visit Sankovski denied having tuberculosis, and gave Miller as his authority.

"On the stand Sankovski said Miller had promised to cure him for \$40, which he paid. The cure consisted, he told Magistrate Oberwager in Essex Market Court, of manipulation of the spine and prescription of certain foods."

We presume that chiropractors are doing this same thing in every community, but who will assume the burden of their prosecution? Here is a strong argument for the Medical Practice Act, which was defeated in the last Legislature.

The New York *Times* of March 29th quotes Dr. W. H. Park in his criticism of the Medical Reference Bureau, which seems to exist in order to oppose vaccination and the use of serums. The article says

"That is an organization that has been putting forward the most horrible statements. The death rate has been cut tremendously by diphtheria antitoxin, which is a most efficient remedy. There were 1,200 deaths from diphtheria in 1919, for instance, and this year only about 500.

"The discouragement is not felt about the remedy itself, which is of remarkable efficacy, but it is felt because of the fact that, with this wonderful remedy in existence, so many parents fail to have their children treated until it is too late. To illustrate, we had a woman bring four children to the Willard Hospital with diphtheria a few days ago.

"One had had it four days, two had it two and one-half days and the other one day. The child that had the disease for four days died fifteen minutes after his arrival.

"I believe, and I have said, that in time the death rate from antitoxin will be reduced by 90 per cent, but I doubt if the final 10 per cent of the cases can be prevented because of the seeming impossibility of carrying public health education to the point where one of our greatest remedies is thoroughly used. Both the antitoxin and the immunization methods are extremely effective agents in warring on this disease."

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL. 25, No 14

NEW YORK, N Y

APRIL 17, 1925

## SOME PRACTICAL CLINICAL AND CYSTOSCOPIC POINTS IN UROLOGICAL DIAGNOSIS \*

By MAXIMILIAN ZIGLER, M D,

NEW YORK CITY

IN making urologic diagnoses one finds that the past history, clinical symptoms, physical and cystoscopic examination, the laboratory and X-ray pictures are all necessary for the proper work-up of a case

Cystoscopic examination of the bladder or ureteral catheterization does not necessarily mean making a correct diagnosis. One must have a complete history of the case plus physical examination before going ahead with the cystoscopic examination. Because then one already will have an idea as to the tentative diagnosis. Yet we have the very frequent experience of having one of our confreres trying to make an appointment with us for cystoscopy only. Just as if that one method of examination were the complete story.

In the physical examination it is important to know whether the meatus is patent. A narrow meatus either congenital or acquired is not an infrequent complication. This slight complication if not noticed until one is ready to perform cystoscopy will be a source of inconvenience and loss of time to the surgeon.

A narrow meatus is not an infrequent condition in both males and females. It is surprising how often a narrow meatus may be present and yet give no symptoms. On the other hand I have seen a number of cases where very marked and many urological symptoms were present as a result of a narrow meatus.

The history of urological patients must involve the past as well as the present history of infections. Tuberculosis plays a very important role in urology. This makes it necessary to go into the minutest details, as to the past personal history of the patient in regard to pulmonary tuberculosis, pleurisy or pneumonia.

In taking histories of patients one must never forget that a great many patients are determined to live down tuberculosis. They feel there is a stigma attached to either of the above named

infections, and they try to forget the same. So that if you inquire the past history of such an infection the patient promptly denies the same. Feeling that the present trouble has no relationship to the past infection, so why tell. This spirit often results disastrously for the patient for it helps to conceal the diagnosis in a difficult or in an early case.

Another infection that plays a very important part in urology is the colon bacillus. In the history it is advisable to inquire if the patient has a tendency toward constipation because not infrequently a severe acute colon infection takes place in the kidneys after a marked attack of constipation. It is also important to inquire whether the patient ever had an attack of pyelitis during pregnancy, infancy, or childhood. Colon bacillus infection of the kidney or pelvis is very apt to develop after exposure to wet or cold especially after excessive indulgence in alcohol.

Besides going into the history of tuberculosis and colon bacillus infection, it is essential to go into the venereal history. After the history as to past infections has been gone into, one should inquire whether any foreign bodies have been introduced into the urethra especially in a vague and puzzling case. Although at times it is difficult to elicit such a history as the following cases will prove. Called by a confrere to see a 60-year-old man. His doctor simply wished me to see him in order to verify his diagnosis of an inoperable prostatic carcinoma. Examination disclosed a hot fluctuating tumefaction around the bulbous urethra. Prostate normal. Patient had a high temperature and was on the point of retention of urine. The diagnosis of peri-urethral abscess of unknown etiology was made. A large abscess was incised and as my finger reached into the pus pocket a sharp object was encountered and on withdrawal it was found to be a tooth pick. Patient confronted with tooth pick denied having introduced the same for sexual gratification. Says that he probably sat on the

\* Read before the Bronx Surgical Society, January 28, 1925



# BOOK REVIEWS



**ANESTHESIA FOR NURSES** By COLONEL WILLIAM WEBSTER, DSO, M.D., CM Professor Anesthesiology, University of Manitoba Medical School. Illustrated C V Mosby Co, St Louis 1924 Price, \$2 00

The book covers the subject as fully as is necessary. In fact, the great question in this subject, as in many others, is how much instruction should be given the nurse. A certain amount of the medical aspects of anesthesia must be introduced in a book to lead up properly to the nursing considerations, while points in technique of administration are outside of the field.

Dr Webster, already the author of a book on anesthesia for general medical service, has used his wide experience in selecting the material necessary for a book of this sort. The practical considerations involved in the nursing care before and after the operation, with emphasis on the mental preparation of the patient, are stressed, and the dangerous events in the course of the operation and at the later time when the nurse is in charge are fully explained. The practical aspect of the case is well covered with careful explanation of the remedial agents to meet any emergency which may arise.

GEO W TONG

**CLINICAL STUDIES IN EPILEPSY**, composed of clinical notes on some epilepsies as bearing on the pathogenesis of idiopathic epilepsy. By DONALD FRASER, M.D., FRFP & S (Glas). William Wood & Co, New York, 1924 Price \$2 50

The scope of this book is thus set forth by the author: "I purposely avoided dealing with questions of heredity, treatment, and the general pathology of epilepsy, being concerned mainly with the meaning and mechanism of the fit in its beginnings as a cerebral process." His effort is to discover some unknown hormone which he postulates as an important factor in resisting the influence of toxin or toxins which initiate the epileptic movement.

From clinical material accumulated in over thirty years' experience he shows the relation of epilepsy to psychology, vaso-constriction, the cerebro-spinal reflex, the endocrine glands, traumatism and tumors, tuberculosis and syphilis, and arrives at the theory that the induction of an epileptic seizure of any kind is due to two main factors "these are a toxin or toxins, whether or however produced, noxious to cell or vessel, and a cerebro-spinal or cerebral reflex set up by the irritation of strain or defects in parts or centres serving special functions."

The book is a stimulating contribution to the slowly accumulating knowledge of this most obscure and terrible of diseases.

ROBERT ORMISTON BROCKWAY

**OUTLINES OF INTERNAL MEDICINE FOR THE USE OF NURSES AND JUNIOR MEDICAL STUDENTS** By CLIFFORD BAILEY FARR, A.M., M.D. Fourth and revised edition. 12mo, 377 pages, 69 illustrations, 6 plates. Phila and New York, Lea & Febiger, 1924. Cloth, \$2 75

This is a comprehensive high grade book and covers the subjects treated in a satisfactory manner. As stated in the preface the book is divided into ten parts, eight of which are devoted to diseases of the various systems and two to harmful agencies invading the body from without.

All the articles are well written with printing paper and illustrations of the highest type. The volume is of handy size and handsomely bound.

The volume is intended principally for a text and reference book for nurses and is heartily recommended for first class training schools.

W E. McCOLLOM

**AFFECTIONS DE L'OEIL EN MEDECINE GENERALE—DIAGNOSTIC ET TRAITEMENT** By Professors F TERRIEN AND G COUSIN. Masson et Cie, 120 Boulevard Saint-Germain, Paris 1924

This work by F Terrien and G Cousin considers affections of the eye in the relation to General Medicine, mainly associating the diagnosis and treatment.

There are chapters on the anatomy and physiology of the eye, which, though brief, are sufficiently complete to meet the purpose of the outlines.

The pen and ink illustrations are well executed and illustrate the points under discussion satisfactorily.

The section on examination of the eye is presented in a practical way and gives a succinct survey of the aspects of direct and indirect vision. Color sense and the light sense are touched upon.

The neurological aspect of the subject is well developed, particularly as expressed in motor anomalies.

The semiology is expanded in a section wherein the authors progress in a systematic order to unfold the ocular manifestations of systemic disease. In this portion of the book many photographs are inserted which are of distinct value. The last few chapters take up the manifestations related to the endocrines, cardiovascular system, respiratory apparatus, etc. Separate diseases are discussed under these heads, especially valuable being that portion dealing with the nervous system. As a whole the book seems very worthy of translation.

J N E

**CLINIQUE MEDICALE DES ENFANTS—AFFECTIONS DE L'APPAREIL RESPIRATOIRE.** P NOBECOURT, Professeur de Clinique Medicales des Enfants à la Faculté de Médecine, de Paris. Masson et Cie, Editeurs, Paris, France, 1924

This is a collection of Clinical Lectures by Professor Nobecourt many of which have been published separately in the various French medical journals. Nobecourt is one of the best known pediatricians not only of France but of all Europe and he has the happy faculty of being a clear and concise clinical teacher. The fact that the various chapters were each clinical lectures makes them very lucid and profitable reading.

Chapters of particular interest are those on Asthma, Whooping Cough and Tuberculosis, Pleura and Lungs in Cardiopathies, and on the various forms of Pleurisy in Children. One notes the frequent references to the tracheo-bronchial glands in the text as is so much more the case with European than with American writers on Pediatric subjects. This work is worthy of its author and his publishers, which is saying a great deal.

WM HENRY DONNELLY

**HISTORY OF THE GREAT WAR BASED ON OFFICIAL DOCUMENTS—MEDICAL SERVICES. GENERAL HISTORY. Vol 2.** By Major-General Sir W G Macpherson, K.C.M.G., C.B., LL.D. Octavo, 510 pages, illustrations and maps. London, His Majesty's Stationery Office. Cloth, 21s. net.

This volume of the History of the Great War presents in detail the problems of the care of the sick and wounded by the British Expeditionary Force in France and Belgium. It is a complete, thorough study which gives in detail the medical activities as they were met in a general way and also the care of the wounded during and after each battle. For any one interested in the problems of medical activities in war, this volume holds a wealth of information. The thoroughness and detail of the work makes it a historical volume. Excellent maps of the battle fields are given throughout the book.

H M M

ent from either tubercular testicle or the syphilitic testicle. Gonococcus infection of the testicle is still called epididymo orchitis in many text books. On careful examination of the testicle during operation or after the subsidence of the acute stage, one will find that there is no involvement of the body of the testicle, that the large size of the testicle is due to the enormous enlargement of the epididymis, the epididymis not infrequently, being as large or even larger than the body of the testicle. In addition, there is an inflammation and oedema of the tunica vaginalis with some accompanying hydrocele, plus some edema of the other layers of the testicle. Furthermore, when the acute inflammation has subsided, one can readily palpate the thickened, knoblike epididymis as the only remaining lesion, while if one palpates the body of the testicle one will find it perfectly normal. In other words, gonococcus inflammation of the testicle is not an epididymo orchitis but an epididymitis.

The second type of inflammation of the testicle is that due to staphylococci and colon bacillus. This type of epididymitis usually occurs in patients who have infections of the bladder, prostate or posterior urethra. This infection not infrequently is a post-operative complication following prostatectomy, lithopaxy, hernia operation, etc.

The clinical symptoms of the staphylococcus-colon bacillus group of epididymitis are not very different from the gonorrheal type except as a rule the swelling and pain in the testicle is not apt to be as acute or severe in the former as it is in the latter type.

The history of the tubercular testicle is usually a chronic one. Very exceptionally a patient may have an acute tuberculosis of the testicle. Occasionally the infection is subacute. The subacute case comes to the office complaining of a lump and a slight pain in the affected testicle. Examination shows slight enlargement of the epididymis. The patient is not as acutely ill as he is in either gonococcus or the mixed infection epididymitis. The chronic type of tubercular testicle is the usual one. History is somewhat as follows. The patient states that he has been struck on the scrotum and then for the first time feels a lump in the testicle, or while taking a bath discovers a lump in the same, or during a routine physical examination this lump is discovered. In addition to noting this lump some patients have slight pain in the testicle, some in addition have slight discharge from the urethra. This latter symptom is quite important and is emphasized because not infrequently a young boy with discharge plus tuberculosis of the epididymis is accused both by his parents and by his doctor of having gonorrhea. In fact, a great many of these cases are treated for gonorrhea for a considerable time and are really made worse by strong chemical and drastic mechanical methods. In urology,

it is important to remember that chronic tuberculosis is stirred up into acute or subacute process by strong Agnoz treatment or by passing sounds or instruments on such cases. In fact, we use this point as an aid to diagnosis and make the following rule that whenever the reaction following instrumentation on the urethra, bladder or prostate is out of proportion to the instrumentation, suspect tuberculosis.

As a rule, the tail of the epididymis is involved in an adult in an early case of testicular tuberculosis. Usually the entire epididymis is involved before the patient comes under observation. The urologist not infrequently sees the case when the entire testicle is involved, with sinus formation well marked. A differential point of diagnosis between adult and early childhood testicular tuberculosis is that in adult life, as just mentioned, the early process is in the tail of the epididymis, while in childhood it is more apt to be located in the body of the testicle. Palpation of the typical tubercular epididymis in the adult will disclose a nodular epididymis, especially the tail. This is considered characteristic. At times, either thickening or nodulation of the vas on the affected side is present. I have found thickening of the vas much more frequently present than nodulation. In fact, neither thickening nor nodulation of the vas have in my experience been present as frequently as one would suppose from reading the literature. In addition to these physical signs the diagnosis of tuberculosis of the epididymis is materially aided by finding an associated prostatitis and seminal vesiculitis of the indurated or the nodular type.

I believe that induration or nodulation of the prostate or seminal vesicles is a more frequent accompaniment of tubercular epididymitis than is induration or nodulation of the vas. In other words, as far as palpation is concerned, I feel that the half-way house, the vas, situated between the epididymis and the prostate and seminal vesicles is less frequently involved than either the epididymis or the prostate and seminal vesicles. If the vas be found thickened it is a definite aid in the diagnosis of genital tuberculosis.

Additional aids in the diagnosis of genital tuberculosis are either sinus formation in the testicles, or physical signs of tuberculosis elsewhere in the body, especially in the lungs. As further aids to the diagnosis of urological tuberculosis are the various laboratory methods. Examination of the urine for tubercle bacilli and guinea pig inoculation, the latter being very much more reliable because of the difficulty of finding the tubercle bacillus in the urine. The disadvantage of guinea pig inoculation is the fact that one must wait about six weeks for a report.

Various authors speak of sinus formation as occurring only in tuberculous epididymitis. I have reported a case of bilateral gummatous epi-

tooth pick but does not know when This case shows how difficult it is to obtain a good history

After a thorough history has been taken one proceeds to the physical examination We usually examine the external genitals first Taking note of the appearance of the same, especially whether there are any anatomical abnormalities such as hypospadias, narrow meatus, false openings, split meatus, etc Then the external genitals are inspected for lesions and the urethra for discharge

Under inspection allow me to quote the following We have had a number of female patients referred to the urological clinic at Lebanon who had frequency of urination as their chief complaint, in whom on inspection before a cystoscope was passed a diagnosis of their condition was made A good example is the following Patient had an eczematous, bluish, shiny, somewhat indurated eruption on the vulva, extending down the buttocks on to the inner surface of the upper thigh This skin condition was diagnosed as diabetic eczema, and the symptom of frequency as being due to diabetes This diagnosis was made prior to urine examination, and was subsequently confirmed by the finding of sugar in the urine and by negative cystoscopic examination Another type of case in which invariably we explain urologic symptoms by inspection is cystocele and rectocele We have seen a considerable number of such cases and have found them negative from the urologic standpoint Inspection gave us the diagnosis

Urethral caruncle in women usually located at the meatus may extend bladderward for about a half inch Inspection will draw your attention to this condition Unless you actually attempt, however, to pass a fair sized sound you can have no idea as to the amount of obstruction the same may cause

After inspection we proceed to palpation We palpate scrotal sac to ascertain if both testicles are present, also to ascertain their size, consistency, etc If enlargement of testicles be found one must differentiate between epididymitis, hydrocele and tumor Both cords are palpated for thickening or inflammation and also for varicocele If bilateral varicocele be found one must think of the possibility of growth in the pelvis or abdomen

After the fifth decade if the patient gives a history of having had warts on his penis for years or a tight foreskin associated with balanitis and develops a lesion, think of epithelioma, especially if the growth has been of slow formation

In the physical examination of the abdomen, special notice is taken if kidneys be movable, prolapsed, enlarged or tender Deep fist percussion over both kidneys, the so-called Murphy sign, is a valuable sign of kidney disease, especially calculous After the physical examination, the patient is requested to void urine and

the macroscopic appearance is noted whether clear, pus cloudy or bloody Twenty-four hour specimen is then sent to laboratory

After performing all the above mentioned preliminaries, one is ready for cystoscopy If there is considerable discharge, especially if purulent, it is not advisable to perform cystoscopy On the other hand if hematuria be present that is the best time to perform cystoscopy, because if one waits until the bleeding stops, one may not be able to find the site of bleeding

Cystoscopic examination of the bladder sphincter of females complaining of frequency as their only symptom, not infrequently will show cystic degeneration of the bladder neck These are the patients whom we used to call "female urinators," for want of a better name, because we did not know the cause and considered the condition as a symptom of a neurotic woman These cases of cystic degeneration of the bladder neck are curable with fulguration combined with dilatation and Agnoz instillation

Until very recently it was not generally known that gonorrheal stricture of the female urethra is quite a prevalent condition and may give a number of urologic symptoms Its usual site is at the meatus It may, however, extend from the meatus all the way back to the bladder Another interesting cystoscopic point in women is that trigonitis is a very prevalent condition, in fact very much more frequent than in men, in spite of the fact that males so frequently have inflammation of their posterior urethra

We will now take up some of the interesting points about genital and also urinary tuberculosis I have purposely not used the frequently misused term, genito-urinary tuberculosis Patients may suffer either from genital tuberculosis, urinary tuberculosis, or the combination of the two, namely, genito-urinary tuberculosis With the modern methods of diagnosis we can as a rule readily place patients in a definite group and are not obliged to use the indefinite term genito-urinary tuberculosis

In a diagnostic study of testicular inflammation, the past history of the patient, as previously mentioned, is essential In dealing with epididymitis there are usually four different bacterial groups to be considered The first is gonococcus, the second mixed infection comprising staphylococcus and colon bacillus, the third tubercle bacillus, and the fourth spirochaete pallida In the gonococcus testicle we usually obtain the history of gonorrhea, either present or past There may be a discharge with or without gonococci demonstrable Onset usually sudden with great pain, acuity, marked swelling and redness of the testicle The testicle is swollen to two or three times its normal size Pain usually so severe that the patient is obliged to go to bed unless the testicles are properly strapped and lifted upon the pubic bone This acuity of symptoms is entirely differ-



of the bladder Usually an ordinary papilloma has a very slender stalk and a slender base with a distinct blood vessel coursing through its center, while malignancy usually has a broad base Secondly, a profound cystitis usually accompanies malignancy, while the bladder is usually clean with papilloma Bullous or cobble stone edema is a not infrequent accompaniment of malignancy, but is not present with papilloma Marked incrustation of the growth, usually phosphatic, is a not infrequent satellite of cancer of the bladder, so much so that a great number of these malignant tumors with incrustation are diagnosed as bladder calculi

In searching for bladder tumors with the cystoscope be sure to not alone look at the usual site, namely the trigone, but also make sure to look up at the vault of the bladder, especially the roof of the bladder sphincter, because occasionally a tumor is located at that site

Occasionally a bladder tumor can be diagnosed by palpation of the base of the bladder through the post prostatic recto-vesical space That is, one can feel induration of the trigone by palpation with the finger in the rectum Sometimes bimanual palpation is an aid in diagnosis The one finger in the rectum palpating the base of the bladder, the other hand pushing the bladder down into the palpating hand Personally I have found this examination negative in most of the cases, even where cystoscopy revealed extensive involvement to the trigonal region, a region which should be very easily palpable through the rectum Prostatic carcinoma on the other hand I have found to be easily detected by palpation This is probably due to the fact that the lobe usually involved is the posterior, which is nearer to the palpating finger than is the trigone

Occasionally the diagnosis of malignancy of the bladder can be made by seeing pieces of the growth in the urine voided These pieces are shreddy flesh like masses which have come away from the tumor Not infrequently some of these pieces may remain attached to the cystoscope These pieces may be sent for diagnosis to the laboratory

In snipping pieces of the growth by means of the rongeur for diagnosis, be sure that you snip from the base of the growth, as the tip or papillomatous stalk may show benign growth only You not only must make sure to take a punch well down into the base of the growth, but also take pieces from various areas, because some areas may not be malignant while others will show characteristic cancerous involvement

#### PROSTATIC HYPERTROPHY

Patients suffering from so-called prostatic hypertrophy must be carefully studied clinically as well as cystoscopically Hypertrophied prostate usually occurs in middle or advanced life.

Such a patient usually gives a history of gradually increasing nocturia for a number of years

However, given a case in which the whole history of symptoms is only of short duration but nevertheless quite marked symptoms, one can suspect trouble other than hypertrophy and most likely malignancy

A prostatic with medium size obstruction who is voiding fairly well suddenly gets up retention What is the usual explanation? The explanation is the same as that for a patient with a stricture of the urethra of size 20 to 24 Fr who suddenly develops retention The stricture case develops an acute edema on top of a stricture of 20 to 24 Fr closes off the urethra to almost nothing, so that no urine can come through The same is true of the prostatic case Due to constipation, getting wet feet, alcohol or sexual overindulgence, an acute edema takes place within the region of the prostatic hypertrophy and causes retention After the acute edema passes, you will be able to pass the same size instrument that you could have passed prior to the retention

There are some urologists who have recently stated that cystoscopy is contra-indicated in the old men with prostatic hypertrophy as there is too much trauma, shock, bleeding, etc., and also because you can diagnose without the cystoscope by clinical symptoms that the patient probably has an hypertrophied prostate This line of argument is not tenable because, should any untoward complication occur as the result of cystoscopy, you can always go ahead and perform supra-pubic drainage Also, we have all seen cases where the finger in the rectum showed a normal prostate and the cystoscope showed marked intra-urethral encroachment or intra-vesical prostate protrusion In other words we know since the advent of the cystoscope that a prostate may enlarge in any one of three or all three directions, that is intra-rectal, intra-vesical, or intra-urethral The surgeon also should know what complications or associated conditions may be present in the bladder, such as stones, diverticula, new growth, etc., also whether the prostate be a small, hard, fibrous or a large, adenomatous prostate These points he must know in order to decide the route he will take, whether the supra-pubic for the latter or the perineal for the former I believe a surgeon who does not avail himself of these advantages is working in the dark

As soon as the diagnosis of a fair size stone in the bladder is made the tendency for the average surgeon who can do lithopaxy is to crush the stone, without studying the conditions associated with that stone, with the result that the condition that caused the stone will soon cause a recurrence of calculus formation Such a case should be studied carefully cystoscopically before doing lithopaxy, in order to know whether there is an associated prostatic obstruc-

didymitis with sinus formation. However, sinus formation in other than tuberculous epididymitis is the exception rather than the rule.

In the syphilitic testicle one usually has at the outset involvement of the head of epididymis. This inflammation, as a rule, is of a chronic type. Not infrequently there is an associated hydrocele. This hydrocele is usually small. Occasionally we get what is called the oyster shell testicle, which is characteristically syphilitic. Diagnosis is at times quite difficult. At times the diagnosis is aided by the past history, by signs of syphilis elsewhere, by positive Wasserman of the blood and finally by the therapeutic test.

#### URINARY TUBERCULOSIS

In the days prior to cystoscopy we used to think that bladder tuberculosis was primary in most of the cases. Today, because of cystoscopy, we know that primary bladder tuberculosis is really an unusual condition. That is, we know that tuberculosis is usually primary in the kidney and secondary in the bladder. The usual clinical symptoms of renal tuberculosis are increased frequency of urination, especially nocturia, painful urination, tenesmus and at times hematuria. This constant desire to urinate with frequency as often as every fifteen minutes, accompanied by severe burning and pain on urination, continued for months or years, makes a pathetic, never-to-be-forgotten picture. Urine may show pus, blood and tubercle bacilli.

Cystoscopically the characteristic points for emphasis are the following. The patient not infrequently has a contracted bladder, especially if his tuberculosis is advanced. This contracted bladder manifests itself clinically by the patient voiding as often as every fifteen or thirty minutes day or night or day and night, voiding but 2 drams to half ounce each time. Cystoscopically one finds that as soon as the above mentioned quantity of fluid is allowed to flow into the bladder, the patient develops terrific spasms, with pain, straining and contraction on the cystoscope, so much so that one must allow the fluid to flow out and with warm solution try to refill slowly. This procedure may have to be tried any number of times before one is able to get a fair degree of distension of the bladder. At times it is almost impossible to get enough tolerance of the bladder for a fair visual field, and by sending such a patient away to the country for a rest for a time, he may return with a tolerant bladder, and an examination may be possible. This lack of distensibility of the bladder, combined with the rapidly accumulating pus mucus and blood, make cystoscopy at such times next to impossible. This peculiar reaction of the bladder to distension, as described above, is characteristic of bladder tuberculosis. There is only one other condition in which contraction of the bladder acts in a somewhat similar manner only, as a rule, not nearly as severe, and that is in bladder malignancy,

especially if the growth is located on the bladder sphincter. In cases of contracted bladder we find that warm solutions are better borne than are cold, also that the bladder is more tolerant to slow filling solutions than to rapidly filling ones. Sometimes a hypodermic of morphine and belladonna will aid the examination. At times novocain 1 per cent injected and forced by the external cut off muscle will help make the examination easier. If other methods fail, sacral anesthesia is ideal.

There are three common types of tuberculosis of the bladder as viewed cystoscopically. First, ulceration around an ureteral opening, second edema around an ureteral opening, third scattered miliary tubercles anywhere in the bladder. The first two types, namely ulceration or edema, are the most common types. I have found the ulcerative type of very much more frequent occurrence than the edematous type. At times there is a combination of edema and ulceration around the ureteral opening. The usual appearance of the ulcerative case is a marked redness around the one or both ureteral openings, with shaggy, roughened edges, excavations and ulcerations making it at times impossible to find the ureteral opening.

At times one does not find the typical ulceration around the ureteral mouth but instead one finds numerous, hemorrhagic, irregular, blotchy like areas, scattered irregularly over the bladder mucous membrane.

The miliary type of bladder tuberculosis is very rare and the cystoscopic picture is the same as tubercles elsewhere in the body. At times creosote pill grains one up to grains ten T I D, causes a very marked specific improvement in the urinary symptoms. Most of these cases are very much irritated by either urotropin or salol.

#### MALIGNANCY OF THE BLADDER

Some urologists consider ordinary papilloma as malignant because of their tendency toward recurrence. This feeling has, however, not been so marked since fulguration has been developed to such a high degree of efficiency. We shall discuss only real malignant bladder tumors. In studying malignancy of the bladder cystoscopically the first thing one is impressed with is that here also as in tuberculosis one has to deal with a contracted bladder. As previously mentioned, I believe that most of the malignancy of the bladder cases can hold more fluid than is possible in the tubercular bladder. The malignant bladder, in addition to being contracted, also shows a marked tendency toward hematuria which is possibly aggravated by the distension and the manipulation of the cystoscope. This contracted bladder symptom, plus the marked hematuria, add greatly to the difficulty of the cystoscopist.

The following are valuable differential points of diagnosis between papilloma and malignancy.

## SCHISTOSOMA HEMATOBIIUM INFECTION AND ITS RELATION TO PERSISTENT URINARY SINUS \*

By WINFIELD SCOTT PUGH, B S, M.D.,

NEW YORK CITY

### INTRODUCTION

CASES of schistosoma infection of the urinary tract have been reported in this country on several occasions. I am sure, however, that many other persistent urinary lesions have appeared in our midst that were undoubtedly caused by this parasite, these cases passing through many hands, often without recognition. We are no longer isolated from the original habitat of this trematode, and as a result of our increasing relations with tropical countries, must expect to find it with greater frequency. During the past twenty years I have seen twenty-one cases of schistosoma infection, six of which were in this country. The disease might be called rare, in this part of the world, but we must always bear it in mind as a possible etiological factor in urinary disease. This remark is particularly applicable to those of us who see many patients from tropical countries.

### DISTRIBUTION

Writers on tropical medicine give the chief source of the disease as Africa, some stating that it is particularly prevalent toward the southernmost part, as the Transvaal and adjacent sections. Others believe it to be more prevalent in the northern section, as in Egypt and its immediate vicinity. Mesopotamia is also given as a point of frequent infection, and some investigators have found the disease in Western Australia. In the Americas, it has been reported in Brazil and we have seen several cases in the Panama Canal Zone.

### ETIOLOGY

In schistosoma infections we have to consider the possibility of three forms of the parasite. The schistosoma hematobium, which is the more frequent in urinary infections, the schistosoma mansoni of intestinal involvement, and the schistosoma japonicum. The latter, at times, wanders into the intestinal tract, but as a rule is satisfied with the production of cirrhotic manifestations in the liver. Among students of tropical medicine the term bilharziosis is usually applied solely to the infection with the schistosoma hematobium, or the urinary form. The three different forms of this trematode are usually sharply limited to the spheres above noted, although schistosoma mansoni has been reported in urinary lesions. We have never seen the latter in the urine nor have any of my friends in tropi-

cal countries, and I am inclined to believe the cases reported were really those of an unusual form of the schistosoma hematobium.

### THE INFECTION

The exact mode of infection is not definitely known, but it is noteworthy that these conditions usually occur in countries where the natives run around barefooted and have the habit of depositing their excrement in whatever place is handy. This suggests a lesion similar to that of early uncinariasis, and we do know that skin itch is common in these countries. Infection through both skin and mucous membrane is suggested by Neatby.

In whatever way the infection occurs we do know that the ova reach the portal system of veins and in this location develop into the adult worms. In the schistosomum hematobium, the ova finally reach the venules of the bladder and then gradually work their way into the bladder submucosa, as the ova is strongly attracted toward anything that resembles water. When the ovum finally reaches real water its capsule ruptures and the so-called miracidium floats free. If it fails to find a suitable host within twenty-four hours, it dies.

Leiper, of the London School of Tropical Medicine, believes that the intermediary host are certain fresh water snails which are found in considerable numbers in the irrigation canals of Egypt and similar places. This author states they also reach what corresponds to a liver in the snail, and the parasite in this stage looks something like a tadpole. In this shape they leave their intermediary host to enter any suitable definitive host.

### SYMPTOMS

The initial symptoms of the disease are never referable to the urinary tract and appear first in a month to six weeks, rarely as long as two months after the infection. Anemia with loss of weight and strength and a dry, scaly skin are common. Early in the disease we also note a leucocytosis of moderate degree with a well-marked eosinophilia.

The urinary symptoms appear in a few days to a week later and usually consist of frequency and painless hematuria, while some cases develop a slight strangury. Several authors tell us that bleeding and dysuria usually cause the anemia, but in the cases we have seen, the anemia was present early in the disease. In some instances of marked hematuria the pain has been noted as excessive, and excessive bleeding is usually

\* From the Urological Department (James Buchanan Brady Foundation) of the New York Hospital.

tion and how extensive the same really is, because it is quite likely that if the prostatic obstruction is of quite a severe degree the enucleation is of paramount importance and not the crushing. In other words, one must get rid of the cause. Also, the cystoscopic picture will give you a good guide as to whether the stone is or is not crushable. The white stones usually are phosphatic and are readily crushable while the dark or black stones are usually oxalate stones and are too hard to be crushed.

### TABES

Tabes, from the urological standpoint, offers some very interesting points in diagnosis. A very early and valuable sign is the loss of sphincteric anal contraction. When the finger is introduced into the normal rectum one finds that one has to overcome resistance to enter, but in tabes one often gets a very early sign of this loss of sphincteric and contraction. It seems as though the finger falls into the rectum, there being no resistance to overcome. This is one of the earliest signs of tabes. A case in point is the following: Patient about 55 years old referred to me with the diagnosis of prostatic hypertrophy, because he suffered with incontinence, frequency, urgency, slow stream, etc. Examination showed loss of sphincteric anal contraction with normal prostate. Further examination showed that patient also had Argyle Robinson pupils, Westphal and Romberg signs. Every surgeon must be on his guard not to operate on such a case, mistaking it for prostatic hypertrophy. In other words, he must be absolutely sure to exclude tabes. Unfortunately a number of cases of tabes have had their prostates taken out in this mistaken diagnosis.

Another case in point is a patient about 30 years old who came to the office because of frequency, loss of sexual power, pain on urination, marked cystitis, etc., with the history that he had had all the most refined technique of urologic diagnosis tried on him, such as pyelograms, cystograms, X-ray, etc., but no diagnosis was made. He has the typical loss of anal sphincteric contraction, Westphal sign and positive blood Wassermann, so that it is important to emphasize the simple examination for diagnosis as well as the more difficult ones.

Cystoscopically there are three important signs of value in diagnosing tabes. The first is relaxation of the internal sphincter, so that on viewing the sphincter through the cystoscope one finds that the waterfall is gone, that is, the inferior segment of the sphincter is relaxed, so that the bladder and urethra are one, second, marked trabeculation localized to each side of the ureteral opening, third, golf hole, or gaping ureteral mouths so that the urine does not spurt out but, so to speak, drops out.

### PYELOGRAMS

It has recently been very definitely shown that strong solutions are no longer necessary for pyelographic diagnosis. Not only have these strong solutions caused damage to the kidneys, but also edema and irritation in the bladder have resulted from solutions of sodium iodide as strong as 25 per cent. It has been shown that a 12½ per cent solution of sodium iodide gives a beautiful picture and yet causes no irritative symptoms. It is considered dangerous to take pyelograms of two kidneys at one sitting, because if there is an untoward reaction, both kidneys would be damaged at one time.

### SUMMARY

1 This paper endeavors to bring out the fact that in urologic diagnosis the history and physical examination should be gone over before cystoscopy. That cystoscopy alone is but one link in the chain and should not precede, but follow, physical examination and history.

2 In studying past history of infections, remember that the tubercular and syphilitic patients attempt to live down their past.

3 In studying chronic epididymitis think of syphilitic epididymitis and make sure to exclude it before operating for a so-called tuberculous epididymitis.

4 The so-called gonorrheal epididymo orchitis is really an epididymitis.

5 A narrow meatus may be of no significance, on the other hand, it may give a long train of symptoms by causing obstruction, back pressure and secondary infection.

6 In studying urologic tuberculosis, remember that you may have either urinary or genital or genito-urinary tuberculosis.

7 An occasional aid in urologic diagnosis is that when reaction following instrumentation is out of proportion to the instrumentation, think tuberculosis.

8 Careful inspection of any urologic case is important because by inspection one may find a narrow meatus, urethral caruncle, cystocele, rectocele, diabetic eczema, lesions on the genitals.

9 A great many so-called "neurotic urinators" in women may have pathology known as cystic degeneration of the bladder neck.

10 Cystoscopically a tubercular kidney is suspected if one has a contracted bladder plus ulceration around an ureteral opening.

11 Malignancy of the bladder cystoscopically shows a contracted bladder, profound cystitis, broad base tumor, possibly accompanied by phosphatic incrustation, plus bullous edema.

12 The cystoscope should be used in the diagnosis of hypertrophied prostate in order to know the extent, location and size of the hypertrophy and its associated complications as diverticula, stones, etc., if they be present.

broke down, urine was cloudy and at times bloody. This condition has continued till the present time. Patient looks pallid and feels weak. A sinus is found in perinaeum at the site of external urethrotomy, which is about one and a half inches long and from which cloudy urine is flowing.

**Blood Examination**—Red cells 4,020,000  
White blood cells, 11,000 Hemoglobin, 80%  
Eosinophiles, 4%

Urine slightly alkaline S G 1.026, cloudy, moderate amount of blood and pus. Microscopic examination shows abundant red blood cells, pus cells, vesical epithelium and the ova of the schistosoma hematobium.

#### TREATMENT

Intravenous injections of tartar emetic were made strictly in accordance with the method of Christopherson and in ten days the urine was clear of parasites. In a few days after the urine became negative the wound in the perinaeum began to respond to stimulation by balsam of Peru, healthy granulations appearing and in three weeks it was entirely closed.

#### CASE II

M K., Persian, age 23, occupation, carpet dealer.

**Family History**—Most indefinite.

**Previous Personal History**—Has had several tropical affections of which we have not heard of before. Thinks he had Spanish influenza about four years ago. Denies venereal history.

**Present Complaint**—Sinus over left kidney and slight hematuria. Patient states that about eight months ago he was operated on in one of our hospitals for what the doctors told him was a perinephritic abscess. Says that he drained considerable pus and urine for about two months, when wound appeared to be almost healed and he then left the hospital. In about one week after leaving the wound broke down again and has continued to discharge considerable pus and some urine ever since.

Examination shows a sinus over the left renal region, surrounded by a mass of tissue that very much suggests carcinoma (section, however, was negative), and from which pus and urine exude. Patient feels weak and has a very pasty appearance.

Examination of the urine from the bladder and from the sinus both show the presence of schistosoma hematobium.

**Blood Examination**—Red cells, 3,986,000  
Whites, 8,200 Eosinophiles, 5%

#### TREATMENT

Intravenous injections of tartar emetic were employed as in the first case, and in two weeks the parasites had disappeared. The wound, after removal of much of the excess granulation tissue, healed completely under stimulation by balsam of Peru in about eighteen days after the disappearance of the parasites.

#### REFERENCES

- Albert, H. Bilharziosis and the war. *Internat Am Museum Bull* No 7, P 270, May, 1918.
- Boulenger, C. L. Bilharziosis in Mesopotamia. *Indian Jour Med Research* 7 P 8, July, 1919.
- Baltzner, W. South African bilharziasis. *Deut Med Woch* 45, P 599, May 29, 1919.
- Blumgart, L. Observations on the diagnostic and prognostic value of the eosinophiles in the circulating blood, with case of rectal infection by schistosoma hematobium. *Med Record*, New York, 1907 LXXXI, PP 560-563.
- Cawston, F G. Bilharziosis, duration of, in South Africa. *Brit Med Jour* 2, P 144, July 29, 1916.
- Cawston, F G. Cercariae of Natal. *Jour Trop Med* 19 201, Sept 1, 1916.
- Cawston, F G. Schistosoma and intermediary hosts in Natal. *J Trop Med* 19, P 154, 1916.
- Cawston, F G. Prophylaxis of bilharzia disease. *Jour Trop Med* 20 P 49, March 1, 1917.
- Cawston, F G. Bilharziosis and the danger of insufficient treatment. C. Perils from persisting parasites. *Practitioner* 109 460-462 Dec., 1922.
- Christopherson, J B., and Newlove, J R. Bilharzia worms in urine. *Jour Trop Med* 21 P 180 Sept. 2, 1918.
- Christopherson, J B. Antimony in bilharziosis, administered as intravenous injections of tartar emetic. *Lancet* 2 P 325 Sept. 7, 1918.
- Christopherson, J B. Intravenous injections of antimony tartrate in bilharziosis. *Brit Med Jour*, 2 P 652 Sept. 7, 1918.
- Christopherson, J B. Antimony tartrate a specific for bilharziosis. *Brit Med Jour* 1, 1021 June 14, 1919.
- Christopherson, J B. Sterilization of ova, during course or cure by antimony. *J Trop Med* 23 P 165 July 1, 1920.
- Christopherson, J B. Demonstration of technique of intravenous injection of antimony tartrate in bilharzia disease. *Proc Royal Soc Med (Sec Trop Dis)* P 14-18 June, 1921.
- Diamantes, O. Emetin in bilharzia hematuria. *Jour d Urol* 7, P 9 to 17 Aug., 1917.
- Ebstein, E. Urinary bladder in bilharziosis, and relation of this condition to uro lithiasis. *Zeit f Urology* 14 P 1 1920.
- Erian, A. Bilharziosis and its treatment by massive doses of emetin. *Practitioner* 103 P 391 Nov., 1919.
- Higgins, M E. Schistosoma haematobium in the Canal Zone. *Jour Amer Med Assn*, 1906 XLVI, 881.
- Leiper, R. T. Bilharzia terminal and lateral-spined eggs. *Brit Med Jour* 1 411, March 18, 1916.
- Mazzone, F. Bilharziosis in Italian colonies in Africa. *Gazz D Osp* 38 P 566 May 6, 1917.
- Neatby and Neatby. Tropical Diseases and Hygiene for Missionaries. *Bale, Ltd, Lond*, 1923 P 416.
- Pedersen, J. Case of schistosoma hematobium. *J Urol* 10, P 175-180 Aug, 1923.
- Piraja, De Silva. La schistosoma a Bahia. *Arch de Parasitol* Paris, 1908-1909 XIII, PP 283-302.
- Piraja, De Silva. Schistosomiasis in Brazil. *J Trop Med*, Lond., 1909 XII, PP 159-164.
- Pfister, E. Endemic cancer of bladder in bilharziosis. *Zeit f Urol* 15 PP 51 1921.
- Salomone, G., and Belli, C. M. Ematurie de un parasitta affine allo schistosomum haematobium. (Bilharzia). *An di med Nav Roma*, 1908 XIV P 181-200.
- Smith, P E. W. Bilharziosis. *Med Jour of Australia*, 1 P 79 Jan. 27, 1917.
- Shaw, C. G. Cystoscopic appearance in Bilharziosis. *Med Jour of Australia* 1 P 85 Jan. 29, 1921.
- Sinderson, H C., and Mills, F A. Rectal papillomata in Schistosoma haematobium infestations. *Brit Med Jour* I 968-969 June 9, 1923.

due to the escape of the adult worms. The ova are always present in the urine, rarely though in large numbers and pyuria is present in varying degrees. On cystoscopy we find quite an interesting picture. Pedersen in his case says the picture suggested at first tuberculosis of the bladder, and at times this appearance is pronounced. The typical picture is somewhat as follows. In the vicinity of the ureteral orifice we see numerous little white ulcerations, with at times quite a yellowish tinge. These ulcers may be anywhere from a pinhead in size to that of a pea. There is usually some swelling and edema and the ureteral orifices are often difficult to locate. Bladder generally is pale and anemic, in the midst of which hemorrhagic areas appear. The trigone just to the inner side of the urethral orifice is raw, uneven and shows numerous little surface swellings, that often suggest a cystitis cystica. These are the egg pouches.

Tumor-like formations sometimes occur, in fact are said by some to be frequent. These masses usually occupy the trigone and have quite an odd color, varying from dark brown to violet. In size they vary greatly but are usually small and have the shape of a wild strawberry. French authors call them mushrooms. These tumors, produced by the irritation of the bilharzia eggs, often simulate a papilloma, and at times the so-called papillo-carcinoma. However, even real carcinoma are said to have been caused by the schistosomum. The tumors are often surrounded by granulation tissue incrustated with urinary salts, which greatly alters the picture and occasions much difficulty in the diagnosis.

Some writers tell us that they have seen the adult worm themselves waving like feathers in the bladder fluid, partly within the bladder substance and partly free. In urine containing pus and blood in quantity we at times find masses of epithelium from the kidney, pelvis and ureter, mixed with amorphous urates. In these little balls of tissue we often find the schistosoma ova, and this means involvement of the kidney or ureters as well as bladder. The deposition of the egg always produces an irritation, the ova acting as a foreign body and in the ureter it undoubtedly often causes a stricture. After operations they frequently cause the persistence of urinary sinuses, as my two cases sum quite well.

#### DIAGNOSIS

The history tells of a life spent in one of the tropical countries where the disease is endemic, or of a prolonged visit there. Symptoms of a chronic cystitis and the passage of blood usually without pain are suggestive, and absolute proof is found in the demonstration of the ova in the urine. When the eggs are found in the urine they can easily be hatched by diluting the urine about 1 to 70 or 1 to 80 with water. The surrounding temperature should be about 120° F in order to provide the necessary warmth. Under

these conditions the miracidium will be seen to assume great activity, quickly break its way out of the sack and the worm swim free in the water.

#### TREATMENT

For many years our treatment was without success, all new methods were given a thorough test and were usually found wanting. When trypanoth and salvarsan appeared we tried them both on a case without any success.

In the treatment of Christopherson our efforts are finally crowned with success and we believe it is a real specific. Christopherson injects intravenously a solution of potassium and antimony tartrate (tartar emetic), in steadily increasing doses until we are no longer able to demonstrate the presence of the parasite. The author describes his method as follows. Place a solution of the strength of half a grain to one cc. of aqua distillata in a sterile rubber-capped bottle. Begin the treatment by injecting one cc of this solution diluted with five cc of normal saline into a prominent vein. Repeat this every other day, gradually increasing the stock solution by one cc. until 5 cc of the solution (2½ grains) is given at one dose. The diluting saline should be increased gradually until the dilute mixture measures 10 cc, using a syringe of not less capacity than this. Great care must be taken to see that the needle is well in the lumen of the vein before the fluid is injected, and the patient should remain in bed for the rest of the day. Physiological effects of antimony will sometimes appear and must be watched for. In adults as much as twenty or thirty grains may be needed, in children less than half of this. In children emetin 1/10 to ¼ grain intramuscularly are sometimes found of value. Local treatments, as bladder irrigations of barley water, 5 l to the pint, or boric acid solution, are said to be of value. They are, however, not necessary, when tartar emetic can be used. Internal medication per ora, I do not believe is of any value whatever.

We report the following two cases of persistent urinary sinus as of interest.

#### CASE I

J. W., Panamanian, married, age 36, occupation, storekeeper.

*Family History*—Father died at 68 apparently of pneumonia. Mother living, has chronic malaria. One sister and brother living and well.

*Previous Personal*—Variola in childhood and yellow fever at about 16. Denies any venereal history.

*Present Condition*—States that about two years ago he began to have difficulty in voiding, his urine was cloudy and at times very bloody. Suddenly complete obstruction occurred and an external urethrotomy was performed. After the operation, wound showed no evidence of healing for six months, when an attempt was made to close it. Wound after this operation promptly

severe Many brilliant results are being obtained in this type of nephritis

The accompanying diagram is an effort to depict the factors influencing the blood chemistry, i.e., the concentration of the various chemical constituents For each substance there is a portal of entrance and of discharge The blood level depends upon (1) the intake, (2) the utilization, (3) the output The intake of all except creatinine is under the direct influence of the diet A typical disease of utilization is diabetes In this the intake of glucose is normal The tissues, however, lacking the pancreatic hormone, insulin, are unable to use it and it is left in the blood stream, the level raising until the kidney threshold is reached and we find glycosuria—nature's safety valve. Thus the fundamental factor to search for in diabetes is the body tolerance for glucose, and by regulating the intake to maintain the blood level at the proper level In nephritis the output is the site of the disease, and when symptoms point to renal involvement the problem is to determine what substance is affected and what the kidney tolerance for it is

All of the above four types of nephritis present, in the late stages, the same general picture of renal insufficiency, the whole structure being affected But the duty of the attending physician is to find out what substances are the ones affected, how badly, and from classifying it to know the natural history of that individual disease Only in this way can his prognosis and treatment be sound My purpose is to give briefly the laboratory aids in determining these factors and a summary of what we consider the normal course of each disease

As taught by Foster, nephritis may be a disturbance of the metabolism and elimination of one of three things—(1) inorganic salts, (2) nitrogenous products, (3) water The last type mentioned is diagnosed by exclusion of the other two The salt retention type is a closing of the gate on the left side of the kidneys as in the diagram and characterized by a low urinary chloride excretion, with consequent high level in the blood, and edema of the tissue due to the salt retention The termination is due to circulatory embarrassment on account of the retained fluids The blood pressure, however, is not much affected The second class, the nitrogen retention nephritis, is a shutting down of the gateways on the right, as diagramed, and is evidenced by very much increased  $N$   $P$   $N$  of the blood, retinal changes, convulsive seizures, and terminates in uremia The patient is quite anemic, with a "cafe au lait" complexion and an arteriosclerosis associated with the enlarged heart and the high blood pressure. This difficulty with the excretion of both salts and nitrogen is found in the late stages of all four types of nephritis but in the early part of the diseases it is characteristic of

the first two, i.e., diffuse glomerulo nephritis, the inflammatory type, and the primary contracted or arteriosclerotic kidney

The laboratory tells definitely which one of these we are dealing with A patient need not be in the hospital to have sufficient tests done but it goes without saying that he is under much better control if he is Even if hospitalized, the attendants should be specially instructed about the technique of the tests The most valuable single test, at the same time one that requires extreme care in the management, is the so-called Mosenthal test The patient is given a carefully measured diet containing a known amount of chlorides, usually 10 grams, with measured water intake The urine is voided every two hours during the day and the separate specimens saved and labeled From two hours after the evening meal until breakfast all urine voided is collected as one night specimen The body should be in a state of equilibrium in regard to all the constituents of the urine The total fluid intake should approximate the total 24 hour volume of urine. The chloride intake should correspond to the total output Moreover, the excretion of salt should show the following variation, namely high concentration in the samples passed after meals and a low concentration during the night. If this does not obtain, but a high chloride content is found at night, the kidneys are overworked in this regard and difficult chloride excretion is evidenced Referring to the diagram, the outpouring is fairly constant in pressure, as the level of chlorides in the blood is high The specific gravity is taken on each specimen It should show the ability of the kidneys to excrete concentrated urine after meals, and the night specimen should show that most of the solids were excreted during the day and with a resultant low gravity in the night specimen Hypostenuria or inability to concentrate the urine, as well as fixation of the gravity around one figure, are signs that mean damaged kidneys Mosenthal states that there should be a variation of at least nine points in the specific gravity, with at least one sample showing a gravity as high as 1020 The volume of each specimen is measured and in a way corresponds to the gravity At night the volume should not be over 350 cc. (the patient being instructed not to drink after the evening meal) If the body, as a reservoir, is overfilled with excretory products and fluids, the influence on the urine is easy to understand, and the kidney will work at full load for the whole 24 hrs in the day A further refinement that can be done is to estimate the nitrogen balance by calculating the amount in the food and the amount in the urine, allowing for that lost in the intestinal evacuations A standard Mosenthal diet is published in various books and articles The one we find most satisfactory is in his article on nephritis

# LABORATORY AIDS IN DIAGNOSING AND TREATING NEPHRITIS \*

By H N COOPER, M.D.,

WATERTOWN N Y

*From Department of Laboratories, House of the Good Samaritan, Watertown, N Y*

**A**S seen in a laboratory serving a general hospital, and reflecting in general the work done on various clinical conditions, kidney disease is a condition about which less critical investigation is carried on than most major body ailments. The tendency has been that if albumin and casts are present in the urine, the case is called nephritis or Bright's disease and further investigation ceases. In other words, nephritis is commonly considered to be a problem of renal insufficiency alone, of one general type and treated by a low protein, salt free diet.

The past few years have seen a great change in the solution of the factors of kidney disease. One of the results of this work has been the identification of a new nephritic entity for which the term "nephrosis" has gained great favor, this is not to be confused with hydro- and pyonephrosis. Nephritis is similar to heart disease. The damage done to the body is by cardiac insufficiency, yet no one is content to simply call the case "cardiac decompensations," but must know what is back

of this faulty action, whether a damaged valve or coronary sclerosis, fibrous myocardium, etc.

I have classed the nephropathies after Mosen-thal

1 Inflammatory changes affecting a whole or a part of the renal structure. This is the type generally called diffuse glomerulonephritis and in the late stages, a secondarily contracted kidney.

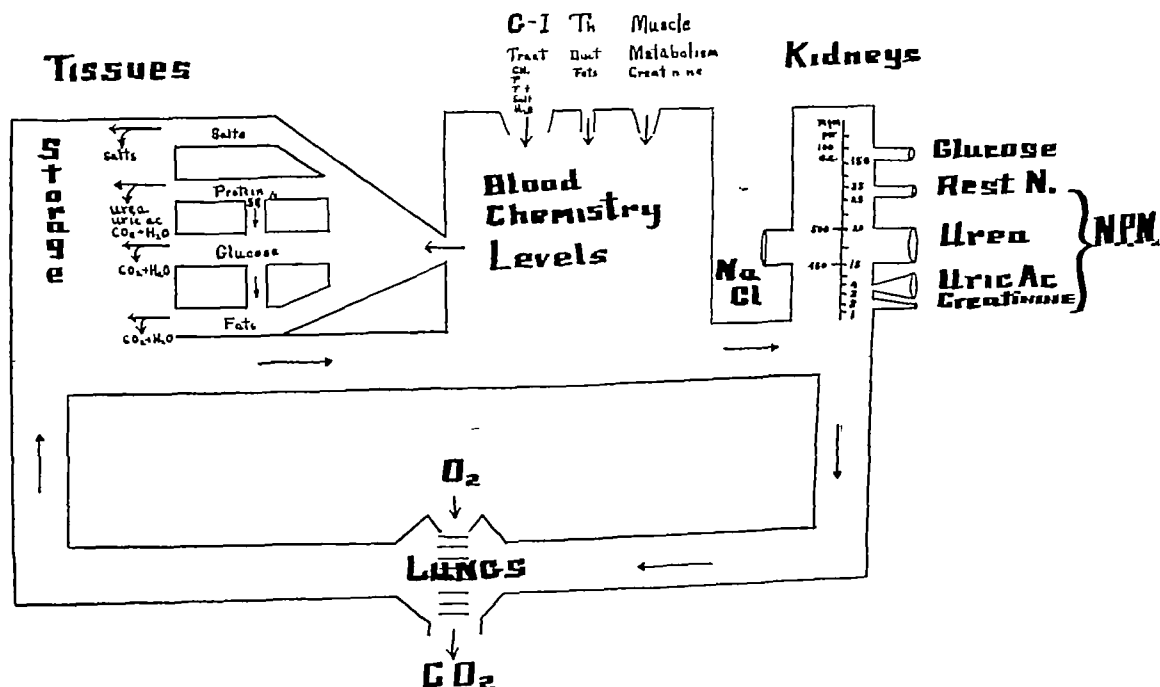
2 Arteriosclerotic kidney, also called primary contracted kidney, in which the kidney picture is a part of the general involvement of the arteries but is classed as a primary condition, i.e., arteriosclerosis localized mainly in the kidneys as it may localize in any one system.

3 Hyperpiesia or essential hypertension. This is not a primary kidney disease but due to the prolonged and intensely high blood pressure the renal blood vessels undergo sclerosis with the resulting picture of a mild primary contracted kidney.

4 Nephrosis, or degenerative changes of the tubules of the kidney, which condition may be temporary unless the toxemia which causes the cellular degeneration is too long standing or too

\* Read before the Watertown City Medical Society, February, 1925

## FACTORS IN BLOOD CHEMISTRY





a contraction of the arterioles of the whole body. It is in the nature of a spasm, as rest in bed invariably lowers the blood pressure, but it is extremely resistant to all kinds of treatment in affecting permanent results. The kidney lesions are similar to those found in the primary contracted kidneys and in fact the pathological picture is a sclerosis of the blood vessels due to the prolonged high blood pressure. The disease is characterized by a large head and no pathology there to account for the hypertrophy, a high systolic and diastolic pressure. It occurs mostly in men who lead a vigorous life and comes on at about 40-45 years of age. It is marked by frequent vascular accidents, mainly in the cerebrum, but easily demonstrated in the retina. Sooner or later, the heart decompensates. In the laboratory we find a urine with a very faint trace of albumin, occasional hyaline casts, slight polyuria, no fixation of the gravity and a normal chloride content. The blood picture shows a N P N of between 35 and 45 mgms per 100 c c. In parenthesis here, it is to be recommended that routine ophthalmological examinations be made on all cases by men who can recognize these eye changes. The first symptom of kidney trouble may be found in the retina.

The fourth type of nephritis to be discussed, is nephrosis. This form of nephritis should be greatly emphasized at this time because of the revolutionary treatment to be given these cases. Hithertofore, a patient with albuminuria and edema, is put on the time honored low protein, salt-free diet of all nephritics. As I will briefly show, this is essentially wrong and in fact a high protein diet is advisable. In outline, this disease is characterized by a gradual onset, protracted course, especially in young adults, marked edema and anasarca with effusion into the serious cavities. There is diminished output of urine, intense albuminuria, with occasional casts. The gravity may be high. No increases in blood pressure, no cardiac hypertrophy, and no nitrogen retention is found. The most characteristic finding, however, is a greatly increased cholesterol content of the blood. The reason for this lipid substance being affected is not understood but is generally attributed to the effect of the degenerated tubular epithelium. The cause for the edema in this type of nephritis is a disturbed osmotic pressure of the blood, resulting from the diminution of the protein content of the blood serum. This condition is directly due to the steady loss of large quantities of albumin in the urine. The change of osmotic pressure causes a retention of fluids in the tissues. This also explains the oliguria. The increased lipid content of the blood indicates according to Epstein, a state of impaired nutrition and constitutes an additional factor in the physio-chemical state of the blood. On this basis, he states the indications for treatment are: First, to increase the protein content of the blood and

thus restore the osmotic power. As one thinks of the enormous outpouring of albumin in the urine, combined with a low intake in the diet, the great loss of body protoplasm is evident. This still further injures the already poorly nourished tissue cells. If the urine should contain 3 per cent albumin (which is about the highest figure found and which occurs in this disease), figuring the 24 hr output at 1000 c c, there is a loss to the body of 30 grams of albumin. This figure is nearly the whole amount taken in, in a normal diet. Therefore, it is not unreasonable to increase the protein in the diet, especially as there is no evidence of retention of nitrogen in the blood. Secondly, treatment is directed toward removing the excess cholesterol which is formed from the fats. Epstein's diet consists then of a high protein content and poor in fats. Starchy foods and water are also limited. His results are remarkable. Diuresis with reduction in edema, followed very shortly after the diet was instituted. In one case, a man age 23, there was an urinary output of protein as high as 41.2 gms in 24 hrs. On the above treatment his edema disappeared completely and permanently and he was later drafted into the army. This type of nephritis occurs often in pregnancy. Careful chemical analysis of the blood is necessary before we can say that the kidneys are overloaded with nitrogen. Of course, it is well known that urea is not affected at all in eclampsia and the N P N but slightly raised. Uric acid is affected most of all, due apparently to a slight impairment of renal function. Toxemias do occur in which nitrogen retention exists but it seems probable that in most cases this is due to a true nephritis. The toxic agent in eclampsia is apparently in the rest nitrogen.

I have only scratched the surface of nephrosis but the importance of the diet and its easy recognition will stimulate further interest in these cases.

In discussing kidney tests, I have confined my remarks to only the four types mentioned. Tuberculosis, tumors, stones and other so-called surgical conditions are not included. The red test—phenolsulphophthalein kidney function test—has its most importance in these surgical cases. The selective function of the kidneys make the condition such that they are easily permeable to the dye but to nitrogen there may be distinct barrier. It is not a reliable indication of the kidneys' function as regards certain individual substances and cannot be included as a help in typing the nephropathies.

The routine examinations on a nephritic are: Routine chemical and microscopic on a 24 hr specimen of urine, a Mosenthal test, and finally that blood examination indicated in the type under suspicion. In general this means a N P N and uric acid on the early cases. If the N P N is raised a Creatinine should be per-

in "Metabolism and Endocrinology" On a carefully controlled experiment, any marked retention is easily demonstrated For example, if there is found a deficiency of three grams in urinary output, we know that for that one day alone the blood chlorides should be raised to 60 mgms, providing the tissues are as saturated as possible There are about 5 liters of blood in the average adult Three grams dissolved in 5000 c c corresponds to 60 mgms per 100 c c and with a normal blood chlorides of 450 to 500 mgms per 100 c c only a slight change is noted but the urinary picture is distinct Thus a Mosenthal test shows us exactly what the kidney is doing at the immediate time To determine the damage already done we resort to the chemistry of the blood

The salt retention type of nephritis, then, shows by the Mosenthal test a retention of chlorides, the blood chloride is raised, there is edema, no marked elevation of the blood pressure, and with the usual signs in the urine of inflammation of the kidneys

The other type of nephritis shows an early retention of nitrogen in the blood What has come to be considered a very sensitive and early sign in this type is an increase in the uric acid This substance is excreted with the most difficulty of all and is represented in the diagram as having a constricted outlet Hence, in slight renal impairment, it increases in the blood sooner than urea or non protein nitrogen This determination should then be made in early cases A rise above 2-3 mgms is abnormal The N P N represents the sum of all the nitrogenous waste products, the figure of urea being about 75 per cent of the total N P N It is composed of urea, uric acid, creatinine, creatin, amino acids and the "rest nitrogen"—unknown substances occasionally amounting to a considerable portion of the N P N Especially in convulsive uremias and eclampsias, the urea may be nearly normal, but due to the great increases in the rest nitrogen, the N P N is affected Hence, most laboratories prefer to do the N P N test rather than the urea The normal figure for N P N is 25-35 mgms per 100 c c

~ Creatinine is most easily excreted of all the products formed in the body, as is shown by a large stoma This is not affected unless very extensive damage has been done to the kidney and a rise in this means a grave prognosis is given 1-2 mgms is the usual content and when present above 5 mgms in chronic cases it signifies a fatal termination within a few months at the most.

In all types of nephritis there is, in advanced cases, a marked acidosis It is comparable to diabetic ketosis, except that it represents in diabetes an increased production of acid bodies, whereas in nephritis it is due to a diminished elimination of acid radicals, notably acid phos-

phates This is commonly the cause of death in nephritis The usual means in the diagnosis of the presence and extent of acidosis is the Van Slyke test for the  $\text{CO}_2$  combining power of the blood or plasma This test parallels the hydrogen ion concentration test, but is less subject to errors A lowering of the  $\text{CO}_2$  combining power of the plasma below 53 volumes per cent means acidosis The lower it is the worse the acidosis From 50-40 per cent there may be no clinical symptoms and here it finds its most value A case cited by Myers A boy admitted to the hospital is supposedly uremic coma, showed a remarkably low N P N, it being 44 mgms and the creatinine was 3.5 mgms, both of these being too low to account for the coma A  $\text{CO}_2$  combining power of 22 volumes per cent showed the difficulty After giving two infusions of bicarbonate of soda, remarkable clinical results obtained, and in less than two weeks the blood chemistry was normal

A word of warning, however, in regard to the indiscriminate use of soda bicarbonate is needed While acidosis is a dangerous condition, over-feeding with bicarbonate results in alkalosis, which also may terminate fatally Alkalosis is present if the  $\text{CO}_2$  combining power of the plasma is over 77 vol per cent An illustrative case, though not a nephritis, is reported by Myers and Killian Following a cholecystectomy  $\text{NaHCO}_3$  was given by rectum for 24 hours A study of the blood chemistry at that time showed a urea N of 29, sugar 262, and  $\text{CO}_2$  of 95 vol per cent There were spasms of the facial muscles and other evidences of tetany, coma, pulmonary edema and death Tetany is one of the chief symptoms of alkalosis In a recent article by McVicar of Mayo clinic, he emphasizes the study of the blood chemistry in intestinal obstruction and states that all these cases show a tendency toward alkalosis and that bicarbonate in treatment is contra-indicated Benefit comes from giving salt, sugar and fluids He definitely states that tetany may be expected whenever the plasma  $\text{CO}_2$  goes above 100 vol per cent, and that it is a complication of this form of toxemia At present, data indicates that large doses of bicarbonate should not be administered without knowledge of the plasma  $\text{CO}_2$  Normally 5-10 grams of soda will render the reaction of the urine alkaline, but in acidosis 100 grams may be needed The method of giving soda until the urine is alkaline is not without danger, as excessive doses are required

Alkalosis and acidosis are illustrations that, following a study of the blood chemistry, rational treatment is indicated and without which one works in the dark

Hyperpiesia, the third main grouping of nephritic conditions, is primarily a disease of the circulatory system in which some stimulus causes

at the De Milt Dispensary. In 1882, the New York Post-Graduate School and the Polyclinic began their work as friendly rivals, while the great undergraduate schools showed them active opposition. Two factors which have contributed to the success of your school have been (1) that of forming a clinical center, instead of there being a necessity for the student to waste his time in going from one hospital or dispensary to another, separated by great distances, and (2) the policy of having the control of the institution and the teaching in the hands of successful clinicians.

Those connected with this institution in its early days agree that to Doctor St. John Roosa should go the chief credit for its success. It is true that Doctor W. A. Hammond, Surgeon General of the Army during the Civil War, and a man of extraordinary vision, was the moving spirit in planning the school, but it was Roosa who carried out those plans in the face of great difficulties and much opposition.

In his address delivered at the inauguration of the New York Post Graduate School, November 11, 1882, Roosa established principles for the conduct of such a school which hold today as well as they did 40 years ago. To give you an idea of the excellence of his views I have made a few notes from this address.

"Our object is not to make more doctors, but to improve those we have. We propose to make a center in which it will be possible for a graduate in medicine to fit himself for the detection and treatment of the diseases that are not fully discussed in the studies and lectures of an ordinary course in a New York Medical College.

"Many practitioners come to New York every year to acquire the practical knowledge of diseases called special, but which they find to be very general.

"It would be easy to show that Berlin and Vienna have acquired their prominence as medical centers not by teaching of undergraduates, but by the instruction furnished to medical men.

"Circumstances over which we have no control have compelled us to add another unendowed school of medicine to those that now exist, but we have no idea that it will remain so. When we have demonstrated our usefulness and the necessity, we shall seek an endowment at the hands of our fellow citizens. We believe that the governing bodies of our universities will yet make them so in fact as well as name, that medical colleges will become an actual part of them and that then the post-graduate medical school will have its appropriate place. Not division, not separation, but unity in university instruction is what we seek and what we believe our institution will ultimately promote.

"Paris, Berlin, and Vienna have obtained their enormous power over medical action and thought, in part at least, because the faculties of their

great universities have comprehended nearly all the men in the cities who have been competent and willing to teach medicine. There has been concentration of effort at one center. That consummation I earnestly hope for New York."

This address shows that Roosa had in mind the providing of courses to supplement deficiencies of the undergraduate training or rather to make better doctors. Some of you may think that such views may have been true 40 years ago, but no longer holding today. If you will read the articles which have been written recently, on the imperfections of our present undergraduate medical training, you will be convinced that we have the same need today of post-graduate clinical training that existed at the time of Doctor Roosa's address. There is no lack of criticism in the following remarks by Cushing.

"However, we will, almost all of us, freely admit that probably nine out of ten students enter medicine with the expectation of engaging in practice and it behooves us, therefore, to give them the best possible training for this responsible career. Whether we are doing so at present is open to grave doubts."

The steady increase in extreme specialization in the pre-clinical years, along with little or no correlation between the basic science departments, has produced a state of bewilderment in the student. Unfortunately, these scientific subjects have progressively become wider in scope and more difficult, so that the clinical teacher who pursued these studies 20 or 30 years ago is not in a position to answer the questions of the groping student as to the proper relation of such studies to the real problems of diagnosis and treatment.

We must all agree with Louis B. Wilson in his statement that the attempt to teach six complete medical sciences in the first two years of the medical course, any one of which would require the full attention of the student during this period, is responsible for the superficial knowledge on the part of the recent graduate of the essentials and unessentials of anatomy, biochemistry, physiology, pathology, bacteriology and pharmacology. This, in his opinion, accounts for the inability of the present day graduate to apply the essential principles of the pre-clinical branches to the study of his cases. Again, he states that the physician who has a sufficiently thorough knowledge of the essentials of the fundamental medical sciences to use them as familiar tools in the every-day study of complicated individual cases, is unfortunately getting rarer, and his production is not favored by the present cramming system in our medical schools.

It is my belief that Pepper has instituted a plan which offers great promise in the correction of this serious defect in medical education. Briefly this plan is in the holding of one clinic each week for the members of the two lower classes, in

formed. A blood chloride on cases with edema and when indicated by the Mosenthal. The chlosterol is indicated in cases with edema with marked albuminuria, and a  $\text{CO}_2$  combining power of the plasma in all cases that are acutely or desperately sick.

In conclusion, the help in investigating these conditions depends upon the individual physician and the particular laboratory. Laboratories, when properly supervised, are now considered not merely a technical shop but a real consultant in

medicine, a specialty all its own and for which as careful training is necessary as other specialties. Some diseases are surgical in nature, others neurological, and so on, while some are pre-eminently laboratory diseases. It is not expected that the general practitioner will know all the technical details, but the plea is offered that the laboratory will be consulted, personally as well as by submitting samples, as this is the only way the full benefits can be obtained. To do justice to the patient is the duty of every physician.

## UNDERGRADUATE DEFICIENCIES AND POSTGRADUATE REQUIREMENTS

By E R STITT, M D REAR ADMIRAL, U S N

IN his "Oath" Hippocrates has given us a professional standard which has held as the ideal of the relations of the physician to himself and his fellow man for almost twenty-five centuries. In his "Law" we have a statement of the essentials for the making of a physician which put beside all our writings on this subject, in this present day, easily takes first rank. In this "Law" we learn that who ever is to acquire a competent knowledge of medicine should first of all have a natural talent, for when Nature leads the way to what is most excellent, instruction in the art takes place, which the student must try to appropriate to himself by reflection, becoming an early pupil in a place well adapted for instruction. He must also bring to the task perseverance and a love of labor. Instruction in medicine is like the culture of the products of the earth. For our natural disposition is, as it were, the soil, the tenets of our teachers are, as it were, the seed, instruction in youth is like the planting of the seed in the ground at the proper season, diligent study is like the cultivation of the fields and it is *time* which imparts strength to all things and brings them to maturity. From this we shall see that Hippocrates clearly valued the early training on the part of our teachers as only the seed in the ground, which would spring from the soil following diligent study but that it was time alone which would give rise to the true physician. Again he tells us that certain persons have the shape and dress and personal appearance of the actor, but are not actors, so also physicians are many in title, but few in reality.

Shall this time which is necessary to make us real physicians be solely a period of individual practice, gaining experience tediously and uncertainly, often through error or failure, or shall we intersperse our professional lives with occa-

sional clinical courses obtained in one of several ways.

This opportunity can best and most expeditiously be gained through some plan of post-graduate training and this, in my opinion, is satisfactorily provided along the lines of the New York Post-Graduate Medical School and Hospital.

Such a school should be located in a great seaport, because shipping brings in a great variety of cases, which sharpen the wits of the hospital staff. Then, too, as the greatest and wealthiest city of America, New York attracts the best medical talent, whose services then become available for clinical teaching. In this great body of medical men are many capable young general practitioners whose services as instructors in the out-patient departments would be of the greatest help to the graduate students.

In your school you have a wonderful mass of clinical material in your dispensary service, capable of great expansion. Mackenzie insists that the general practitioner is the only man suitably placed to elucidate the problems of the commencement of diseases and their progress towards their eventual termination. Hence he argues that the general practitioner should take a more active and prominent part in teaching.

In the hospital you have beds to receive cases transferred from the dispensary, so that the student may follow up such patients in the wards, where are provided facilities for scientific observation and research. Among the essentials for a post-graduate medical school the House of Delegates of the American Medical Association stressed the availability of ample clinical material, to afford the student in the general practitioner courses opportunity personally to examine patients in the out-patient departments, as well as in the hospital wards, including facilities for laboratory examinations. Apparently post-graduate work along the lines of that then existing in Europe was first taken up in America in 1875,

\* Address at the dedication of the James McKernan Building of the Post Graduate Medical School and Hospital January 22, 1925.

conjunction with the medical seminar, served as the basic training

Very important for these men were the courses in neurology and psychiatry. With an inexpensive diagnostic set, a microscope and sufficient equipment for making simple urine and blood examinations, I am convinced that these physical examination specialists will be able to pass on physical deficiencies without having to call in the services of a group of specialists except in rare instances.

Considering the present widespread interest in annual physical examinations, and the recognized shortcomings of the average general practitioner to conduct such examinations, would not such a training be desirable and practicable for University medical extension courses?

Would it not be well for the New York Post-Graduate School, with its body of enthusiastic young teachers, to take part in this movement? You may question my excluding the older teachers, but I have done so advisedly, because the missionary work of going from small town to small town, and even villages, covering many miles of travel each day, for six or eight weeks, is a young man's game and requires a young man's enthusiasm.

I doubt not but that many of you are wondering at the omission of any reference to post-graduate instruction for the making of specialists. We know that some of our Universities are devoting most of their postgraduate medical efforts to the elaboration of two and three-year courses, planned to produce a fully equipped specialist. In England, they do not look with favor on such methods for training specialists, but prefer that the well-trained general practitioner, who may aspire to spe-

cialism, attain his qualifications by holding junior appointments, such as clinical assistant.

Again, taking counsel with Hippocrates, we believe that a general practitioner should have a natural talent for the specialty he proposes to cultivate. We know that many a poor ophthalmologist might have made a successful psychiatrist, or a failure as a surgeon a success as a sanitarian.

I am firm in the belief that no one should enter upon a specialty until he has had a few years of general practice, not only that he himself may know that he has aptitude for the specialty he has in mind, but that his colleagues may be of the same opinion, and recognize in him the man they would choose to call in consultation. I think it is well for a postgraduate medical school to have courses in the specialties, but these should be for the making of the best type of general practitioner, and it may be that some of the present generation can at length follow in the footsteps of Johnathan Hutchinson, a multi, or super-specialist. Let the specialist come up from the ranks of the general practitioner, surely and slowly demonstrating his fitness for specialism, and then receiving the stamp of qualification through graded service in a special clinic. This point of view is forcefully expressed by that leader of English medical thought, Clifford Allbutt, in the following paragraph:

"If one qualifies as a specialist by falling into ignorance of all else, his pretension is vain, if he is to look his problem fully and intelligently in the face, he must take up the all else into that special study. The harm of specialism lies not in a limited field but because the specialism is reached by not carrying the whole into the part."

## BREAST FEEDING

By FRANK HOWARD RICHARDSON, M D,

Chairman of the Post Graduate Education Committee of the Brooklyn Pediatric Society

BROOKLYN NEW YORK

Abstract of the first Clinical Lecture in a course on Practical Pediatrics given in the Southside Hospital, Bay Shore N Y, under the auspices of the Suffolk County Medical Society

My subject is "Simplified Infant Feeding and the Breast." Modern infant feeding can be immensely simplified. Its elements are first, breast feeding, and second, complementary feedings of cow's milk, if necessary.

The preparation of artificial foods has also been greatly simplified, and consists of two essentials: first, the modification of the milk with water and sugar only, and second, boiling the milk.

My lecture will consist principally of the elaboration of these principles.

Feeding a baby on commercial artificial foods is not the easy process that many people think

The formulas are complicated, and have a basis of cow's milk, and the preparation of the foods is troublesome and time-consuming. It is a much simpler process to put the baby on the breast, and give it complementary feedings if necessary.

Most of the work on simplified feeding has been done in private practice. The hospitals have done little accurate work in that line because well babies seldom go to the hospital, or stay there long enough for accurate studies.

Ninety-six per cent of all women can nurse their babies to some extent if they will go at it in the right way. They may not be able to pro-

which the practical application of anatomy, physiology and physiological chemistry is correlated with the subjects studied during that week. I have learned from Professor Pepper that this correlation has meant exacting study, on his part, to keep abreast of the current class work in the fundamental sciences.

This plan involves such effort on the part of the clinical teacher many years removed from his fundamental sciences, that I doubt whether it will become generally adopted.

Would it not be possible for such an institution as the New York Post-Graduate College to have a course in internal medicine in which the clinical side of the cases could be presented by the senior professors, and the correlation of the fundamental sciences presented by junior teachers in whose minds the essentials of anatomy, physiology and other basic medical sciences are still fresh?

In such a course an effort should be made to demonstrate the possibility of making diagnoses in a large proportion of cases by the methods used by the great clinicians of 5 years ago. I do not mean to belittle the advantages of blood chemistry, electrocardiography and the like, but I do believe such aids have their place more in confirming than in making diagnoses. Some of our recent graduates would feel themselves helpless in an ill-equipped, small-town hospital, not so much from the lack of the various modern laboratories as from the lack of a staff of specialists capable of performing and interpreting laboratory tests. In other words, there is too much dependence on others to make our diagnoses.

Allow me to quote from an article by Sir George Makins, in which he says:

"The habitual resort to special methods, and the belief that complicated apparatus is necessary in the investigation of the ordinary problems of disease, is likely to do as much toward the destruction of the art of the practitioner as the methods of science can do to help it."

In our worship of the science of medicine we bid fair to lose that art of medicine which gave the old family doctor such a hold on the people of a former generation. I would even recommend a postgraduate school to give courses in practical nursing, a lost art for the physician, and one which stands in danger of disappearing in the tendency to substitute science for art in the modern training of nurses.

There is too much made of theory and basic principles and too little of practice and observation.

I believe that the majority of clinical teachers will agree with Capen's statement that the natural and instinctive action of the human mind is to proceed from practice to theory,

from the concrete to the abstract, and that to give theory first and practice last is a pedagogical sin. Theory should be illuminated by practice.

The physician should be trained to observe and investigate. We should give thought to President Burton's views that the art of the practice of medicine would seem to be identical with the art of investigation, for investigation is also an art, and the educational approach to the training of the investigator and the physician appear identical.

The earnest physician should make it his endeavor to refresh his knowledge by taking post graduate courses every two or three years. There is now so much to be learned in our own schools and clinics that many students do not think it necessary to go abroad for further training. I believe we should first avail ourselves of the post-graduate opportunities now offered at home, but it would be wise to intersperse this periodic professional refreshment with attendance on European clinics. Flexner was right when he recently said that however much we have improved we are not good enough to be sufficient unto ourselves, and we never shall be. Science is international, it advances in most unexpected fashion, now here, now there. And stimulus does not communicate itself best through the printed page. Men must know one another and work with one another.

The plan we have been outlining of having medical men come to a medical centre for post-graduate instruction is manifestly the desirable one, but many of our country practitioners, eager for professional improvement and greatly needing such opportunities, cannot for various reasons absent themselves from their homes. To meet such demands there is now developing a program of University extension for medical teaching.

Where a hospital has been available, as a center to conduct clinics, the success of the movement has been unquestioned, and even when such clinics have been conducted in towns without hospitals, the value of the training has been attested by the country physicians, enrolling in such courses. Naturally, outside of hospitals, only courses in such subjects as pediatrics, physical diagnosis and pathology are practicable. During the past year I have had two of our medical officers take up special training to fit them to conduct our annual physical examinations and to pass on the physical qualifications of recruits. It may interest you to know that I selected the New York Post-Graduate School as the institution offering the training best adapted to this purpose. The diagnostic clinic, taken in

to use in place of a suppository. It consists of a pencil of soap three or four inches long with its upper end enlarged to serve as a handle. The advantage of the soap stick is that the mother can see it and can hold it in the rectum, and can use it over and over.

How should we empty a breast?

Not with a breast pump. The breast pump does not imitate the act of sucking. It fails to withdraw the milk, and it does not stimulate the production of more milk.

Not by massaging the whole breast. Massage does violence to the breast, and is not a proper procedure even when the breasts are enlarged and hard.

The proper way to empty a breast is to "milk" it as a dairyman draws milk from a cow. A study of a diagram of the milk ducts will indicate the rational method of withdrawing milk from them.

The outlet tubes of the milk glands converge toward the nipple, and end in reservoirs, which open upon the surface of the nipple.

How shall we draw milk from a woman's breast? The two photographs show the process. The first act consist in grasping the breast, just back of the areola, between the thumb and forefinger.

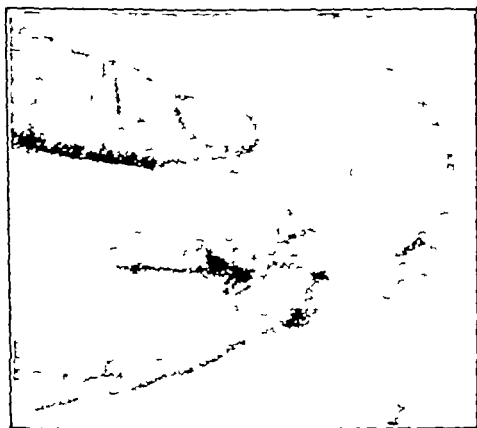


FIG. 1—Grasping the Areola.

The second act consists of closing the thumb and finger upon the breast tissue, and drawing them forward. The fingers do not slip over the skin, but they draw the whole grasped part forward.

About five minutes time will usually be sufficient for emptying a breast by this method. The mother can easily learn to do it. Teach her to use the right hand for her left breast, and vice-versa.

It is impossible to draw a breast so dry that not a single drop of milk will be obtained. The breast continues to secrete milk while the milk is being drawn.

Practically every woman who has had a baby of nursing age will have some milk in her breast for weeks or months after weaning. This may readily be drawn in drops. Drawing the milk regularly every three or four hours will stimulate the breasts to produce an increased quantity which in two or three weeks will be sufficient for the needs of a baby. This is not a mere theory, it works.

At first the milk may come in drops, but after a few days a spurting stream may be obtained. The demonstration of a spurting stream has a tremendous psychological effect on the mother and her relatives.

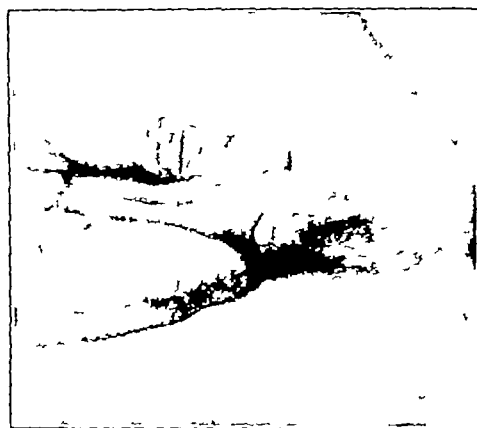


FIG. 2—Compressing the Breast Tissue.

#### DRAWING MILK FROM THE BREAST

It must not be supposed that emptying the breast is the only procedure that is necessary in order to produce an abundant flow of milk. Equally important is it that a woman should avoid getting tired, either physically or mentally. Fatigue is the greatest enemy of a full flow of milk. Dairymen all know that.

Food has little or no effect on the production of milk, it only it is abundant.

Now a word as to complementary feedings. The materials consist of cow's milk, water, and sugar.

The milk to be used is the best quality of milk

obtainable. It may be well to remove some of the cream if the milk is unusually rich.

The amount of water to be added to the milk is equal to the amount of the milk. It is seldom necessary to make the feeding more than half water, and only a quarter water is the more usual proportion. The principal use of the water is to supply the amount of water that the baby needs.

The sugar may be dextre-maltose, milk sugar, or plain cane sugar. The amount is usually one ounce to each quart of the mixture, increased to 1½ ounces per quart as the baby gets older. Don't use so much sugar that the milk tastes sweet and leads the baby to refuse the breast.

vide all the milk that a baby requires, but even a small proportion of breast milk is sufficient to provide the special vitamins and other elements which tend to make breast-fed babies more healthy and vigorous than those which are entirely artificially fed

Breast milk will practically always agree with a baby. The notion of its often disagreeing comes from the common observation that a baby often cries and kicks with so-called "colic" after it is nursed. Colic means hunger in ninety-nine per cent of all cases, and will be cured by additional food given as a complementary feeding.

It is a common belief that menstruation impairs the quality of breast milk. It can do so only by inducing a loss of water, and undue fatigue.

The modern standard of baby feeding is to give the child all the breast milk that the mother can produce, and then to give him all the artificial food he wants. A standard rule is to place the baby on the breast for twenty minutes, and let it get as much breast milk as it can, and then immediately give it as much artificial food as it wants. But be sure to start the feeding with breast nursing.

Suppose a mother has little or no milk, or loses her milk, what can be done then?

The production of breast milk can be stimulated rapidly and surely by an extremely simple procedure which every dairyman knows all about.

A sure way to *stop* the production of milk—that is, to dry up a milk producing animal—is to stop drawing the milk. Failure to empty the breast completely is almost as bad as not emptying it at all. Every dairyman knows the necessity of stripping the last drops of milk at milking time. The first essential in promoting the flow of milk is to empty the breasts completely at each nursing.

Dairymen also recognize the extreme importance of regularity of milking time. The production of milk will fall off if the animal is milked at five o'clock on one day and nine o'clock on another, according to the convenience of the farmer. Regularity of nursing is equally important to mothers.

It is not desirable that a mother should burden herself by nursing her child every two hours. If the baby wakes up and demands food within two hours after a nursing, the child has probably got too little food, and the clear indication is for a larger amount of complementary feeding.

A mother can put her child on a four-hour interval of feeding, and she can even skip a nursing and give the child one feeding of the artificial food, provided the feeding times are regularly spaced and maintained. Eight hours freedom from nursing on occasion when necessary is enough to enable any woman to attend to her social duties.

It is not necessary to use both breasts at every

feeding. Use one breast at a feeding and the other breast at the next feeding.

How long should a baby nurse? About two-thirds of the amount in the breast will be drawn during the first five minutes. There is usually nothing to be gained by continuing the nursing beyond twenty minutes, though it may occasionally be desirable. A good rule is to nurse the baby twenty minutes, and then spend five minutes in drawing the remaining milk by hand.

Emptying a breast completely at each nursing is necessary in maintaining or promoting the flow of milk. Emptying the breast is the only practical stimulant to the production of milk—and it is an efficient stimulant. Cases are known in which the stimulation of nursing virgin women has caused the regular production of a full flow of milk.

If a baby is hungry, why does it fail to draw all the milk from the breast? We don't know why some babies are lazy and simply will not nurse. Others will stop their efforts if only a small amount of milk flows, or the milk comes slowly.

We must accept the fact that many babies often fail to empty the breast, and therefore the artificial emptying of the breast is necessary. However, there are two conditions which often prevent babies from nursing—first, air in the stomach, and second, a full rectum.

A considerable amount of air in the stomach is a natural condition in young babies. Milk will not run into a stomach that is full of air, any more than it will run into a narrow-mouthed jug that contains air, but remove the air and the milk will flow into the stomach readily.

The application of this principle is plain. A baby may start to nurse, but in a few minutes be satisfied because the food plus the air fills the stomach. But in a quarter or half an hour it wakes up crying and kicking, and when the mother takes it up and pats it a lot of air is belched up, and the "colic" (which was hunger) stops, and the child takes a normal amount of food.

If a child does not nurse well, air in its stomach is the first cause to be considered. The means of diagnosis, and the treatment, consists in the mother's holding the baby over her shoulder, thus expelling the air. The baby will then nurse normally. It is well for a mother to use this as a routine procedure during every nursing.

A full rectum, and gas confined in the stomach, may also prevent a baby from nursing. If a baby does not nurse after the removal of gas from its stomach, give it a soap suppository in order to make its bowels move. The expulsion of feces and gas will often be followed by normal nursing.

A soap stick is a simple device which is handy





# EDITORIALS



The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

**Editor-in-Chief**—NATHAN B VAN ETEN, M.D.,  
New York  
**Associate Editor**—ORRIN SAGE WIGHTMAN, M.D.,  
New York  
**Executive Editor**—FRANK OVERTON, M.D.  
Patchogue

### COMMITTEE ON PUBLICATION

**E. ELIOT HARRIS, M.D., Chairman** New York  
**ORRIN SAGE WIGHTMAN, M.D.** New York  
**EDWARD LIVINGSTON HUNT, M.D.** New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

**President**—OWEN E. JONES, M.D. Rochester  
**First Vice President**—GEORGE A. LEITNER, M.D. Piermont  
**Second Vice President**—LUZERNE COVILL, M.D. Ithaca  
**Speaker**—E. ELIOT HARRIS, M.D. New York  
**Vice-Speaker**—GEORGE M. FISHER, M.D. Utica  
**Secretary**—EDWARD LIVINGSTON HUNT, M.D. New York  
**Assistant Secretary**—WILBUR WARD, M.D. New York  
**Treasurer**—CHARLES GORDON HEDD, M.D. New York

### CHAIRMAN, STANDING COMMITTEES

**Arrangements**—FREDERICK H. FLAHERTY, M.D. Syracuse  
**Public Health and Medical Education**—JOSHUA M. VAN COTT, M.D., Brooklyn  
**Scientific Work**—ANDREW MACFARLANE, M.D. Albany  
**Medical Economics**—HENRY LYLE WINTER, M.D. Cornwall  
**Legislation**—JAMES N VANDER VEER, M.D. Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex President and the Councilors of the District Branches.

**First District**—EDWARD C. RUSHMORE, M.D. Tuxedo Park  
**Second District**—FRANK H. LASHER, M.D. Brooklyn  
**Third District**—ARTHUR J. BEDALL, M.D. Albany  
**Fourth District**—CHARLES C. TREMBLEY, M.D. Saranac Lake  
**Fifth District**—NELSON O. BROOKS, M.D. Oneida  
**Sixth District**—GEORGE H. FOX, M.D. Binghamton  
**Seventh District**—WILLIAM I. DEAN, M.D. Rochester  
**Eighth District**—HARRY R. TRICK, M.D. Buffalo

### COUNSEL

**GEORGE W. WHITESIDE, Esq., 27 William St.** New York  
Telephone, Broad 1744

### ATTORNEY

**ROBERT OLIVER, Esq., 27 William St.** New York

### EXECUTIVE OFFICER

**JOSEPH S. LAWRENCE, M.D.** 51 Chapel Street, Albany

### SECTION OFFICERS

**Medicine**  
**Chairman**—ROBERT L. LEVY, M.D. New York  
**Secretary**—L. WHITTINGTON GORHAM, M.D. Albany

**Surgery**  
**Chairman**—MARSHALL CLINTON, M.D. Buffalo  
**Secretary**—EDWARD S. VAN DUSEN, M.D. Syracuse

**Obstetrics and Gynecology**  
**Chairman**—HAROLD C. BAILEY, M.D. New York  
**Secretary**—NATHAN P. SEARS, M.D. Syracuse

**Pediatrics**  
**Chairman**—JOSEPH C. PALMER, M.D. Syracuse  
**Vice-Chairman**—ROGER H. DENNETT, M.D. New York  
**Secretary**—ARTHUR W. BENSON, M.D. Troy

**Eye, Ear, Nose and Throat**  
**Chairman**—ARTHUR G. BENNETT, M.D. Buffalo  
**Secretary**—EUGENE E. HINMAN, M.D. Albany

**Public Health, Hygiene and Sanitation**  
**Chairman**—PAUL B. BROOKS, M.D. Albany  
**Secretary**—ARTHUR D. JACQUES, M.D. Lynbrook

**Neurology and Psychiatry**  
**Chairman**—EUGENE N. BOUDREAU, M.D. Syracuse  
**Secretary**—CLARENCE O. CHENEY, M.D. Utica

For a list of the officers of the county medical societies, see April 10th issue, advertising page 2

## TUBERCULOSIS DAY

The X-ray demonstration alone will be worth a day's time of any practicing physician. Commercial firms will demonstrate the recent improvement in X-ray machines and trained roentgenologists will demonstrate the uses that may be made of the machine and how to secure the best results. Dr. Lloyd and associates from the Monroe County Tuberculosis Sanatorium will bring with them a variety of radiographs which they will explain individually to any physician who will visit with them long enough.

Dr. Amberson, of Loomis Sanatorium, will have on exposition several series of radiographs showing the progress of recovery from the time the patients entered the Sanatorium until dis-

charged, and several radiographs made months subsequent to discharge.

Dr. Bela Schick will exhibit several series of radiographs made on infants from a year to three years of age, which show admirably how in the early stages of children so young the disease is less clearly defined than in later years.

Dr. Henry D. Chadwick, of Westfield Sanatorium, Massachusetts, will exhibit several series of radiographs taken from children between the ages of seven and seventeen, in whom no definite clinical symptoms of tuberculosis could be found save history of loss of weight or anemia. The radiographs show definite enlargement of the lymphatic glands in the vicinity of the hilum

It is now the custom to boil the milk which is fed to babies

First, boil the water which is to be used  
Second, add the cold milk to the boiling water, bring the mixture to a boil, and continue the boiling for three minutes

Third, add the sugar

Fourth, let the mixture cool, and keep it in a cool place

This simple procedure is about all there is in the modern preparation of artificial food for infants

Boiling the milk need not arouse a fear of scurvy, especially if the baby also gets some breast milk. But any possibility of a deficiency disease is prevented by giving orange juice. Start with a teaspoonful once a day when a baby is two or three months old, and increase it up to the juice of half an orange

Thirty drops of cod liver oil twice daily, increased later to a teaspoonful, is an insurance against rickets. It is readily taken and never does harm

As to the amount of artificial food to be given after a breast feeding—give the baby as much as it wants. Some babies will vomit or rather regurgitate some of the milk. This may be curdled, as milk should naturally be after it has lain in the stomach a short time

Some babies will pass curds in their stools, and remain perfectly well. These babies seem to have an active peristalsis, which hurries the milk down the intestine before it is fully digested

Green stools often alarm both the mother and the doctor. A green stool in itself is no cause for worry

Mothers run into all sorts of difficulties in

feeding their babies, and they appreciate the supervision of a physician who is really interested in well babies and in keeping them well. Mothers must be educated in regard to bringing their well babies to their doctors. It is the doctor's duty to offer his services to his mothers, and then to give them actual service according to modern pediatric standards. A physician is perfectly ethical in offering service to the well babies of his families

It is more satisfactory for the doctor to have the mothers bring their babies to his office, rather than for him to go to the mother's house.

A doctor needs scales for weighing the babies. It is good psychology for a doctor to provide the visible means for practicing pediatrics. Excellent scales may be bought for less than fifteen dollars. A desirable kind is one that can be carried in a suit case to the homes of the patients, if necessary

We will now show this case. She is a healthy, well-nourished woman who gave birth to a healthy child three weeks ago, but she has "lost her milk," from no apparent cause

We find that the breasts and nipples are well formed, and normal. As we express the milk in the way we have just discussed, we obtain a drop or two at each act of expression. You will note that the patient herself is able to draw the milk, and that she says she is anxious to "bring her milk back"

She will express the milk for five minutes every three hours during the day, after inducing the baby to nurse as much as it will

We will ask the patient to return in two weeks, and we expect that she will then have a good flow of rich milk

## Deaths

BENNETT, FRANCIS J. A., Auburn, University of Michigan, 1911, Fellow American Medical Association, Member State Society, Orthopedic Surgeon, City and Mercy Hospitals. Died February 9, 1925

BOWERS, JOSEPH HENRY, Albany, Albany Medical College, 1912, Fellow American Medical Association, Member State Society, Attending Obstetrician St. Peter's Hospital. Died March 30, 1925

KAUFMANN, WILLIAM PEROT, Haverstraw, University of Toronto, 1906, Fellow American Medical Association, Member State Society, Visiting Physician Good Samaritan Hospital. Died April 3, 1925

LYON, JONATHAN FISH, New York City, Heidelberg 1880, Fellow American Medical Association, Member State Society. Died April 9, 1925

MERRITT, FREDERICK CHARLES, Sayville, Trinity, Toronto Canada, 1891, Fellow American Medical Association,

Member State Society, Physician South Side Hospital, Bay Shore. Died April 7, 1925

MILLER, AARON B., Syracuse, University of Maryland, 1882, Fellow American Medical Association, American College of Surgeons, American Obstetrical & Gynecological Society, Member State Society, Consulting Gynecologist Memorial & Free Dispensary, Gynecologist St. Joseph Hospital. Died March 28, 1925

SWAIN, FRANK S., Corning, Ohio Medical College, 1903, Fellow American Medical Association, Member State Society, Surgeon Corning Hospital. Died March 7, 1925

ZABRISKIE, WILLIAM H., Glen Cove, College of Physicians and Surgeons of New York, 1885, Fellow American Medical Association, Member State Society, Surgeon Nassau Hospital. Died March 31, 1925

learners, for they are illustrated by actual cases which the students bring

The ideal outfit for giving postgraduate instruction in the practice of medicine consists of three elements

1 A hospital to supply cases for study and the facilities for their observation and treatment

2 A group of learners—the doctors on the hospital staff

3 A leader—a doctor who has had a little wider experience than the members on the staff

To bring together these three elements is the fundamental conception of the Joint Committee on Graduate Education of the Medical Society of

the County of Kings and the Long Island College Hospital Medical School The novel feature of the Kings County plan of graduate education is that it permits physicians to attend classes without loss of time from their practice Much of the instruction is given after four o'clock—between office hours and supper If the classes cannot come to the teacher, the teachers come to the classes

This plan of graduate medical education is no mere theory It is entirely practical, as is shown by its successful operation in Brooklyn, and its extension into Suffolk County

JOHN E JENNINGS

---

### TEACHING CLINICS

We believe that one of the functions of the Medical Society of the State of New York is to raise the standard of the art and science of medicine among the great mass of its members While the members wish to be informed regarding the latest developments of the surgery of the heart valves, a subject of infinitely more general value is that of the management of the heart patient

It is certainly the function of this Journal to print educational articles of a medical nature The Editor is necessarily somewhat of a pedagogue who lays out reading courses to the members of the State Society Some of the courses which he prepares do not interest certain groups, and other courses seem to be either too elementary or ultra scientific

We believe there is a field for simple articles on elementary topics, such as breast feeding We all know how few details of breast feeding are taught to medical students,—there is not time enough to begin to cover them all

Then, too, the medical school deals with medical topics impersonally,—a doctor in private practice usually deals with a patient primarily, and with a disease only secondarily

We believe there is a large field for simple articles that are almost text book in their nature, on practical every-day topics Does a doctor know, for example, the fundamental principles of modern breast feeding? Let him turn to page 653 of this Journal and read the abstract of an actual clinical lecture on breast feeding given to a class of twenty average physicians who were so impressed with the practical suggestions of the lecture that they at once agreed to meet weekly for more lectures

We would like to secure one or two similar articles on other topics for each issue We think that "office orthopedics," for example, will make an excellent subject for elementary articles on the cure of feet which ache and are sore

We also venture to suggest that the State Medical Society could readily promote teaching clinics as parts of the programs of country medical societies We know, for example, that the members of the Staff of the University of Syracuse are ready to supply clinical demonstrators to go on the program of any medical society in their vicinity The Medical Societies of Suffolk and Nassau counties are adopting the clinics Why don't other counties do the same? F O

---

### THE NURSE REGISTRY

In the golden age of long ago hallowed by legend and nebulous in memory the nurse caring for the sick was an outstanding community character known by everybody and sought by everyone in need of nursing care Today in the State of New York alone there is an army of thirty to forty thousand men and women who obtain a livelihood by attendance on the sick or from allied activities Today one seeking the services of one of this host of nurses rarely has acquaintance with or even knowledge of the particular individual who responds to the call The want is supplied through bureaus or agencies quite similar

in character to those employment agencies which supply labor on demand These bureaus, technically Nurse Registries, in number are many They are differentiated by several terms, those conducted by training schools only register their own graduates, those managed by nursing organizations only register nurses who have similar credentials to the members of the organization, those operated in any other way register all applicants whatever their training or experience and they are called "commercial registries"

According to the quantity and quality of the preparation for nursing service these thou-

In several of the series portions of the lungs were involved. He gives a very satisfactory explanation of the progress of the disease as due to the destruction of a gland discharging into a neighboring bronchus. In none of such cases was the apex involved, thus confirming his diagnosis.

It is hoped that Dr. Cole will find it convenient, between eleven and twelve o'clock on Thursday, to present his moving picture on construction and interpretation of radiographs.

If any physician is having trouble with his X-ray machine in securing satisfactory radiographs or if he has radiographs difficult to diag-

nose, it is suggested that he seek advice and aid of any of the men in charge of the exhibits. No question will be considered too elemental or simple to be discussed and answered by those in charge. It will aid them to make their contributions more valuable to have subjects brought to them for discussion.

For the interest of those who may have no special questions, there will be given in the afternoon a short talk by one of the roentgenologists on the technique of taking a radiograph and interpreting it. (Program, p. 669) J. S. L.

## MEDICAL SURVEYS

The medical surveys which we began early last summer were an outgrowth of our reportorial attempts as we visited a few medical centers seeking news and suggestions for the Journal. We found that the physicians in every community were doing some one or two things exceedingly well, and in a way that was worthy of publicity. We also found that the doctors of a community seldom could give accurate information regarding medicine in their own county, or city, and much less regarding it in other parts of the State.

We were gratified with the absence of sectionalism. Physicians have a fraternalism which gives them a kindly feeling for their confreres throughout the State.

We have just made a medical survey of Greater New York. It is necessarily superficial and sketchy,—as are all such surveys of the city, whether they are made by individuals or endowed corporations.

If we survey impersonally, we can draw all manner of conclusions. We can decide that the physicians of Greater New York are self-satisfied, and know little about medicine in other parts of the State. Or we can point to the marvellous

achievements in surgery and research, and the immense hospitals and medical schools, and can conclude that with all these advantages the physicians of New York City must be super-doctors. And we will be equally right and wrong, as are most other investigators.

We tried to approach our survey from a *personal* point of view. The great city has several thousand physicians with the same training and inspirations as their up-state confreres. They are confronted with problems that are their own, and belong to no one else. The physicians in each section have solved their own problems in their own particular way. It happens that the methods of solution adopted by the Manhattan physicians, differ fundamentally from those developed in Brooklyn, but who shall say which is the better? Each is best for its own community.

But in one respect we have found entire unanimity among the doctors of both Greater New York and the rest of the State. They are entirely fraternal, cooperative, earnest, and sincere, and all are earnestly trying to solve the problems which are within the scope of the Medical Society of the State of New York.

F. O.

## THE PRINCIPLES OF GRADUATE MEDICAL EDUCATION

We are now at the cross roads in medical education. The training of physicians in medical schools is both a science and an art. The medical schools can teach medical science, but they cannot teach the art of practicing medicine.

What is skill? It consists of information, experience, subconscious memories, wisdom, and action. It can be transmitted from one individual to another provided the recipient has both inspiration and desire.

A physician is like a school child who is satisfied to be like the others in his own group. A school boy who is in a class with more advanced pupils will study hard in order to keep up with his superiors. In a group of medical equals there

is no one to show the others better methods of diagnosis and treatment, but a group with a leader is a learning group.

The hospital where all the physicians of a community come together offers the means whereby a physician can learn the art of the practice of medicine. It can take the place of the preceptor of former days when the younger men learned from those who were more experienced.

The hospital is a place of learning in distinction from teaching. It is a place where the members of the staff confer with the consultant as his social equal. It is a voluntary association, and the subjects of discussion are chosen by the



# LEGAL



By GEORGE W. WHITESIDE, Esq.  
Counsel, Medical Society of the State of New York

## SHOULD NOT THE PROFESSION DISCOURAGE BASELESS MALPRACTICE SUITS?

As the Annual Meeting of the House of Delegates approaches, we pause to look back upon the past year to give an account of our stewardship in this department.

We find that active as we have been in the disposition of suits brought against doctors, we have been unable to keep pace with the influx of new suits, that although we disposed of ninety-nine cases, we received one hundred and eighty-one, and that our calendar of pending lawsuits against physicians is now two hundred and eighty-four.

Of the ninety-nine cases that we have disposed of, seven were settled, ninety-two were won, and none were lost. These figures indicate that 7 per cent of the cases disposed of had merit on the plaintiffs' side and if we adopt this ratio for pending cases it would indicate that of the two hundred and eighty-four cases pending, about twenty are based upon actual liability.

It is not the case of actual liability that really gives trouble, because the damage that has been done can be assessed and paid for under our present system of group insurance. This system is but right to the doctor and fair to the patient. The cases which in fact are not based upon actual liability, give the most anxiety, for we realize that by one method or another the plaintiff will seek to bring forward such testimony as will create a legal liability and result in an assessment of damages against the physician, whether that judgment be just or not. To defeat these efforts occupies a great deal of our attention and is cause for considerable of our anxiety. In practically every such cause there is something—usually in the result of the doctor's treatment—that makes the patient believe that he has a just grievance. There is some excuse for this attitude on the part of the layman, but there is also in such cases, hidden away somewhere, some doctor who, either by injudicious criticism or from motives less worthy, is responsible for inciting the plaintiff to start his action. In the last analysis it is this type

of doctor upon whom the responsibility for many such suits rests. In at least one instance that could be proved by the record. A young doctor in a community was dragged through days of anxious trial because another and older man who seemed to resent the invasion of his territory by the younger physician, sought to discredit him in the eyes of the community by fomenting a malpractice suit against his rival. This covert attack was unmasked during the course of the trial and the only one discredited by the lawsuit was the doctor who promoted it.

We also have to deal with the doctor who, for a price, or from a baser motive, takes the witness stand and assumes to be an expert on matters concerning which he has little or no learning. Such a man glibly gives opinions that are oft-times ridiculous and usually reckless. Such opinion cannot be the result of an honest conviction, as the cross-examination usually discloses, but it is in the case, it is before the jury, and is a peg upon which a jury can place its verdict. It is not only the hungry lawyer, but also the hungry doctor, who is responsible for much of this litigation. We hope in the future not simply to rest content with such a record as we are able to show this year, where no case has been lost and only seven settled, but to go down deeper and take steps that will make the fomenting of this litigation anything but a pleasurable pastime for lawyers and doctors and to place the responsibility for groundless actions upon those who are responsible and to make such responsibility an undesirable load for any professional man to carry.

The discouragement of groundless malpractice actions is the duty of every physician and in performing this duty he will do a service to the profession and no injustice to any patient who has a just cause of action. We expect justice to be done the physician and we are ready, and fortunately able, to do justice to the patient who has a just complaint.

## ALOPECIA AS A RESULT OF X-RAY THERAPY

The plaintiff, a boy of about ten or twelve years of age, an inmate of an orphan asylum, was one of nine orphans in said asylum who had developed the disease of favus. All the boys had been treated medically for nine or ten months

without any apparent results from such treatment. The physician who was treating the boys had requested the defendant, an X-ray therapist, to administer X-ray treatment to the boys.

The entire scalp of the plaintiff was treated

sands of individuals are classified as licensed nurses, trained nurses, trained attendants and practical nurses, the first three classes are created under and protected by the Public Health Law of the State, the last group includes those who, for one reason or another, have failed to complete the prescribed courses in hospital training schools, and, those who never have had any hospital training whatsoever

It seems that no legal machinery exists whereby some constituted authority inspects and controls the activities of nurse registries such as is provided by the business law for other labor employment bureaus to protect the public and the registrants from improper exploitation. The former glaring evils and odious scandals in the conduct of labor employment bureaus led the public to demand their control by licensure. The underlying fundamental motives for the existence of the alumnae registries rest in the reciprocal relations with the hospital in service to its patrons, those of the registries conducted by licensed nurses rest in service to the patient and in mutual protection, while those of the commercial registry rest solely in financial gain. Registries as conducted by Registered Nurses are financed from society membership with annual dues, while commercial registries are run upon the basis of a percentage of the fees of the nurses, which naturally opens a door for irregularity and exploitation when unscrupulously conducted.

The most frequent complaint is that nurses overcharge. In order to show that the registries conducted by alumnae associations and by groups of registered nurses are not guilty of promoting excessive fees, and, that if such complaint be true and based on actual facts, the fault lies with unscrupulous nurses and with the commercial registries, a survey was made in 1923 of fees posted in registries con-

ducted by other than the commercial registries in seventeen representative cities of seventeen northern, eastern, southern and western states. The fees were scheduled under general medical and surgical service, obstetrics, contagious diseases, mental diseases, alcohol and drug addiction, the fees ranged from a minimum of \$5 00 a day to a maximum of \$11 00 a day for addicts. The rate for "24-hour duty" was \$7 00 a day in seven cities, \$6 00 a day in five cities, and \$5 00 a day in five cities, in only six cities there was a separate rate made for "12-hour duty", advances of from \$1 00 to \$4 00 per day were fairly general for obstetrical, mental, addict and contagious service. These figures indicate that the schedules for nursing service hardly have advanced in proportion to the cost of living, and, that it is not the licensed or registered nurse who is "hard-boiled"

As the professional reputation of the registered nurse seriously suffers when irregular and incompetent nursing service at exorbitant rates is supplied by the nurse registries, the New York State Nurses Association conducted an exhaustive investigation of commercial registries so that no one better than the registered nurses themselves know the conditions existing therein. To prevent professional smirching the State Nurses Association has asked co-operation and support from the physicians in a program sent to each County Medical Society for the establishment of a central registry in each community to be called the "Official Nurse Registry" upon the governing board of which shall be both physicians and lay persons. This central "Official Registry" shall register and send out for employment registered nurses, trained nurses, trained attendants and practical nurses," all of which groups shall be controlled by certain rules and regulations applicable to their own amount of experience." A T LYTL.

## NEW PROCEDURES IN MEDICINE

To what extent should physicians generally adopt the newer procedures, such as the toxin-antitoxin administration for diphtheria immunization?

We have heard public health experts question the wisdom of giving the toxin-antitoxin material to every physician that asks for it, on the ground that the composition of the mixture must be exact, and the interpretation of the results require experience and special knowledge.

Will the average doctor give the time and thought necessary to prepare himself to give the

Schick test and the toxin-antitoxin? If the doctors will not prepare themselves, then let the authorities of the Departments of Health and of Education provide the means of giving the test and the immunization at public expense.

Also, let the doctors through their county medical societies vote to support the work, and to approve the appointment of one of their number in each community who shall do the work in schools and baby clinics at public expense.

If doctors do not want to do this most excellent work in their private practice, let them direct its performance by public agencies. F O



# LEGAL



By GEORGE W. WHITESIDE, Esq  
Counsel Medical Society of the State of New York

## SHOULD NOT THE PROFESSION DISCOURAGE BASELESS MALPRACTICE SUITS?

As the Annual Meeting of the House of Delegates approaches, we pause to look back upon the past year to give an account of our stewardship in this department

We find that active as we have been in the disposition of suits brought against doctors, we have been unable to keep pace with the influx of new suits, that although we disposed of ninety-nine cases, we received one hundred and eighty-one, and that our calendar of pending lawsuits against physicians is now two hundred and eighty-four

Of the ninety-nine cases that we have disposed of, seven were settled, ninety-two were won, and none were lost. These figures indicate that 7 per cent of the cases disposed of had merit on the plaintiffs' side and if we adopt this ratio for pending cases it would indicate that of the two hundred and eighty-four cases pending, about twenty are based upon actual liability

It is not the case of actual liability that really gives trouble, because the damage that has been done can be assessed and paid for under our present system of group insurance. This system is but right to the doctor and fair to the patient. The cases which in fact are not based upon actual liability, give the most anxiety, for we realize that by one method or another the plaintiff will seek to bring forward such testimony as will create a legal liability and result in an assessment of damages against the physician, whether that judgment be just or not. To defeat these efforts occupies a great deal of our attention and is cause for considerable of our anxiety. In practically every such cause there is something—usually in the result of the doctor's treatment—that makes the patient believe that he has a just grievance. There is some excuse for this attitude on the part of the layman, but there is also in such cases, hidden away somewhere, some doctor who, either by injudicious criticism or from motives less worthy, is responsible for inciting the plaintiff to start his action. In the last analysis it is this type

of doctor upon whom the responsibility for many such suits rests. In at least one instance that could be proved by the record. A young doctor in a community was dragged through days of anxious trial because another and older man who seemed to resent the invasion of his territory by the younger physician, sought to discredit him in the eyes of the community by fomenting a malpractice suit against his rival. This covert attack was unmasked during the course of the trial and the only one discredited by the lawsuit was the doctor who promoted it.

We also have to deal with the doctor who, for a price, or from a baser motive, takes the witness stand and assumes to be an expert on matters concerning which he has little or no learning. Such a man glibly gives opinions that are oft-times ridiculous and usually reckless. Such opinion cannot be the result of an honest conviction, as the cross-examination usually discloses, but it is in the case, it is before the jury, and is a peg upon which a jury can place its verdict. It is not only the hungry lawyer, but also the hungry doctor, who is responsible for much of this litigation. We hope in the future not simply to rest content with such a record as we are able to show this year, where no case has been lost and only seven settled, but to go down deeper and take steps that will make the fomenting of this litigation anything but a pleasurable pastime for lawyers and doctors and to place the responsibility for groundless actions upon those who are responsible and to make such responsibility an undesirable load for any professional man to carry.

The discouragement of groundless malpractice actions is the duty of every physician and in performing this duty he will do a service to the profession and no injustice to any patient who has a just cause of action. We expect justice to be done the physician and we are ready, and fortunately able, to do justice to the patient who has a just complaint.

## ALOPECIA AS A RESULT OF X-RAY THERAPY

The plaintiff, a boy of about ten or twelve years of age, an inmate of an orphan asylum, was one of nine orphans in said asylum who had developed the disease of favus. All the boys had been treated medically for nine or ten months

without any apparent results from such treatment. The physician who was treating the boys had requested the defendant, an X-ray therapist, to administer X-ray treatment to the boys.

The entire scalp of the plaintiff was treated

with X-ray, the technic used, according to defendant, being that recommended by physicians generally. However, a skin reaction followed the application of the X-ray twelve days after the treatment and the hair on the entire scalp dropped out and there was no re-growth of the hair, the plaintiff remaining completely bald, the health of the boy, however, not being affected by the X-ray.

The Adamson method of dividing up the scalp was used and the exposure on the scalp made at five separate points, each exposure at right angles to the other at each of the five points. The factors of dosage were two milliamperes, six

minutes, seventy kilowatts (equalling a six-inch spark gap on defendant's machine), eight inch skin target distance and no filters.

After examination into the authorities upon X-ray technic and consultation with various X-ray therapists, it was concluded that the dose of X-ray was excessive and caused the alopecia.

Four of the nine boys were treated with the X-ray, alopecia resulting to the four, and the favus on the other five boys cleared up under medical treatment without any loss of hair.

The claim of the four boys against the X-ray therapist was compromised and settled.

---

### ALLEGED NEGLIGENCE IN OPERATION WITH RESULTANT LOSS OF OVARY

A surgeon having performed an operation upon a woman patient was not paid for his services. Subsequently, after numerous attempts to collect his bill, he instituted an action to recover the value of his services. This case came on for trial, but resulted in a disagreement of the jury. After the trial, the patient again visited the surgeon and both she and her husband declared that they had never refused to pay him, but they were obliged to defend the action which he had instituted. The patient then asked that the surgeon make an examination of her, to determine the cause of pain at her menstrual periods, which she claimed she had been troubled with since the operation. At the time of the trial of the surgeon's action to collect for his services, it was contended on behalf of the defendant patient that a stricture of the ureter was discovered some eighteen months after the surgeon had performed his operation, it being the defendant's

contention that this condition existed at the time of the operation. The urologist to whom the patient had been referred by the surgeon testified that at the time he examined and treated the patient he discovered no stricture of the ureter and found nothing wrong with the urinary tract.

An action of alleged malpractice was instituted against the surgeon after the trial of the action to collect for the services rendered, claiming that because of the carelessness of the surgeon in the performance of the operation the plaintiff was required to submit to a further operation for the removal of an ovary and that the loss of such ovary was due to the defendant's carelessness. The action for alleged malpractice not having been commenced within two years after the performance of the defendant's operation, a motion to dismiss the complaint upon that ground was granted, favorably terminating the malpractice action in favor of the surgeon.

---





# State Department of Health



## SULPH-ARSPHENAMINE SUPPLIED BY DEPARTMENT

The Division of Social Hygiene is now prepared to supply physicians with sulph-arsphenamine for the treatment of indigent cases of syphilis. The State Department of Health still believes that arsphenamine is the drug of first choice where facilities are available for carrying out the proper technique of the preparation and

administration which are necessary when using this drug. Sulph-arsphenamine is primarily recommended for those cases where suitable veins are difficult or impossible to find, for children, and for use in rural communities where the proper facilities for giving arsphenamine are not available.

## DIES OF BOTULISM AFTER EATING HOME-CANNED STRING BEANS

A woman recently died in Buffalo from botulism, according to a history which was furnished the Division of Communicable Diseases by Dr. Walter S. Goodale, superintendent, Buffalo City Hospital. This woman opened a jar of home-canned string beans and ate about a tablespoonful. Her daughter tasted of these beans but owing to the disagreeable taste did not swallow any of them. The rest of the beans were discarded. On the following day the mother developed nausea and vomiting. The next day she

experienced difficulty in swallowing, in articulation and in moving the tongue, also dizziness. These symptoms increased, and there was a disturbance of vision with drooping of the eyelids. She died twelve days after eating the beans. A specimen of the discarded beans was obtained by the local laboratory. *Bacillus botulinus* was found to be present. A salt solution extract of the beans was highly toxic, 1 cc. of a 1:1000 dilution killing guinea pigs within 12 hours.

## CURED OR ARRESTED?

The conference of Venereal Disease Control Officers of the State Departments of Health and the United States Public Health Service which met in Hot Springs, Arkansas, in December, went on record as advocating a more careful use of the word "cure" in relation to the treatment of syphilis.

A news release of the United States Public Health Service concerning this conference states that

The indiscriminate use of the word "cure" in the treatment of syphilis should be discontinued and instead the patient should be made to think merely of an

arrested condition as in tuberculosis. Persons undergoing treatment for syphilis should expect and seek observational control at appropriate intervals and under proper medical care through a period of years—instead of considering themselves cured after a few months or a year's treatment in order to avoid late involvement of the heart, blood vessels and nervous system.

A complete comprehensive report of this conference dealing with recommendations for the policy, management, methods and standards of examination, diagnosis and treatment of syphilis for clinics is to be sent to all upstate physicians by the Division of Social Hygiene of the State Department of Health.

## ANOTHER POST-DIPHTHERITIC DEATH FROM CARDIAC INVOLVEMENT

Another sudden death following diphtheria was recently added to the considerable number which have already been reported. In this case the patient was a boy of five. The report states that a physician saw him on the first day of the disease but as no membrane was observed, antitoxin was not given until two days later. Only a very slight membrane, confined to the tonsils, appeared during the course of the illness. It cleared up rapidly

after use of antitoxin. The child was apparently well, and was up and about his room. He died suddenly, following some unusual exertion.

This case not only illustrates the need of the early administration of antitoxin, even in mild cases, but it also shows that greater care is called for in keeping patients in bed for a longer period, especially in cases where antitoxin is administered later than the first day of the disease.

## DEMAND FOR STERILE OBSTETRIC PACKAGES GROWS

The public health nurse for the city of Beacon reports that the call for sterile obstetric packages is increasing so fast that the local Red Cross Society find it difficult to keep up with the demand.

The Century Club of Amsterdam has given fifty dollars to the local public health nurse to be used in purchasing material for the packages and the club has arranged to help in preparing them.

with X-ray, the technic used, according to defendant, being that recommended by physicians generally. However, a skin reaction followed the application of the X-ray twelve days after the treatment and the hair on the entire scalp dropped out and there was no re-growth of the hair, the plaintiff remaining completely bald, the health of the boy, however, not being affected by the X-ray.

The Adamson method of dividing up the scalp was used and the exposure on the scalp made at five separate points, each exposure at right angles to the other at each of the five points. The factors of dosage were two milliamperes, six

minutes, seventy kilowatts (equalling a six-inch spark gap on defendant's machine), eight inch skin target distance and no filters.

After examination into the authorities upon X-ray technic and consultation with various X-ray therapists, it was concluded that the dose of X-ray was excessive and caused the alopecia.

Four of the nine boys were treated with the X-ray, alopecia resulting to the four, and the favus on the other five boys cleared up under medical treatment without any loss of hair.

The claim of the four boys against the X-ray therapist was compromised and settled.

---

### ALLEGED NEGLIGENCE IN OPERATION WITH RESULTANT LOSS OF OVARY

A surgeon having performed an operation upon a woman patient was not paid for his services. Subsequently, after numerous attempts to collect his bill, he instituted an action to recover the value of his services. This case came on for trial, but resulted in a disagreement of the jury. After the trial, the patient again visited the surgeon and both she and her husband declared that they had never refused to pay him, but they were obliged to defend the action which he had instituted. The patient then asked that the surgeon make an examination of her, to determine the cause of pain at her menstrual periods, which she claimed she had been troubled with since the operation. At the time of the trial of the surgeon's action to collect for his services, it was contended on behalf of the defendant patient that a stricture of the ureter was discovered some eighteen months after the surgeon had performed his operation, it being the defendant's

contention that this condition existed at the time of the operation. The urologist to whom the patient had been referred by the surgeon testified that at the time he examined and treated the patient he discovered no stricture of the ureter and found nothing wrong with the urinary tract.

An action of alleged malpractice was instituted against the surgeon after the trial of the action to collect for the services rendered, claiming that because of the carelessness of the surgeon in the performance of the operation the plaintiff was required to submit to a further operation for the removal of an ovary and that the loss of such ovary was due to the defendant's carelessness. The action for alleged malpractice not having been commenced within two years after the performance of the defendant's operation, a motion to dismiss the complaint upon that ground was granted, favorably terminating the malpractice action in favor of the surgeon.

---



# State Department of Health



## SULPH-ARSPHENAMINE SUPPLIED BY DEPARTMENT

The Division of Social Hygiene is now prepared to supply physicians with sulph-arsphenamine for the treatment of indigent cases of syphilis. The State Department of Health still believes that arsphenamine is the drug of first choice where facilities are available for carrying out the proper technique of the preparation and

administration which are necessary when using this drug. Sulph-arsphenamine is primarily recommended for those cases where suitable veins are difficult or impossible to find, for children, and for use in rural communities where the proper facilities for giving arsphenamine are not available.

## DIES OF BOTULISM AFTER EATING HOME-CANNED STRING BEANS

A woman recently died in Buffalo from botulism, according to a history which was furnished the Division of Communicable Diseases by Dr. Walter S. Goodale, superintendent, Buffalo City Hospital. This woman opened a jar of home-canned string beans and ate about a tablespoonful. Her daughter tasted of these beans but owing to the disagreeable taste did not swallow any of them. The rest of the beans were discarded. On the following day the mother developed nausea and vomiting. The next day she

experienced difficulty in swallowing, in articulation and in moving the tongue, also dizziness. These symptoms increased, and there was a disturbance of vision with drooping of the eyelids. She died twelve days after eating the beans. A specimen of the discarded beans was obtained by the local laboratory. *Bacillus botulinus* was found to be present. A salt solution extract of the beans was highly toxic, 1 cc of a 1:1000 dilution killing guinea pigs within 12 hours.

## CURED OR ARRESTED?

The conference of Venereal Disease Control Officers of the State Departments of Health and the United States Public Health Service which met in Hot Springs, Arkansas, in December, went on record as advocating a more careful use of the word "cure" in relation to the treatment of syphilis.

A news release of the United States Public Health Service concerning this conference states that

The indiscriminate use of the word "cure" in the treatment of syphilis should be discontinued and instead the patient should be made to think merely of an

arrested condition as in tuberculosis. Persons undergoing treatment for syphilis should expect and seek observational control at appropriate intervals and under proper medical care through a period of years—instead of considering themselves cured after a few months or a year's treatment in order to avoid late involvement of the heart, blood vessels and nervous system.

A complete comprehensive report of this conference dealing with recommendations for the policy, management, methods and standards of examination, diagnosis and treatment of syphilis for clinics is to be sent to all upstate physicians by the Division of Social Hygiene of the State Department of Health.

## ANOTHER POST-DIPHTHERITIC DEATH FROM CARDIAC INVOLVEMENT

Another sudden death following diphtheria was recently added to the considerable number which have already been reported. In this case the patient was a boy of five. The report states that a physician saw him on the first day of the disease but as no membrane was observed, antitoxin was not given until two days later. Only a very slight membrane, confined to the tonsils, appeared during the course of the illness. It cleared up rapidly

after use of antitoxin. The child was apparently well, and was up and about his room. He died suddenly, following some unusual exertion.

This case not only illustrates the need of the early administration of antitoxin, even in mild cases, but it also shows that greater care is called for in keeping patients in bed for a longer period, especially in cases where antitoxin is administered later than the first day of the disease.

## DEMAND FOR STERILE OBSTETRIC PACKAGES GROWS

The public health nurse for the city of Beacon reports that the call for sterile obstetric packages is increasing so fast that the local Red Cross Society find it difficult to keep up with the demand.

The Century Club of Amsterdam has given fifty dollars to the local public health nurse to be used in purchasing material for the packages and the club has arranged to help in preparing them.

with X-ray, the technic used, according to defendant, being that recommended by physicians generally. However, a skin reaction followed the application of the X-ray twelve days after the treatment and the hair on the entire scalp dropped out and there was no re-growth of the hair, the plaintiff remaining completely bald, the health of the boy, however, not being affected by the X-ray.

The Adamson method of dividing up the scalp was used and the exposure on the scalp made at five separate points, each exposure at right angles to the other at each of the five points. The factors of dosage were two milliamperes, six

minutes, seventy kilowatts (equalling a six-inch spark gap on defendant's machine), eight inch skin target distance and no filters.

After examination into the authorities upon X-ray technic and consultation with various X-ray therapists, it was concluded that the dose of X-ray was excessive and caused the alopecia.

Four of the nine boys were treated with the X-ray, alopecia resulting to the four, and the favus on the other five boys cleared up under medical treatment without any loss of hair.

The claim of the four boys against the X-ray therapist was compromised and settled.

### ALLEGED NEGLIGENCE IN OPERATION WITH RESULTANT LOSS OF OVARY

A surgeon having performed an operation upon a woman patient was not paid for his services. Subsequently, after numerous attempts to collect his bill, he instituted an action to recover the value of his services. This case came on for trial, but resulted in a disagreement of the jury. After the trial, the patient again visited the surgeon and both she and her husband declared that they had never refused to pay him, but they were obliged to defend the action which he had instituted. The patient then asked that the surgeon make an examination of her, to determine the cause of pain at her menstrual periods, which she claimed she had been troubled with since the operation. At the time of the trial of the surgeon's action to collect for his services, it was contended on behalf of the defendant patient that a stricture of the ureter was discovered some eighteen months after the surgeon had performed his operation, it being the defendant's

contention that this condition existed at the time of the operation. The urologist to whom the patient had been referred by the surgeon testified that at the time he examined and treated the patient he discovered no stricture of the ureter and found nothing wrong with the urinary tract.

An action of alleged malpractice was instituted against the surgeon after the trial of the action to collect for the services rendered, claiming that because of the carelessness of the surgeon in the performance of the operation the plaintiff was required to submit to a further operation for the removal of an ovary and that the loss of such ovary was due to the defendant's carelessness. The action for alleged malpractice not having been commenced within two years after the performance of the defendant's operation, a motion to dismiss the complaint upon that ground was granted, favorably terminating the malpractice action in favor of the surgeon.



# State Department of Health



## SULPH-ARSPHENAMINE SUPPLIED BY DEPARTMENT

The Division of Social Hygiene is now prepared to supply physicians with sulph-arsphenamine for the treatment of indigent cases of syphilis. The State Department of Health still believes that arsphenamine is the drug of first choice where facilities are available for carrying out the proper technique of the preparation and

administration which are necessary when using this drug. Sulph-arsphenamine is primarily recommended for those cases where suitable veins are difficult or impossible to find, for children, and for use in rural communities where the proper facilities for giving arsphenamine are not available.

## DIES OF BOTULISM AFTER EATING HOME-CANNED STRING BEANS

A woman recently died in Buffalo from botulism, according to a history which was furnished the Division of Communicable Diseases by Dr. Walter S. Goodale, superintendent, Buffalo City Hospital. This woman opened a jar of home-canned string beans and ate about a tablespoonful. Her daughter tasted of these beans but owing to the disagreeable taste did not swallow any of them. The rest of the beans were discarded. On the following day the mother developed nausea and vomiting. The next day she

experienced difficulty in swallowing, in articulation and in moving the tongue, also dizziness. These symptoms increased, and there was a disturbance of vision with drooping of the eyelids. She died twelve days after eating the beans. A specimen of the discarded beans was obtained by the local laboratory. *Bacillus botulinus* was found to be present. A salt solution extract of the beans was highly toxic, 1 cc of a 1:1000 dilution killing guinea pigs within 12 hours.

## CURED OR ARRESTED?

The conference of Venereal Disease Control Officers of the State Departments of Health and the United States Public Health Service which met in Hot Springs, Arkansas, in December, went on record as advocating a more careful use of the word "cure" in relation to the treatment of syphilis.

A news release of the United States Public Health Service concerning this conference states that

The indiscriminate use of the word "cure" in the treatment of syphilis should be discontinued and instead the patient should be made to think merely of an

arrested condition as in tuberculosis. Persons undergoing treatment for syphilis should expect and seek observational control at appropriate intervals and under proper medical care through a period of years—instead of considering themselves cured after a few months or a year's treatment in order to avoid late involvement of the heart, blood vessels and nervous system.

A complete comprehensive report of this conference dealing with recommendations for the policy, management, methods and standards of examination, diagnosis and treatment of syphilis for clinics is to be sent to all upstate physicians by the Division of Social Hygiene of the State Department of Health.

## ANOTHER POST-DIPHTHERITIC DEATH FROM CARDIAC INVOLVEMENT

Another sudden death following diphtheria was recently added to the considerable number which have already been reported. In this case the patient was a boy of five. The report states that a physician saw him on the first day of the disease but as no membrane was observed, antitoxin was not given until two days later. Only a very slight membrane, confined to the tonsils, appeared during the course of the illness. It cleared up rapidly

after use of antitoxin. The child was apparently well, and was up and about his room. He died suddenly, following some unusual exertion.

This case not only illustrates the need of the early administration of antitoxin, even in mild cases, but it also shows that greater care is called for in keeping patients in bed for a longer period, especially in cases where antitoxin is administered later than the first day of the disease.

## DEMAND FOR STERILE OBSTETRIC PACKAGES GROWS

The public health nurse for the city of Beacon reports that the call for sterile obstetric packages is increasing so fast that the local Red Cross Society find it difficult to keep up with the demand.

The Century Club of Amsterdam has given fifty dollars to the local public health nurse to be used in purchasing material for the packages and the club has arranged to help in preparing them.

with X-ray, the technic used, according to defendant, being that recommended by physicians generally. However, a skin reaction followed the application of the X-ray twelve days after the treatment and the hair on the entire scalp dropped out and there was no re-growth of the hair, the plaintiff remaining completely bald, the health of the boy, however, not being affected by the X-ray.

The Adamson method of dividing up the scalp was used and the exposure on the scalp made at five separate points, each exposure at right angles to the other at each of the five points. The factors of dosage were two milliamperes, six

minutes, seventy kilowatts (equalling a six-inch spark gap on defendant's machine), eight inch skin target distance and no filters.

After examination into the authorities upon X-ray technic and consultation with various X-ray therapists, it was concluded that the dose of X-ray was excessive and caused the alopecia.

Four of the nine boys were treated with the X-ray, alopecia resulting to the four, and the favus on the other five boys cleared up under medical treatment without any loss of hair.

The claim of the four boys against the X-ray therapist was compromised and settled.

### ALLEGED NEGLIGENCE IN OPERATION WITH RESULTANT LOSS OF OVARY

A surgeon having performed an operation upon a woman patient was not paid for his services. Subsequently, after numerous attempts to collect his bill, he instituted an action to recover the value of his services. This case came on for trial, but resulted in a disagreement of the jury. After the trial, the patient again visited the surgeon and both she and her husband declared that they had never refused to pay him, but they were obliged to defend the action which he had instituted. The patient then asked that the surgeon make an examination of her, to determine the cause of pain at her menstrual periods, which she claimed she had been troubled with since the operation. At the time of the trial of the surgeon's action to collect for his services, it was contended on behalf of the defendant patient that a stricture of the ureter was discovered some eighteen months after the surgeon had performed his operation, it being the defendant's

contention that this condition existed at the time of the operation. The urologist to whom the patient had been referred by the surgeon testified that at the time he examined and treated the patient he discovered no stricture of the ureter and found nothing wrong with the urinary tract.

An action of alleged malpractice was instituted against the surgeon after the trial of the action to collect for the services rendered, claiming that because of the carelessness of the surgeon in the performance of the operation the plaintiff was required to submit to a further operation for the removal of an ovary and that the loss of such ovary was due to the defendant's carelessness. The action for alleged malpractice not having been commenced within two years after the performance of the defendant's operation, a motion to dismiss the complaint upon that ground was granted, favorably terminating the malpractice action in favor of the surgeon.

2 Those of medical extension, or of an academy of medicine

- (a) library,
- (b) graduate education

The activities of the Society during 1924 are set forth in a report of thirty-four pages on the size of this Journal. Nine pages are devoted to lists of members and the personnel of the committees, and eight to the Library. This report is made annually, and is unique among county medical societies.

The Society holds eight meetings a year on the third Tuesday evening of each month except during the summer. The average attendance is between two hundred and three hundred. The major affairs of the Society are settled at the meetings, and debates sometimes continue until one or two o'clock in the morning. The Society is entirely democratic in its methods of conducting its affairs.

The programs of the meetings during the last year or two have been on topics of civic medicine, for the scientific work of the Society is conducted through its organized graduate education system.

The Society carries on its routine affairs largely through its council of officers and its committees. In addition to the usual ones which manage the internal affairs, the Society has committees which carry out important lines of civic policies.

The Committee on Legislation has been unusually active, and has impressed itself on the members of the Legislature. While its decisions have not always coincided with the policies of majority of the legislative committees of other county societies, yet the amount of work done has been monumental, and the high motives of the members have been unquestioned.

A committee on Illegal Practice has set the pace for ferreting out quacks and securing evidence against those who practice medicine without licenses. It has worked in close harmony with the District Attorney, and holds an enviable record in the enforcement of the Medical Practice Law in Brooklyn.

One of the most important committees has been that on Public Health. This committee has been extremely active and has cooperated with other health agencies, among which are the Health Department, the Committee on Dispensary Development, the Associated Out-Patient Clinics, the Visiting Nurses' Association, the Maternity Center Association, and the Brooklyn Tuberculosis Committee. Many of its studies have been similar to those made by academies of medicine in other large cities, and its expenses have been largely met by voluntary contributions. The Committee has promoted the idea that organizations of practicing physicians are

the natural bodies that should take the lead in all lines of work which have to do with health, and it has succeeded in its ideals to a remarkable degree.

An outstanding accomplishment of the Committee on Public Health has been an extensive demonstration of Periodic Health Examinations which were described on page 739 of the June, 1924, issue of this journal. The work of this Committee has attracted the notice of public health workers throughout the nation.

The Milk Commission of the Society directs the production of certified milk, and is probably the most active and efficient in New York State. It maintains corps of inspectors under its director, Dr. Harris A. Moak, and supervises 14 dairies. Its laboratory work is done at 360 Park Place, Brooklyn.

The Society has an active Visiting Committee whose object is to call on sick members of the Society.

The Historical Committee, under the chairmanship of Dr. William Schroeder, has done an immense amount of biographical work relating to both new and deceased members.

The Committee on Medical Economics has considered matters concerning the relation of physicians to other organizations, such as insurance companies and the State Compensation Commission. It has also spoken for the medical profession in the relation of physicians to lay public health organizations, such as the Brooklyn Maternity Center Association.

A Committee on Press Reference was appointed during the past year for the purpose of giving authoritative statements on medical subjects to daily newspapers when medical news stories develop. The Society gave one of its regular meetings to a discussion of this subject, and the editors of all the daily papers in Brooklyn were present and spoke in favor of the project. The Committee has received recognition from the newspapers, and the only difficulty in the way of an extensive use of the service seems to be the impatience of the editors to publish news before the physicians have time to investigate the stories. The Committee has also worked in cooperation with the Committee on Publicity.

Another object of the Committee was to prepare medical articles for the newspapers to publish. According to the report of the Committee the reason that few of its articles have been published has been that the articles submitted to the committee have been too technical for the lay reader. The report concludes "It is our hope that, during the year to come, we shall be able to gather a series of articles for publication which will be of benefit to the community which we serve."



# MEDICAL SURVEY



## MEDICAL SURVEY NUMBER 9 MEDICINE IN KINGS COUNTY

**EDITOR'S NOTES** —The information on which this Survey is based was obtained through the cooperation of Dr John E Jennings, President of the Medical Society of the County of Kings, and Dr Alec N Thomson, Secretary of the Public Health Committee of the Society

Kings county forms one of the Boroughs of Greater New York, and constituted the city of Brooklyn previous to the formation of the city of Greater New York. It is located on the south-west end of Long Island, and has an area of about 71 square miles. Its population is about 2,200,000, according to the estimates used by the New York City Department of Health. It is almost equal to the population of Manhattan, and at its present rate of growth, will soon exceed that of Manhattan.

**PHYSICIANS** The number of physicians in Kings County is 2631, according to the Directory of the Medical Society of the State of New York. This gives a proportion of one physician to every 835 inhabitants. This proportion is nearly double that of Manhattan where there is one doctor to every 432 of population, but the proportion in the Bronx Borough is one to 950, in Queens, one to 1220, in Richmond, one to 1300. In New York State outside of Greater New York there is one doctor to every 770 of population.

The practice of medicine in Brooklyn partakes of the nature of practice in small cities to greater extent than in any other great city. The reasons for this fact are two fold.

First Brooklyn is a city of homes in contrast with Manhattan which is a great commercial center for the whole nation.

Second Brooklyn has developed from a group of isolated villages which grew and extended their boundaries until they fused themselves into one big city, but each section has retained much of its own individuality.

The peculiar manner of development of Brooklyn is reflected in the medical professions. The physicians of Brooklyn have the characteristics of family physicians to a greater extent than those of any other great city. The city is well supplied with specialists and consultants, the majority of whom have risen from the ranks of general practitioners, and have retained their intimate associations with family doctors.

Brooklyn has developed medically as if it were an independent unit separated a hundred miles from the rest of New York City. It has a Class A medical school, an extremely active

county medical society, and a medical library which ranks among the half dozen greatest in the United States. It is also the medical center for the rest of Long Island with about 800,000 population and 800 physicians.

**MEDICAL SOCIETIES** The principal medical organization of Brooklyn is the Medical Society of the County of Kings, which is an integral part of the Medical Society of the State of New York. The County Society has 1578 members, or 60 per cent of the physicians who are listed in the Directory of the State Medical Society. This proportion of membership is about the same as that in all of Greater New York and throughout the State. The Society added 145 new members in the past year.

The Medical Society of the County of Kings combines the functions of a county medical society with those of an academy of medicine. It owns its own building, maintains its own library, conducts graduate education work, and performs other functions which are usually assumed by an Academy of Medicine. The medical organizations of Brooklyn are unified to greater extent than in any other county of the State.

The Society has recently adopted a sliding scale of dues according to the year of graduation of the members. Those who have graduated recently and are not yet established in a large practice, pay yearly dues of ten dollars, in addition to the State dues, while those who have been a considerable time in practice and have had an opportunity for financial gain, pay twenty-five dollars. The plan is working satisfactorily.

**SOCIETY BUILDING** The building now occupied by the County Medical Society is located at 1313 Bedford avenue, within one block of the Nostrand Avenue Station of the Long Island Railroad. It was built in 1898, and its value is rated at \$100,000. The funds were raised by subscriptions given by Brooklyn physicians and their friends. The building houses the Library and Reading Room, and contains an Assembly Hall which seats 450 persons. Plans are being perfected for an addition which will double the present capacity of the building.

The activities of the Medical Society of the County of Kings may be classified as follows:

1 Those common to all county medical societies

- (a) meetings,
- (b) committee work.



2 Those of medical extension, or of an academy of medicine

- (a) library,
- (b) graduate education

The activities of the Society during 1924 are set forth in a report of thirty-four pages of the size of this Journal. Nine pages are devoted to lists of members and the personnel of the committees, and eight to the Library. This report is made annually, and is unique among county medical societies.

The Society holds eight meetings a year, on the third Tuesday evening of each month except during the summer. The average attendance is between two hundred and three hundred. The major affairs of the Society are settled at the meetings, and debates sometimes continue until one or two o'clock in the morning. The Society is entirely democratic in its methods of conducting its affairs.

The programs of the meetings during the last year or two have been on topics of civic medicine, for the scientific work of the Society is conducted through its organized graduate education system.

The Society carries on its routine affairs largely through its council of officers and its committees. In addition to the usual ones which manage the internal affairs, the Society has committees which carry out important lines of civic policies.

The Committee on Legislation has been unusually active, and has impressed itself on the members of the Legislature. While its decisions have not always coincided with the policies of majority of the legislative committees of other county societies, yet the amount of work done has been monumental, and the high motives of the members have been unquestioned.

A committee on Illegal Practice has set the pace for ferreting out quacks and securing evidence against those who practice medicine without licenses. It has worked in close harmony with the District Attorney, and holds an enviable record in the enforcement of the Medical Practice Law in Brooklyn.

One of the most important committees has been that on Public Health. This committee has been extremely active and has cooperated with other health agencies, among which are the Health Department, the Committee on Dispensary Development, the Associated Out-Patient Clinics, the Visiting Nurses' Association, the Maternity Center Association, and the Brooklyn Tuberculosis Committee. Many of its studies have been similar to those made by academies of medicine in other large cities, and its expenses have been largely met by voluntary contributions. The Committee has promoted the idea that organizations of practicing physicians are

the natural bodies that should take the lead in all lines of work which have to do with health, and it has succeeded in its ideals to a remarkable degree.

An outstanding accomplishment of the Committee on Public Health has been an extensive demonstration of Periodic Health Examinations which were described on page 739 of the June, 1924, issue of this journal. The work of this Committee has attracted the notice of public health workers throughout the nation.

The Milk Commission of the Society directs the production of certified milk, and is probably the most active and efficient in New York State. It maintains corps of inspectors under its director, Dr. Harris A. Moak, and supervises 14 dairies. Its laboratory work is done at 360 Park Place, Brooklyn.

The Society has an active Visiting Committee whose object is to call on sick members of the Society.

The Historical Committee, under the chairmanship of Dr. William Schroeder, has done an immense amount of biographical work relating to both new and deceased members.

The Committee on Medical Economics has considered matters concerning the relation of physicians to other organizations, such as insurance companies and the State Compensation Commission. It has also spoken for the medical profession in the relation of physicians to lay public health organizations, such as the Brooklyn Maternity Center Association.

A Committee on Press Reference was appointed during the past year for the purpose of giving authoritative statements on medical subjects to daily newspapers when medical news stories develop. The Society gave one of its regular meetings to a discussion of this subject, and the editors of all the daily papers in Brooklyn were present and spoke in favor of the project. The Committee has received recognition from the newspapers, and the only difficulty in the way of an extensive use of the service seems to be the impatience of the editors to publish news before the physicians have time to investigate the stories. The Committee has also worked in cooperation with the Committee on Publicity.

Another object of the Committee was to prepare medical articles for the newspapers to publish. According to the report of the Committee the reason that few of its articles have been published has been that the articles submitted to the committee have been too technical for the lay reader. The report concludes "It is our hope that, during the year to come, we shall be able to gather a series of articles for publication which will be of benefit to the community which we serve."

**THE LIBRARY** The library of the Medical Society of the County of Kings ranks third among the medical libraries of the Nation in point of age, fifth in actual size, and second to none in usefulness. It was founded in 1844 through the contributions of the physicians of Brooklyn. It now has 100,000 volumes and is increasing at the rate of 3,000 volumes annually. It is now exceeded in number of volumes by only the following four medical libraries in the country: The Library of the Surgeon General's office in Washington, the Philadelphia College of Physicians, the New York Academy of Medicine, the Boston Medical Library.

The library is housed in the modern fireproof building of the County Medical Society, but its space is crowded like that of the other large medical libraries.

The library employs a full-time librarian, Mr. Charles Frankenberger, who, with his staff of three assistants, is active and efficient in the management and enlargement of the library in assisting physicians in its use.

The library has no large endowment, but it is supported almost entirely from medical sources. A Medical Library Association is an auxiliary organization, which has been in existence since 1903 and which was formed for the purpose of applying its dues to the support of the library, and the influence of its members to the promotion of the interests of the library. There are a dozen organizations of specialists that subscribe to periodicals and books which are presented to the library, the *Long Island Medical Journal* brings in over 400 periodicals in exchanges from all over the world, and the new books from its book review department, the Brooklyn Dental Societies also contribute literature. While no one source of support is great, yet the aggregate of the smaller contributions from purely medical sources enables the library to keep fully abreast of the times.

The library is maintained for practical use, and in order to increase its efficiency the principal current periodicals (total number received, 1,016), and the review books are kept in the reading room on shelves which are accessible to physicians without their needing to consult the library staff. This service enables a physician to browse in his own way among the newer medical periodicals and books.

**GRADUATE EDUCATION** The County Medical Society conducts an extensive system of graduate medical education work along two lines: first, a series of lectures, and second, organized clinical courses.

The object of both the lectures and the clinical courses has been to instruct general practitioners in the art and science of the practice of clinical medicine. The teaching specialists

have tried to give family doctors a broad insight into conditions which require expert attention, realizing that the ordinary physician must know the fundamentals of a dozen or more specialties. The point of view of the teachers may be illustrated by the instruction on hearts. Instead of giving lectures on "The Surgery of the Heart Valves" they were upon "The Cardiac Patient."

The lectures are in charge of a special committee, and are given by prominent men who are noted for their ability in teaching and lecturing as well as their scientific attainments. They are given in the Society's building on Friday afternoons at five o'clock, and each one has been attended by over four hundred doctors. The Assembly Room has always been filled to overflowing. The series is commonly known as the "Five o'Clock Lectures."

The series of lectures have been completed, and two have been published in book form. The 1924 series consisted of twenty lectures, the first five of which were as follows:

Dr. George D. Stewart, "The Gall Bladder"

Dr. Foster Kennedy, "Fits,"

Dr. Haven Emerson, "Periodic Health Examinations,"

Dr. James T. Case, "The Colon,"

Dr. Harold E. B. Pardee, "The Cardiac Patient"

The 1923 volume of lectures is a practical classic on the management of common conditions which every physician meets, and the 1924 volume promises to be equally good.

The teaching clinics have been arranged by a joint committee of the Medical Society of the County of Kings and the Long Island College Hospital Medical School. They are held in eleven hospitals which can supply patients and teaching equipment. The hours of instruction are suited to the classes, and many meet at four o'clock. The object is to enable physicians to attend the courses without interrupting their practice. The courses are printed in a catalogue and appendices are issued monthly. The 1924 enrollment was 163 physicians.

The Committee has offered to extend the courses to the rural sections of Long Island, and a class in pediatrics has been formed with 25 members who meet weekly in the South Side Hospital in Bay Shore. Other classes are being formed in other rural parts of the Island.

The Brooklyn clinics set a new standard in graduate education, and are conducted on this simple principle: "Here is a group of doctors who desire practical instruction along a specific line. Give it to them at their convenience."

**GROUP MEDICAL SOCIETIES** The Medical Society of the County of Kings has not formed sections in the several branches of medicine, but

those who practice the various specialties have formed group societies, such as those in ophthalmology, gynecology, surgery, urology, dermatology, pediatrics, pathology, neurology, and internal medicine

The physicians of Brooklyn have also formed societies along geographic lines which largely coincide with those of the villages into which Brooklyn was formerly divided. Among the important local societies which are active are those of Bay Ridge, Flatbush, Williamsburg, East New York, New Utrecht, North Brooklyn, and Greenpoint.

The physicians of Brooklyn came in close touch with those from other parts of Long Island through the Associated Physicians of Long Island, and the Second District Branch of the Medical Society of the State of New York. The Associated Physicians performs nearly all the functions which a district branch is expected to perform. It holds three meetings a year, and exerts a great influence on medical affairs throughout the Island. It has about 1,000 members, over two-thirds of whom come from Brooklyn.

**THE LONG ISLAND MEDICAL JOURNAL.** The Associated Physicians of Long Island publishes a monthly journal, the Long Island Medical Journal, whose pages are open to any group of physicians on Long Island. It has promoted the activities of the Medical Society of the County of Kings to a greater extent than those of any other society, and might almost be considered to be the organ of the County Society.

**THE BULLETIN.** The Medical Society of the County of Kings publishes a four-page monthly Bulletin containing announcements of the meetings and other activities of the Society. It is written in a sprightly style of compelling interest.

**THE MEDICAL SCHOOL.** Brooklyn has a medical school—The Long Island College Hospital Medical School—which is listed as Class A, and which has trained some of the most prominent physicians of the City. It was founded in 1854, and has always had a deep influence in local medical affairs. It has cooperated with the County Medical Society in offering instruction to practicing physicians. The members of its staff are active in the local societies, and in the practice of medicine, and thereby they maintain a practical point of view which is reflected in their teaching.

The medical school utilizes several hospitals for teaching, but tentative plans are under way to associate the medical school with the Kings County Hospital, and thus form one of the greatest medical teaching centers in the world. The Kings County Hospital is a part of the Municipal Hospital System of Greater New York. It is located in about the center of Brooklyn, adjoining the grounds of the Kingston Avenue Contagious

Disease Hospital and the Brooklyn State Hospital for the Insane. The three groups cover over 40 city blocks, and have a capacity of 4,000 beds for every known disease. These form a ready-made medical center which is adapted to giving instruction better than any other center in the world. The Brooklyn physicians are developing the plans for a greater medical school quietly yet effectively.

**HOSPITALS.** Brooklyn is well supplied with hospitals. When the American College of Surgeons met in Greater New York in 1924, the managers of the hospitals of Brooklyn formed a Council for the purpose of coordinating their efforts to entertain the visiting surgeons. Their work proved to be so valuable to the hospitals themselves that the Council was continued. The Council has representatives from all the general hospitals in Brooklyn, and twenty-three hospitals are listed as members.

The total number of beds in the hospitals of the Council is 6,300, of which 1,800 are in the Kings County Hospital, the largest in the city. This gives a proportion of about three beds for every one thousand inhabitants. But the number of beds available for the sick is much greater than this, for the Council includes only the larger and better equipped hospitals.

Eleven of the hospitals are listed as teaching hospitals, and clinics are given in them under the auspices of the Joint Committee on Graduate Education.

The Long Island College Hospital is an integral part of the Medical School, and much of the clinical instruction of the students is given in the amphitheaters of the operating rooms.

**DISPENSARIES.** The Public Health Committee of the Medical Society of the County of Kings has cooperated with the Hospital Council to raise the standards of the dispensaries to those of the hospitals. Many of the hospitals belonging to the Council conduct outpatient departments, and are trying to secure the adoption of standards which shall include an organized staff of competent physicians, a complete record of every case, adequate laboratory service, and proper services along nursing, social, and clerical lines. The object is to place dispensary service on the same high plane as that of a first-class hospital.

**VISITING NURSING.** Brooklyn has a Visiting Nursing Association with headquarters at 80 Schermerhorn Street. It has a corps of 90 graduate registered nurses who give skilled care to the sick in their homes, and teach families how to keep well. The nurses work from 8 30 A. M. to 5 30 P. M., and charge a fee of one dollar for each visit to those who are able to pay, but no one is refused on account of lack of funds.

**THE LIBRARY** The library of the Medical Society of the County of Kings ranks third among the medical libraries of the Nation in point of age, fifth in actual size, and second to none in usefulness. It was founded in 1844 through the contributions of the physicians of Brooklyn. It now has 100,000 volumes and is increasing at the rate of 3,000 volumes annually. It is now exceeded in number of volumes by only the following four medical libraries in the country: The Library of the Surgeon General's office in Washington, the Philadelphia College of Physicians, the New York Academy of Medicine, the Boston Medical Library.

The library is housed in the modern fireproof building of the County Medical Society, but its space is crowded like that of the other large medical libraries.

The library employs a full-time librarian, Mr. Charles Frankenberger, who, with his staff of three assistants, is active and efficient in the management and enlargement of the library in assisting physicians in its use.

The library has no large endowment, but it is supported almost entirely from medical sources. A Medical Library Association is an auxiliary organization, which has been in existence since 1903 and which was formed for the purpose of applying its dues to the support of the library, and the influence of its members to the promotion of the interests of the library. There are a dozen organizations of specialists that subscribe to periodicals and books which are presented to the library, the *Long Island Medical Journal* brings in over 400 periodicals in exchanges from all over the world, and the new books from its book review department, the Brooklyn Dental Societies also contribute literature. While no one source of support is great, yet the aggregate of the smaller contributions from purely medical sources enables the library to keep fully abreast of the times.

The library is maintained for practical use, and in order to increase its efficiency the principal current periodicals (total number received, 1,016), and the review books are kept in the reading room on shelves which are accessible to physicians without their needing to consult the library staff. This service enables a physician to browse in his own way among the newer medical periodicals and books.

**GRADUATE EDUCATION** The County Medical Society conducts an extensive system of graduate medical education work along two lines: first, a series of lectures, and second, organized clinical courses.

The object of both the lectures and the clinical courses has been to instruct general practitioners in the art and science of the practice of clinical medicine. The teaching specialists

have tried to give family doctors a broad insight into conditions which require expert attention, realizing that the ordinary physician must know the fundamentals of a dozen or more specialties. The point of view of the teachers may be illustrated by the instruction on hearts. Instead of giving lectures on "The Surgery of the Heart Valves" they were upon "The Cardiac Patient."

The lectures are in charge of a special committee, and are given by prominent men who are noted for their ability in teaching and lecturing as well as their scientific attainments. They are given in the Society's building on Friday afternoons at five o'clock, and each one has been attended by over four hundred doctors. The Assembly Room has always been filled to overflowing. The series is commonly known as the "Five o'Clock Lectures."

The series of lectures have been completed, and two have been published in book form. The 1924 series consisted of twenty lectures, the first five of which were as follows:

Dr. George D. Stewart, "The Gall Bladder"

Dr. Foster Kennedy, "Fits,"

Dr. Haven Emerson, "Periodic Health Examinations,"

Dr. James T. Case, "The Colon,"

Dr. Harold E. B. Pardee, "The Cardiac Patient."

The 1923 volume of lectures is a practical classic on the management of common conditions which every physician meets, and the 1924 volume promises to be equally good.

The teaching clinics have been arranged by a joint committee of the Medical Society of the County of Kings and the Long Island College Hospital Medical School. They are held in eleven hospitals which can supply patients and teaching equipment. The hours of instruction are suited to the classes, and many meet at four o'clock. The object is to enable physicians to attend the courses without interrupting their practice. The courses are printed in a catalogue and appendices are issued monthly. The 1924 enrollment was 163 physicians.

The Committee has offered to extend the courses to the rural sections of Long Island, and a class in pediatrics has been formed with 25 members who meet weekly in the South Side Hospital in Bay Shore. Other classes are being formed in other rural parts of the Island.

The Brooklyn clinics set a new standard in graduate education, and are conducted on this simple principle: "Here is a group of doctors who desire practical instruction along a specific line. Give it to them at their convenience."

**GROUP MEDICAL SOCIETIES** The Medical Society of the County of Kings has not formed sections in the several branches of medicine, but

# NEWS NOTES

## ANNUAL MEETING

### TUBERCULOSIS SESSION

Thursday, May 14th, Hotel Syracuse

#### Sub-Committee in Charge of Demonstration

EDWARD R. BALDWIN, M.D., *Honorary Chairman*  
HARRY A. BRAY, M.D., *Chairman*

HARRY J. BRAYTON, M.D.  
WILLIAM E. LAWSON, M.D.

JOHN J. LLOYD, M.D.

#### Part One—Morning

##### DEMONSTRATION SESSION

###### Pathological

###### FRESH SPECIMENS

- (a) Demonstration of gross and microscopic specimens of human tuberculosis
- (b) Demonstration of gross and microscopic specimens of bovine tuberculosis  
Victor Moore, M.D., Cornell University, Ithaca.

###### BACTERIOLOGICAL

State Department of Health, Division of Laboratories

- (a) Cultures of pathogenic acid-fast bacilli
- (b) Various preparations of tuberculin
- (c) Methods of staining the tubercle bacilli, in urine, sputum and feces

###### X-RAY SESSION

- (a) Tuberculosis in infants  
Bela Schick, M.D., New York City
- (b) Tuberculosis in childhood.  
Henry D. Chadwick, M.D., Westfield Sanatorium, Mass.
- (c) Technic of X-ray exposures of the chest.
- (d) Demonstration of stereoscopic films
- (e) Interpretation of chest radiograms  
J. J. Lloyd, M.D., and Associates, Monroe Co. Tuberculosis Sanatorium, Rochester, N. Y.
- (f) Radiogram in intestinal tuberculosis  
Frederick H. Heise, M.D., Homer L. Sampson, Trudeau Sanatorium, Trudeau, N. Y.
- (g) Pulmonary tuberculosis—moving pictures
- (h) Demonstration charts of moving pictures  
L. Gregory Cole, M.D., New York City

###### PHYSICAL DIAGNOSIS

- (a) Demonstration of physical signs by the stethophone and other methods  
H. J. Brayton, M.D., and Associates, Onondaga San., Syracuse, N. Y.

###### HELIO THERAPY

- (a) Demonstration of work by representatives of J. N. Adam Memorial Hospital, Perrysburg, N. Y.
- (b) Application of mercury quartz lamp in treatment of laryngeal, intestinal lymphatic, bone and joint tuberculosis  
Edgar Mayer, M.D., Saranac Lake, N. Y.

#### DISCUSSION OF PARTICULAR LESIONS

- (a) Surgical—  
Tuberculosis of the bones  
Tuberculosis of the glands.
- (b) Skin manifestations of tuberculosis  
Schuyler P. Richmond, M.D., Syracuse, N. Y.
- (c) Tuberculosis of the eye.  
Arthur J. Bedell, M.D., Albany, N. Y.
- (d) Tuberculosis of the larynx.
- (e) Tuberculosis in pregnancy
- (f) Tuberculosis of the genito-urinary tract  
Henry G. Bugbee, M.D., New York City

#### CLINICAL AND HOSPITAL FACILITIES

Portable clinics  
County hospitals  
Vital statistics  
State Department of Health, Division of Tuberculosis  
Public health clinics and demonstrations  
By the Milbank Foundations  
County tuberculosis committee work. By the State  
Charities Aid Association.

#### ERADICATION OF BOVINE TUBERCULOSIS

Division of Farms and Markets

#### LIBRARY REFERENCES

Books, Periodicals and Journals  
State Department of Education, Medical Library, Miss  
Frances K. Ray

#### Part Two

##### SCIENTIFIC SESSION

###### Diagnosis

- (a) History and symptoms  
David R. Lyman, M.D., New Haven, Conn.
- (b) Physical signs  
Henry B. Doust, M.D., Syracuse.
- (c) X-ray diagnosis  
J. B. Amberson, Jr., M.D., Loomis Sanitarium, Loomis

###### SURGICAL TREATMENT

- (a) Pneumothorax.  
Edward N. Packard, M.D., Saranac Lake.
- (b) Phrenectomy and thioracoplasty

###### TREATMENT BY HELIO THERAPY

Horace L. Grasso, M.D.,  
J. N. Adams, Memorial Hospital, Perrysburg  
Note: The addresses will be limited to 15 minutes  
The discussions will be limited to 3 minutes

The Association also supports 12 orthopedic nurses who visit cases suffering with infantile paralysis and other orthopedic conditions. The Association is endorsed by the Medical Society of the County of Kings. It prepared a four-page folder describing the nursing service, and sent a copy to every physician in the city. A unique feature of the folder was a set of standing orders to which the Association had agreed. The orders enumerate the procedures which a nurse may follow without being considered to practice medicine. The following paragraph illustrates the scope of the orders:

"For infants and children with fever undiagnosed,—confine to bed, colonic irrigation with salt solution,—soda bicarb. Give boiled water. For infantile convulsions, give hot mustard bath, (tablespoonful of mustard to one gallon of water) no food."

The nursing service is becoming increasingly popular and appreciated by the Physicians of Brooklyn.

**TUBERCULOSIS WORK** The Brooklyn Bureau of Charities, at 69 Schermerhorn Street, acts as the Tuberculosis Committee of Brooklyn. The Bureau obtains most of its tuberculosis funds by the sale of Christmas Seals which it obtains directly from the National Tuberculosis Association. Among its other activities the Bureau supports two tuberculosis clinics, a nutritional clinic, and a summer camp for undernourished children.

The Tuberculosis Committee provided the funds for the periodic health examination demonstration of the Medical Society of the County of Kings, and has carried on an intensive campaign to popularize the examination.

The Bureau does a large amount of work in assisting needy families along many lines besides those of financial relief. It has found that sickness is the most common single cause of dependency and it gives prominence to those lines of relief work which have a medical bearing.

**THE BROOKLYN CHILDREN'S AID SOCIETY** The Brooklyn Children's Aid Society has offices at 72 Schermerhorn Street. It provides milk to the twenty-five Baby Health Stations of the City, and follows up the babies in their homes. It supports the Wave Crest Convalescent Home

at Far Rockaway for the post-operative care of children from the various hospitals. It has a capacity of 50 beds, which will soon be increased by 120 additional beds.

**BROOKLYN SOCIETY FOR THE PREVENTION OF CRUELTY TO CHILDREN** This Society is active in all phases of work among children which are neglected or abused. Its work is largely medical, but it is one of the principal legal agencies for the care and control of children who are either "Bad" or are the victims of unsocial environments.

**THE CHAMBER OF COMMERCE** The Brooklyn Chamber of Commerce has many activities which have important effects on health. It furnishes a strong combination of professional men and laymen helping toward the maintenance and improvement of the public health. It has a committee on Public Health which has made extensive investigations into methods of the disposal of garbage and sewage. The Committee has investigated the causes of loss of life from the inhalation of illuminating gas, since this is the second largest cause of accidental loss of life in Brooklyn.

A special committee carries on a continuous campaign for a "cleaner Brooklyn."

**IN CONCLUSION** We have sketched medical conditions in Brooklyn in outline only. The physicians of Brooklyn form an independent body of doctors who have always done their own thinking, and have developed many progressive ideas along original lines. One item of progress has been that of raising the standards of the art and science of the practice of medicine by the entire body of physicians. Another has been the promotion of the practice of civic medicine by the County Medical Society. Another has been the insistence that physicians shall be prominent advisors of lay organizations having health objects.

Modesty is a characteristic of Brooklyn doctors and their organizations, and they are poor advertisers. Their policy has been "If a thing needs doing, go and do it without talking about it." The Brooklyn physicians have not done any one thing in a spectacular way, but they have accomplished a great mass of detailed work which is a model for physicians elsewhere.

F O

## GORGAS MEMORIAL

It is "The Gorgas Idea" to give to every individual the heritage of good health to which he is entitled by means of

Scientific research into the cause, prevention and cure of disease

The application of such preventive and curative measures as may be necessary under the supervision of the leaders in scientific medicine

Saving to the world the present economic loss in human resources from preventable disease

Preventing the stupendous economic loss resulting from sickness, ill health and preventable deaths

Transforming disease infested localities into fertile and productive areas thus increasing the wealth of the individual and the nation

William Crawford Gorgas devoted his life to the practical demonstration of scientific theories along preventive and curative lines with the far-reaching results so familiar to every man and woman of this day. The methods established by him at Cuba and Panama completely eradicated yellow fever from these hotbeds of the disease. As a result, our own southern states are forever rid of the horrors of "yellow jack," which, before his time, cost so many human lives and billions of dollars. In one well-remembered epidemic in the Mississippi Valley the toll was 13,000 lives and an economic loss of hundreds of millions of dollars.

As Surgeon General of the United States Army during the great War, with the responsibility of the health and physical well-being of five million men on his shoulders, he demonstrated the value of periodical medical examinations for the purpose of revealing incipient and unsuspected diseases. The statistics of the War Department reveal that this procedure, coupled with prompt application of the necessary curative measures when illness did develop, succeeded in keeping five million men exposed to the hardships of camp life in better condition physically than a like number in civil life.

For many months physicians and surgeons and laity throughout the United States have been endorsing the movement to perpetuate the name of William Crawford Gorgas in the organization known as the Gorgas Memorial whose twofold aim may be inferred from the above, namely, scientific research in the Gorgas Institute in Panama and everywhere to disseminate health information by means of the press, magazine articles, the lecture platform, the radio and motion picture films, particularly emphasizing the importance of periodic health examinations by the family doctor.

Of interest to all connected with the Gorgas Memorial is a recent announcement by Dr. D. M.

Gallie, Chairman of the Gorgas Committee for the American Dental Association, and Dr. W. H. G. Logan, Secretary of the Gorgas Memorial Institute that the 35,000 dentists who are members of the American Dental Association have joined hands with the physicians and surgeons of the Gorgas Memorial Institute in a nation-wide effort to cut down the 25,000 cases of illness which occur every year in the United States.

According to Dr. Logan, who is both physician and dentist, at least 87 per cent of the people are in need of dental care. A large number have dangerous mouth infections which are apt to cause serious ills in later life.

"Disease germs," explained Dr. Logan, "breed in the mouth on the twenty to thirty inches of teeth surface, in between the teeth, about their roots and in the tonsils. As long as infection is present, there is a continuous flow of poisons which may result in damage to the vital organs of the body, so that a person's life may be cut short many years."

"Besides rheumatism, certain kinds of heart trouble, kidney trouble and a generally lowered resistance, which makes it possible for other disease germs to attack the body, infected teeth can result in many lesser aches and pains. Neuralgia, insomnia and a general breakdown are many times due to mouth infections."

"Periodic physical examination sponsored by the Gorgas Memorial Institute daily reveal cases which need dental treatment. When the dentist discovers an infected mouth, he knows that the patient often needs medical attention as well, so as to counteract the damage done by disease germs from his mouth."

"Thus by working together for a common cause, the physician and dentist will be able to detect the real cause of a patient's illness, and to remove the cause, thereby prolonging life and sustaining health for the individual."

Dr. George David Stewart, Chairman of the New York City Executive Committee of the Gorgas Memorial, reports an overwhelming number of letters in response to his recent talk over radio station WEAJ, when he outlined the purposes of the Gorgas Memorial. Mr. George F. Baker, Jr., listening in, sent his personal check for \$1,000 to Dr. Stewart "for the splendid preventive effort in which you and other men in the medical profession are interested."

"It seems to me," added Mr. Baker, "that you fellows (of the scientific medical profession) are all the time thinking of things for the benefit of humanity."

The Gorgas Memorial appreciates the generosity of Mr. Baker and congratulates him on his sentiments regarding the medical profession. We trust that others follow his example.

## THE MEDICAL SOCIETY OF THE COUNTY OF QUEENS

A regular meeting of the Medical Society of the County of Queens was held Tuesday evening, March 31, 1925, at Eagle Palace, Jamaica, at 9 00 P M., with the president, Dr Courten, in the chair

The minutes of the previous meeting were read and approved as corrected The following candidates for membership were presented

David B Blumenfeld, M D, Woodhaven,  
Peter A E Saponaro, M D, Astoria, Irving  
Singer, M D, Jamaica

By resolution the secretary was instructed to cast one ballot for the election of the candidates

Dr McMahon, Chairman of the Legislative Committee, reported as to the fate of the several bills in which the society was interested in the legislative assembly of the state Dr Steffen offered an amendment to the by-laws, providing that the name of the Committee on Publicity and Public Health Instruction be changed to Committee on Publicity

Moved and seconded that the amendment be adopted

Dr Steffen asked that the members of the society send into the Committee on Publicity before the 10th of each month items of news, reports of hospital meetings, etc., for publication in the bulletin

Dr Luther F Warren, Professor of Medicine at the Long Island College Hospital, presented a paper on "The Pneumonias"

After giving a brief history of the different forms of treatment for the disease, and giving data to emphasize the importance of the subject, the chief part of the paper was an interesting and instructive review of the work done at the Long Island College Hospital, and at other clinics with the various forms of modern specific treatment

The use of type I serum in patients suffering from pneumonia of that type was followed with fair regularity by a fall of temperature, and an improvement in the general condition lessening of pain, malaise, cyanosis and dyspnoea, and the clinics where the treatment has been used report a lower mortality rate

The serum is given in 50 c.c. or 100 c.c. doses repeated at varying intervals until usually about 10 c.c. is administered, introduced slowly and treatment is pre-  
t has been used report  
essary

serum treatment is the  
actions—chill and rise of  
ns of serum disease, occur-  
cent of cases treated, viz.,  
ns, adenitis or arthritis, all  
current In an attempt to

avoid this disadvantage the use of antibody solution was introduced but has proved ineffectual in sterilizing the blood stream or influencing the course of the disease

Dr Warren is of the opinion that the use of vaccine is of some benefit in those cases running a more prolonged course

Under the topic of abortive treatment, the reader expressed the opinion that urotropin, camphor and quinine are of value if administered early

Dr Carl Eggers, Surgeon at Lenox Hill Hospital, in his paper on the Surgical Complications of Pneumonia, confined his remarks chiefly to Empyema

The mortality rate of this condition varies from 1-2 per cent to 25 per cent, variations depending on differences in virulence of organism, in individual resistance and on type and time of operation

Careful study of each individual patient is required, including typing of organism present

Not all fluids are infected, and many clear spontaneously or by tapping, not all infected fluids are empyemata

Empyemata complicating lobar pneumonia are usually confined to pleura overlying affected lobe, soon become thick, and evacuation is followed by prompt recovery

In broncho-pneumonia, patient is sicker, and evacuation should be delayed, but there are no hard and fast rules

Decision is based on general impression and careful study of case

As a general rule, thin fluids should be aspirated, thick fluids drained by open operation

Aspiration, usually, does not cure empyema, but is intended to bridge over difficult period and relieves embarrassment from amount of fluid

Intercostal incision is often effectual, but does not provide as good drainage as rib resection, and does not obviate possibility of osteomyelitis of rib

Dr Eggers uses the closed method of drainage as temporary measure in acute cases with extensive exudate to be followed later by rib resection

The reader exhibited a series of lantern slides of X-ray pictures illustrating cases, many of them being chronic empyemata of long standing

Secondary rises of temperature, if other foci can be eliminated, probably means formation of pockets of pus, and here the X-ray is invaluable for diagnosis

In the chronic case, Dr Eggers frequently makes use of X-ray pictures after introduction into the sinus of a solution consisting of Bismuth subcarbonate 20 per cent, acacia 3 per cent in a bland oil, the oil being introduced by gravity, due care being taken to permit exit of air from cavity

J S THOMAS



and that even a man who owns one cow and sells a small quantity of milk only to his neighbors must have his cow tuberculin tested'

---

Publicity of the manner of spreading contagious is commendable, provided the reasons assigned are truthful and well balanced. We are in doubt about the effect of shaking hands on the spread of influenza, but the *Olean Herald*, March 25th, makes an editorial comment on the subject, as follows

"Dr. John Sundwall of the University of Michigan health service says the 'flu' epidemic is due mainly to the friendly handshake

"The infectious organisms of this group of diseases are present in the discharges from the nose and mouth,' he explains and the average man's hands are contaminated with these secretions. A man who has the infection and whose hands are contaminated meets and shakes hands with a friend. Shortly the other's fingers go to his mouth, and the route of transmission is completed'

"It may be futile to urge people to shake hands less, and to stay at home in strict privacy when they have the 'flu' or any other highly contagious disease. There are still many who boast that they 'don't believe in germs,' and the rest are pretty careless. Nothing could suppress the aggressive 'glad hand artist'. But surely it is not too much to ask those suffering either from the 'flu' or from 'common colds,' to wash their hands more frequently. That would help some."

The doctor's statement starts all right by saying that the germs of influenza are in the discharges of the throat and mouth, but he assigns a round-about route of transference of the germs from the sick to the well,—nose of sick person, hands of sick person, hands of well person, nose of well person. Why not tell the public that a far more probable route is that of sneezes, coughs, and loud talking

---

Now and then we find a gem of medical writing that combines truth with high literary merit. The *Hoodstock* (Ulster County) *Weekly*, March 21st, contains a vivid description of the events of a country doctor's busy day which reassures us that the old-fashioned general practitioner still makes his lengthy rounds and in his speedy rush from town to cross roads, is often stopped by decrepit octogenarians and gossiping women who want to know how a distant friend is doing. The doctor writes

"Old Jerry Sparks ahead in the road. He sees us coming and flags us with his cane. On go the brakes. 'Doc, how is Sile getting on?' We hurriedly assure him that Sile is out of danger. Jerry leans on his cane and prepares himself for

a 'real nice visit.' We cut him short and say 'We are in an awful hurry.' We step on the gas. Another two minutes gone forever.

'We stop in to see a little baby desperately sick with broncho-pneumonia. The old grandmother is peeved because we do not prescribe onion poultices to wrists and ankles. Go on, Grandma. Put on the onion poultices. It will not hurt the baby any and will make you feel better.'

---

Dr. Downer writes in this strain for a column or two and ends

"Now we are at the little bridge, and see the little brook sparkling in the moonlight as it hurried on to the sea. That little old ramshackle house over the hill witnessed its tragedy a generation ago. The fair daughter who had gone off to the city, and returned because she had nowhere else to go, was the actress. A hurried call at midnight, on a stormy night, when all nature seemed in revolt. Well, no one has ever known, for the doctor learned early that silence and charity are the greatest of virtues.

"We rambled along and saw the belated moon casting a sheen over the lake. We wondered how many years that picture had been recurring, and if primitive man appreciated its glory. We became analytical, and wondered how many medical men, at that very moment when all the world was in slumber, were abroad on errands of mercy. As the moon waned, the stars brightened, which led us to think of the majesty of the universe. A cloud scudded low, shutting out the distant mountain top. Was it right that a few in this world could live in luxury, while so many lived from hand to mouth? Was it right that a doctor should work day and night, day in and day out, year in and year out? We were commencing to sympathize with ourselves, and really assured ourselves that we were the victims of injustice. In our momentary pessimism we had forgotten family and friends, the wonders of nature, the blue sky, the clouds. We had forgotten the long hard struggle that man had gone through from primitive savagery to his present state of opulence. As we clattered over the loose planked bridge, it woke us from our pessimism.

"Oh, stop sympathizing with yourself," we muttered, "someone must do the hard work. Why not you?" After all would life be worth living unless it be a life of service? You have your work to do, so do it and stop whining. You have your compensations. The fact that you are trying to be a service to your fellows, is your reward. None other is worth while."

This is one of Dr. Downer's weekly health talks. We suggest that he send it to a high-class literary magazine with a national circulation.



# THE DAILY PRESS



New York City has a coordination committee which is composed of 22 representative of the greater social agencies of Greater New York. It was started by "Better Times, Inc.," which is an organization for publishing a magazine called "Better Times." The magazine is promoted and financed by a group of philanthropists, and representatives of social departments of the city government, and the coordination committee is the result of the adoption of the winning plan in a prize contest for the better coordination of the social agencies of the city.

The object of the committee is to coordinate the activities of the various agencies in health, charity, and social uplift. It plans to form a permanent welfare council, and then to disband as a committee. Its budget for the first two years is between 25,000 and 50,000.

The New York *Telegram*, March 28th, contains an editorial on the proposed activities of the Committee, and says:

"No better argument for closer cooperation by all the city's 2,000 public and private welfare agencies could be found than the statistical report just made public by a committee on co-ordination of which Robert W. De Forest is chairman.

It shows that the various groups are distributing about \$80,000,000 a year for philanthropic purposes, of which \$48,550,000, or a little more than sixty per cent, comes from private sources and the rest from city appropriations."

"City funds are disbursed mainly through the Department of Public Works, the Health Department, the Board of Child Welfare, Bellevue and the allied hospitals, parks and playgrounds and certain private institutions."

"With 2,000 accredited agencies in the field there is bound to be some waste through overlapping. It is for the purpose of reducing this to a minimum that the co-ordination committee has undertaken this work. It is a task which should receive the support of the entire community."

The Brooklyn *Eagle*, March 29th, contains a short account of the action of the immigrant authorities in barring unhealthy immigrants among whom were some Irishmen. Their exclusion immediately started trouble according to the account which says:

"On Thursday attorneys appeared before Judge Knox in the Manhattan Federal Court and asked that a governmental investigation be made

of the increasing number of exclusions of the Irish on the grounds these newcomers had weakened hearts.

"Since the outbreak of the World War in 1914 the races of all the war-torn countries have a higher percentage of cardiac weakness," said Dr. Billings last night. "This disease is due to great nervous strain, physical strain and privation, all of which tend to weaken the muscular strength of the heart. The conditions under which these people in the war countries lived have given many valvular troubles.

"A cause of cardiac in the British Isles is the cold. The English and Irish suffer from tonsillitis. This weakens the heart. And both the Irish and the English are noted for their bad teeth. Diseased teeth cause heart disease also.

"He said that the Public Health Service has been able to give 'more thorough medical examinations to incoming immigrants since the reduction of the quotas allowed to enter the country.'"

Stringent ordinances regarding the sale of milk are being adopted throughout the State, most of which follow a standard from which has been suggested by the State Department of Health. The *Batavia News*, March 25, contains an account of the adoption of milk regulations by the City Board of Health, but the article is headed "Complaint About Junk," because a few lines at the end referred to a complaint about an unsightly junk pile. The reference to the milk ordinance is as follows:

"Enforcement of the ordinance that provides that only milk from tuberculin tested cows can be sold in the city of Batavia was taken up at the meeting of the *Board of Health* held at city hall last evening and as a result one dealer who does not handle tuberculin tested milk will be notified that his milk does not comply with the ordinance. The dealer will be given ten days to make arrangements so that his milk will conform with the standard authorized by the ordinance.

"On motion of Dr. Frederick D. Carr it was voted that no milk be accepted for sale in the city of Batavia from any distributor whose total supply does not come from a herd of 100 per cent tuberculin tested cows. No milk shall be accepted whose scoring is not equivalent and does not conform with the regulations of the city of Batavia.

"It was further emphasized by the board that this milk ordinance applies to every dealer, no matter how large or how small his herd may be,

and that even a man who owns one cow and sells a small quantity of milk only to his neighbors must have his cow tuberculin tested"

---

Publicity of the manner of spreading contagious is commendable, provided the reasons assigned are truthful and well balanced. We are in doubt about the effect of shaking hands on the spread of influenza, but the *Olean Herald*, March 25th, makes an editorial comment on the subject, as follows

"Dr. John Sundwall of the University of Michigan health service says the 'flu' epidemic is due mainly to the friendly handshake

"The infectious organisms of this group of diseases are present in the discharges from the nose and mouth," he explains, and the average man's hands are contaminated with these secretions. A man who has the infection and whose hands are contaminated meets and shakes hands with a friend. Shortly the other's fingers go to his mouth, and the route of transmission is completed."

"It may be futile to urge people to shake hands less, and to stay at home in strict privacy when they have the 'flu' or any other highly contagious disease. There are still many who boast that they 'don't believe in germs,' and the rest are pretty careless. Nothing could suppress the aggressive 'glad hand artist.' But surely it is not too much to ask those suffering either from the 'flu' or from 'common colds,' to wash their hands more frequently. That would help some.

The doctor's statement starts all right by saying that the germs of influenza are in the discharges of the throat and mouth, but he assigns a round-about route of transference of the germs from the sick to the well,—nose of sick person, hands of sick person, hands of well person, nose of well person. Why not tell the public that a far more probable route is that of sneezes, coughs, and loud talking

---

Now and then we find a gem of medical writing that combines truth with high literary merit. The *Hoodstock* (Ulster County) *Weekly*, March 21st contains a vivid description of the events of a country doctor's busy day which reassures us that the old-fashioned general practitioner still makes his lengthy rounds, and in his speedy rush from town to cross roads, is often stopped by decrepit octogenarians and gossiping women who want to know how a distant friend is doing. The doctor writes

Old Jerry Sparks ahead in the road. He sees us coming and flags us with his cane. On go the brakes. "Doc, how is Sile getting on?" We hurriedly assure him that Sile is out of danger. Jerry leans on his can and prepares himself for

a 'real nice visit.' We cut him short and say 'We are in an awful hurry.' We step on the gas. Another two minutes gone forever.

"We stop in to see a little baby desperately sick with broncho-pneumonia. The old grandmother is peeved because we do not prescribe onion poultices to wrists and ankles. Go on, Grandma. Put on the onion poultices. It will not hurt the baby any and will make you feel better."

---

Dr. Downer writes in this strain for a column or two and ends

"Now we are at the little bridge, and see the little brook sparkling in the moonlight as it hurried on to the sea. That little old ramshackle house over the hill witnessed its tragedy a generation ago. The fair daughter who had gone off to the city, and returned because she had nowhere else to go, was the actress. A hurried call at midnight, on a stormy night, when all nature seemed in revolt. Well, no one has ever known, for the doctor learned early that silence and charity are the greatest of virtues.

"We rambled along and saw the belated moon casting a sheen over the lake. We wondered how many years that picture had been recurring, and it primitive man appreciated its glory. We became analytical, and wondered how many medical men, at that very moment when all the world was in slumber, were abroad on errands of mercy. As the moon waned, the stars brightened, which led us to think of the majesty of the universe. A cloud scudded low, shutting out the distant mountain top. Was it right that a few in this world could live in luxury, while so many lived from hand to mouth? Was it right that a doctor should work day and night, day in and day out, year in and year out? We were commencing to sympathize with ourselves, and really assured ourselves that we were the victims of injustice. In our momentary pessimism we had forgotten family and friends, the wonders of nature, the blue sky, the clouds. We had forgotten the long hard struggle that man had gone through from primitive savagery to his present state of opulence. As we clattered over the loose planked bridge, it woke us from our pessimism.

"Oh, stop sympathizing with yourself," we muttered, "someone must do the hard work. Why not you? After all would life be worth living unless it be a life of service? You have your work to do, so do it and stop whining. You have your compensations. The fact that you are trying to be a service to your fellows, is your reward. None other is worth while."

This is one of Dr. Downer's weekly health talks. We suggest that he send it to a high-class literary magazine with a national circulation.



# THE DAILY PRESS



New York City has a coordination committee which is composed of 22 representative of the greater social agencies of Greater New York. It was started by "Better Times, Inc.," which is an organization for publishing a magazine called "Better Times." The magazine is promoted and financed by a group of philanthropists, and representatives of social departments of the city government, and the coordination committee is the result of the adoption of the winning plan in a prize contest for the better coordination of the social agencies of the city.

The object of the committee is to coordinate the activities of the various agencies in health, charity, and social uplift. It plans to form a permanent welfare council, and then to disband as a committee. Its budget for the first two years is between 25,000 and 50,000.

The New York *Telegram*, March 28th, contains an editorial on the proposed activities of the Committee, and says:

"No better argument for closer cooperation by all the city's 2,000 public and private welfare agencies could be found than the statistical report just made public by a committee on co-ordination of which Robert W. De Forest is chairman.

It shows that the various groups are distributing about \$80,000,000 a year for philanthropic purposes, of which \$48,550,000, or a little more than sixty per cent, comes from private sources and the rest from city appropriations."

"City funds are disbursed mainly through the Department of Public Works, the Health Department, the Board of Child Welfare, Bellevue and the allied hospitals, parks and playgrounds and certain private institutions."

"With 2,000 accredited agencies in the field there is bound to be some waste through overlapping. It is for the purpose of reducing this to a minimum that the co-ordination committee has undertaken this work. It is a task which should receive the support of the entire community."

The Brooklyn *Eagle*, March 29th, contains a short account of the action of the immigrant authorities in barring unhealthy immigrants among whom were some Irishmen. Their exclusion immediately started trouble according to the account which says:

"On Thursday attorneys appeared before Judge Knox in the Manhattan Federal Court and asked that a governmental investigation be made

of the increasing number of exclusions of the Irish on the grounds these newcomers had weakened hearts.

"Since the outbreak of the World War in 1914 the races of all the war-torn countries have a higher percentage of cardiac weakness," said Dr. Billings last night. "This disease is due to great nervous strain, physical strain and privation, all of which tend to weaken the muscular strength of the heart. The conditions under which these people in the war countries lived have given many valvular troubles.

"A cause of cardiac in the British Isles is the cold. The English and Irish suffer from tonsilitis. This weakens the heart. And both the Irish and the English are noted for their bad teeth. Diseased teeth cause heart disease also.

"He said that the Public Health Service has been able to give 'more thorough medical examinations to incoming immigrants since the reduction of the quotas allowed to enter the country.'"

Stringent ordinances regarding the sale of milk are being adopted throughout the State, most of which follow a standard from which has been suggested by the State Department of Health. The *Batavia News*, March 25, contains an account of the adoption of milk regulations by the City Board of Health, but the article is headed "Complaint About Junk," because a few lines at the end referred to a complaint about an unsightly junk pile. The reference to the milk ordinance is as follows:

"Enforcement of the ordinance that provides that only milk from tuberculin tested cows can be sold in the city of Batavia was taken up at the meeting of the Board of Health held at city hall last evening and as a result one dealer who does not handle tuberculin tested milk will be notified that his milk does not comply with the ordinance. The dealer will be given ten days to make arrangements so that his milk will conform with the standard authorized by the ordinance.

"On motion of Dr. Frederick D. Carr it was voted that no milk be accepted for sale in the city of Batavia from any distributor whose total supply does not come from a herd of 100 per cent tuberculin tested cows. No milk shall be accepted whose scoring is not equivalent and does not conform with the regulations of the city of Batavia.

"It was further emphasized by the board that this milk ordinance applies to every dealer, no matter how large or how small his herd may be,

# NEW YORK STATE JOURNAL *of* MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL. 25, No 15

NEW YORK, N. Y.

APRIL 24, 1925

## TWENTY-FIVE YEARS' PROGRESS IN MEDICAL EDUCATION IN INTERNAL MEDICINE AND THE MEDICAL SPECIALTIES \*

By SAMUEL W. LAMBERT, M.D.,

NEW YORK CITY

THE successful internist today must be an expert in many branches of medicine to which some of his colleagues devote their entire time, study and research. There are specialists in tuberculosis, in heart disease, in gastroenterology, in syphilis, in pediatrics, in neurology and in other subdivisions of internal medicine. All of these are useful to their patients in exact proportion as they are wise in a knowledge of general diagnosis and pathology, both medical and surgical, and the internist and medical specialist alike to be successful must be skillful in the use of the ophthalmoscope and other instruments of special diagnosis and must be versed in the interpretation of the electro-cardiograph and the radiograph and of the many findings of the instruments and methods of precision in use in the clinical laboratories. From the viewpoint of medical education and of this review, the medical specialties may be considered to include all of the above mentioned groups of diseases of the organs of digestion, of circulation, of the chest and especially neurology, psychology, pediatrics and dermatology and syphilology.

In 1900, medical education in the United States was at the beginning of a great reform. The universities had recently discovered their own medical schools or were ready to absorb into their academic family circles one of the numerous medical outcasts existing in their neighborhoods. Less than a dozen schools among the 160 existing in the country were trying to better their facilities and improve their educational tender to their students. These outstanding exceptions to the general rule were working in isolated attempts without mutual co-operation or conferences with each other. The great majority of the schools were conducted on a discredited proprietary basis largely for the benefit of the professorial proprietors both to increase their personal prestige and for their financial profit.

\* Read at the Meeting of the Council on Medical Education of the American Medical Association in Chicago, March 9, 1925.

In the best schools the entrance requirements were being advanced to the present standard of two years of college work, but a large number of their students were voluntarily offering for entrance a full four-year course with a bachelor degree. A fourth year had already been added to the curriculum which was being crystallized into a thing of fixed hours and of inelastic and limited opportunity for each student, no matter what his mental calibre might be. The new time added to the medical course had been absorbed by the specialties, both medical and surgical, and by an extension of the work in the laboratories of the experimental medical sciences. The methods of teaching of internal medicine had not advanced to a development commensurate with that given in the laboratories or the specialties. Medicine was taught largely by theoretical and clinical lectures to whole classes in an amphitheater and in small groups at the bedside in the wards of a hospital and to a lesser extent in dispensary services. The students had a very limited opportunity to observe and examine the sick patient. Much of the best teaching of the students of these ten or twelve higher grade schools was still being done in 1900 in extra-mural classes of limited numbers by younger teachers who might also be connected with the medical school but who often had no academic standing whatever. These quiz-masters were a holdover from the days of the old proprietary school system in which they formed an important and valuable teaching agent. Conditions of education in all branches of medicine in the one hundred and forty odd poor schools of this period were so chaotic and their work of such miserable quality that it is not worth while to refer to this phase of the subject at all. Even the best characteristics of the proprietary school had disappeared entirely.

In 1900, medical specialties were receiving in these higher class schools greater attention than was being given to the basic subject of Medical



# BOOK REVIEWS



ABT'S PEDIATRICS Vols 4 and 5 By 150 Specialists  
 Edited by ISAAC A. ABT, M.D. Volume 4, containing  
 1271 pages with 271 illustrations (Set to be complete  
 in eight octavo volumes.) Phila. and London, W B  
 Saunders Company, 1924 Cloth, \$10.00 per volume.  
 Sold by subscription

This fourth volume in the series of Pediatrics takes up in detail the Pleura, the Lungs, the Heart, the Mediastinum, the Blood, the Ductless Glands and the Kidneys. Each subject is covered in a complete manner, and as is inevitable from different authors covering different chapters, there is some repetition of subject, but even in the repetition, the subject is presented from a different angle, which makes it valuable. The chapter on the Surgery of the Thorax, by Everts A. Graham, and especially that dealing with empyema, is to be read for its wealth of detail and its conservative attitude.

Electrocardiography in children is more complete and has more supporting statistics than the reviewer has seen elsewhere. This is by Max Seham, who says "In the premature and during the first three months of life, the normal electrocardiogram indicates a right ventricular preponderance. At about the fourth month, R 1 becomes larger than S 1, and from then on the ventricular complex approaches the adult type of curve." And again "The S deflection is the most characteristic and distinctive of the ventricular complex in childhood. In lead I it is relatively and absolutely higher than in any other period of life, and in the other leads it is relatively higher than in the adult."

Transfusion of blood is covered by Lester J. Unger, and as is to be expected the two-way syringe method is recommended. There is, however, some discussion given to the citrate method of transfusion. He says "It is therefore superfluous to attempt a grouping of an infant's blood. One should rather test the blood directly against that of the prospective donor."

Infantilism, with its main divisions, type Lorain and type Brissaud, and their subdivisions, is very fully covered and in an interesting case history manner by Emil Goetsch.

After having picked some of the high spots as above, it occurred to the reviewer that there were a large number of other subjects that could well have been mentioned. In fact, nearly every subject treated can be used for reference. The printing and paper are excellent and the illustrations are frequent and clear, which makes for easy reading. For the physician dealing with children the completed work will be invaluable.

Volume the Fifth of Abt's Pediatrics 865 pages, 375 illustrations includes widely separated subjects, such as Diseases of the Face and Jaws, Orthopedic Surgery, Tuberculosis, Hereditary Syphilis, Erythema Infectiosum, Erythema Nodosum, Bubonic Plague, Actinomycosis, Glandular Fever, Dengue, the Trypanosomiasis, Malta Fever, Kala-azar in Children, Yellow Fever in Children, Malaria, and Infection and Immunity.

The care and treatment of healthy and painful feet is brimful of practical suggestions, some of which the pediatricist can employ with great advantage to his patients. I refer here to the prophylactic foot advice, which should be part of every pediatricist's stock in trade. Then again he should be able to diagnose the abnormalities which will respond to simple treatment and measures, and those which must be referred to the orthopedic surgeon for correction. These matters are made very plain.

The chapter on Hereditary Syphilis deserves special mention for the very good illustrations of the pathology, and the complete handling of treatment.

We cannot close this brief review without favorable comment on the chapters on Erythema Infectiosum, Malaria, and Infection and Immunity.

As the volumes come from the press one after another regard for this work as a practical every-day reference work and working guide rises higher.

ARCHIBALD D. SMITH

OPERATIVE SURGERY Covering the Operative Technique Involved in the Operations of General and Special Surgery By WARREN STONE BICKHAM, M.D., F.A.C.S. Vol 6, completing the set Octavo, 989 pages, 1224 illustrations. General Index to Vols 1 to 6 Octavo, 189 pages. Phila. and London, W B Saunders Co., 1924 Cloth, \$10 per volume. Index volume free. sold by subscription only.

The sixth and final volume of this splendid set is just off the press. It deals in conclusion with operations upon the male genital organs. The approved operations are also described upon the female genito-urinary organs. A final chapter includes operations for deformities and disabilities not considered elsewhere.

As in the other volumes, Dr Bickham has shown the same discriminating care in the selection of illustrations which the really purposeful, as well as the same accurate lucid descriptions of the various operative steps of surgical procedure. It is felt that this set of surgeries will be a monument to the author and that no practitioner who does surgical work should be without this splendid adjunct.

A separately bound index volume for handy reference has been added to the set.

R. H. FOWLER.

COMMON INFECTIONS OF THE FEMALE URETHRA AND CERVIX By FRANK KIDD, M.A., M.Ch., F.R.C.S., and A. MALCOLM SIMPSON, B.A., M.B., D.P.H. With additional chapters by GEORGE T. WESTERN, M.D., and M. S. MAYOU, F.R.C.S. Octavo of 191 pages illustrated. (Oxford Medical Publications.) London, Humphrey Milford, 1924 Cloth, \$2.50.

This small book is worthy of the attention of any doctor who has to deal with this particular branch of medicine.

There can be no doubt of what the authors wish to convey, as the style of the book is simple, clear and indeed forceful when dealing with controvertible matter.

Many old beliefs that are taught today by some of the leading gynecologists are ruthlessly destroyed, and even though the conclusions of the authors may not be taken *in toto*, yet the challenge remains and considerable work and painstaking observations must be made in order to refute the authors' conclusions.

Take but on instance—infection of the Bartholin gland—the authors state that 38 per cent of the infections of this gland are non-gonorrheal. This conclusion is based not alone on observation but on thorough laboratory investigation as well.

The book is replete with such instances of old ideas destroyed. In treatment the authors again offer methods radically different to much that is taught.

In conclusion the reviewer feels that however much the reader may differ with the authors, they cannot refute the authors' conclusions unless backed by modern laboratory aid and a prolonged study of the subject in question.

G W P

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL. 25, No 15

NEW YORK, N. Y.

APRIL 24, 1925

## TWENTY-FIVE YEARS' PROGRESS IN MEDICAL EDUCATION IN INTERNAL MEDICINE AND THE MEDICAL SPECIALTIES\*

By SAMUEL W. LAMBERT, M.D.,

NEW YORK CITY

THE successful internist today must be an expert in many branches of medicine to which some of his colleagues devote their entire time, study and research. There are specialists in tuberculosis, in heart disease, in gastro-enterology, in syphilis, in pediatrics, in neurology and in other subdivisions of internal medicine. All of these are useful to their patients in exact proportion as they are wise in a knowledge of general diagnosis and pathology both medical and surgical, and the internist and medical specialist alike to be successful must be skillful in the use of the ophthalmoscope and other instruments of special diagnosis and must be versed in the interpretation of the electro-cardiograph and the radiograph and of the many findings of the instruments and methods of precision in use in the clinical laboratories. From the viewpoint of medical education and of this review, the medical specialties may be considered to include all of the above mentioned groups of diseases of the organs of digestion, of circulation, of the chest and especially neurology, psychology, pediatrics and dermatology and syphilology.

In 1900, medical education in the United States was at the beginning of a great reform. The universities had recently discovered their own medical schools or were ready to absorb into their academic family circles one of the numerous medical outcasts existing in their neighborhoods. Less than a dozen schools among the 160 existing in the country were trying to better their facilities and improve their educational tender to their students. These outstanding exceptions to the general rule were working in isolated attempts without mutual co-operation or conferences with each other. The great majority of the schools were conducted on a discredited proprietary basis largely for the benefit of the professorial proprietors both to increase their personal prestige and for their financial profit.

In the best schools the entrance requirements were being advanced to the present standard of two years of college work, but a large number of their students were voluntarily offering for entrance a full four-year course with a bachelor degree. A fourth year had already been added to the curriculum which was being crystallized into a thing of fixed hours and of inelastic and limited opportunity for each student, no matter what his mental calibre might be. The new time added to the medical course had been absorbed by the specialties, both medical and surgical, and by an extension of the work in the laboratories of the experimental medical sciences. The methods of teaching of internal medicine had not advanced to a development commensurate with that given in the laboratories or the specialties. Medicine was taught largely by theoretical and clinical lectures to whole classes in an amphitheater and in small groups at the bedside in the wards of a hospital and to a lesser extent in dispensary services. The students had a very limited opportunity to observe and examine the sick patient. Much of the best teaching of the students of these ten or twelve higher grade schools was still being done in 1900 in extra-mural classes of limited numbers by younger teachers who might also be connected with the medical school but who often had no academic standing whatever. These quiz-masters were a holdover from the days of the old proprietary school system in which they formed an important and valuable teaching agent. Conditions of education in all branches of medicine in the one hundred and forty odd poor schools of this period were so chaotic and their work of such miserable quality that it is not worth while to refer to this phase of the subject at all. Even the best characteristics of the proprietary school had disappeared entirely.

In 1900 medical specialties were receiving in these higher class schools greater attention than was being given to the basic subject of Medical

\* Read at the Meeting of the Council on Medical Education of the American Medical Association in Chicago, March 9, 1925.



# BOOK REVIEWS



**ABT'S PEDIATRICS** Vols 4 and 5 By 150 Specialists  
 Edited by ISAAC A. ABT, M.D. Volume 4, containing 1271 pages with 271 illustrations (Set to be complete in eight octavo volumes) Phila. and London, W. B. Saunders Company, 1924 Cloth, \$10.00 per volume. Sold by subscription

This fourth volume in the series of Pediatrics takes up in detail the Pleura, the Lungs, the Heart, the Mediastinum, the Blood, the Ductless Glands and the Kidneys. Each subject is covered in a complete manner, and as is inevitable from different authors covering different chapters, there is some repetition of subject, but even in the repetition, the subject is presented from a different angle, which makes it valuable. The chapter on the Surgery of the Thorax, by Everts A. Graham, and especially that dealing with empyema, is to be read for its wealth of detail and its conservative attitude.

Electrocardiography in children is more complete and has more supporting statistics than the reviewer has seen elsewhere. This is by Max Seham, who says "In the premature and during the first three months of life, the normal electrocardiogram indicates a right ventricular preponderance. At about the fourth month, R 1 becomes larger than S 1, and from then on the ventricular complex approaches the adult type of curve." And again "The S deflection is the most characteristic and distinctive of the ventricular complex in childhood. In lead I it is relatively and absolutely higher than in any other period of life, and in the other leads it is relatively higher than in the adult."

Transfusion of blood is covered by Lester J. Unger, and as is to be expected the two-way syringe method is recommended. There is, however, some discussion given to the citrate method of transfusion. He says "It is therefore superfluous to attempt a grouping of an infant's blood. One should rather test the blood directly against that of the prospective donor."

Infantilism, with its main divisions, type Lorain and type Brissaud, and their subdivisions, is very fully covered and in an interesting case history manner by Emil Goetsch.

After having picked some of the high spots as above, it occurred to the reviewer that there were a large number of other subjects that could well have been mentioned. In fact, nearly every subject treated can be used for reference. The printing and paper are excellent and the illustrations are frequent and clear, which makes for easy reading. For the physician dealing with children the completed work will be invaluable.

Volume the Fifth of Abt's Pediatrics 865 pages, 375 illustrations includes widely separated subjects, such as Diseases of the Face and Jaws, Orthopedic Surgery, Tuberculosis, Hereditary Syphilis, Erythema Infectiosum, Erythema Nodosum, Bubonic Plague, Actinomycosis, Glandular Fever, Dengue, the Trypanosomiasis, Malta Fever, Kala-azar in Children, Yellow Fever in Children, Malaria, and Infection and Immunity.

The care and treatment of healthy and painful feet is brimful of practical suggestions, some of which the pediatricist can employ with great advantage to his patients. I refer here to the prophylactic foot advice, which should be part of every pediatricist's stock in trade. Then again he should be able to diagnose the abnormalities which will respond to simple treatment and measures, and those which must be referred to the orthopedic surgeon for correction. These matters are made very plain.

The chapter on Hereditary Syphilis deserves special mention for the very good illustrations of the pathology, and the complete handling of treatment.

We cannot close this brief review without favorable comment on the chapters on Erythema Infectiosum, Malaria, and Infection and Immunity.

As the volumes come from the press one after another regard for this work as a practical every-day reference work and working guide rises higher.

ARCHIBALD D. SMITH

**OPERATIVE SURGERY** Covering the Operative Technique Involved in the Operations of General and Special Surgery By WARREN STONE BICKHAM, M.D., F.A.C.S. Vol 6, completing the set. Octavo, 989 pages, 1224 illustrations. General Index to Vols 1 to 6 Octavo, 189 pages. Phila. and London, W. B. Saunders Co., 1924. Cloth, \$10 per volume. Index volume free. sold by subscription only.

The sixth and final volume of this splendid set is just off the press. It deals in conclusion with operations upon the male genital organs. The approved operations are also described upon the female genito-urinary organs. A final chapter includes operations for deformities and disabilities not considered elsewhere.

As in the other volumes, Dr. Bickham has shown the same discriminating care in the selection of illustrations which the really purposeful, as well as the same accurate lucid descriptions of the various operative steps of surgical procedure. It is felt that this set of surgeries will be a monument to the author and that no practitioner who does surgical work should be without this splendid adjunct.

A separately bound index volume for handy reference has been added to the set.

R. H. FOWLER.

**COMMON INFECTIONS OF THE FEMALE URETHRA AND CERVIX** By FRANK KIDD, M.A., M.Ch., F.R.C.S., and A. MALCOLM SIMPSON, B.A., M.B., D.P.H. With additional chapters by GEORGE T. WESTERN, M.D., and M. S. MAYOU, F.R.C.S. Octavo of 191 pages illustrated. (Oxford Medical Publications) London, Humphrey Milford, 1924. Cloth, \$2.50.

This small book is worthy of the attention of any doctor who has to deal with this particular branch of medicine.

There can be no doubt of what the authors wish to convey, as the style of the book is simple, clear and indeed forceful when dealing with controvertible matter.

Many old beliefs that are taught today by some of the leading gynecologists are ruthlessly destroyed, and even though the conclusions of the authors may not be taken *in toto*, yet the challenge remains and considerable work and painstaking observations must be made in order to refute the authors' conclusions.

Take but one instance—infection of the Bartholin's gland—the authors state that 38 per cent of the infections of this gland are non-gonorrheal. This conclusion is based not alone on observation but on thorough laboratory investigation as well.

The book is replete with such instances of old ideas destroyed. In treatment the authors again offer methods radically different to much that is taught.

In conclusion the reviewer feels that however much the reader may differ with the authors, they cannot refute the authors' conclusions unless backed by modern laboratory aid and a prolonged study of the subject in question.

G. W. P.



# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL. 25, No 15

NEW YORK, N Y

APRIL 24, 1925

## TWENTY-FIVE YEARS' PROGRESS IN MEDICAL EDUCATION IN INTERNAL MEDICINE AND THE MEDICAL SPECIALTIES\*

By SAMUEL W LAMBERT, M.D.,  
NEW YORK CITY

THE successful internist today must be an expert in many branches of medicine to which some of his colleagues devote their entire time, study and research. There are specialists in tuberculosis, in heart disease, in gastro enterology, in syphilis, in pediatrics, in neurology and in other subdivisions of internal medicine. All of these are useful to their patients in exact proportion as they are wise in a knowledge of general diagnosis and pathology both medical and surgical, and the internist and medical specialist alike to be successful must be skillful in the use of the ophthalmoscope and other instruments of special diagnosis, and must be versed in the interpretation of the electro-cardiograph and the radiograph and of the many findings of the instruments and methods of precision in use in the clinical laboratories. From the viewpoint of medical education and of this review, the medical specialties may be considered to include all of the above mentioned groups of diseases of the organs of digestion, of circulation, of the chest and especially neurology, psychology, pediatrics and dermatology and syphilology.

In 1900, medical education in the United States was at the beginning of a great reform. The universities had recently discovered their own medical schools or were ready to absorb into their academic family circles one of the numerous medical outcasts existing in their neighborhoods. Less than a dozen schools among the 160 existing in the country were trying to better their facilities and improve their educational tender to their students. These outstanding exceptions to the general rule were working in isolated attempts without mutual co-operation or conferences with each other. The great majority of the schools were conducted on a discredited proprietary basis largely for the benefit of the professorial proprietors both to increase their personal prestige and for their financial profit.

In the best schools the entrance requirements were being advanced to the present standard or two years of college work, but a large number of their students were voluntarily offering for entrance a full four-year course with a bachelor degree. A fourth year had already been added to the curriculum which was being crystallized into a thing of fixed hours and of inelastic and limited opportunity for each student, no matter what his mental calibre might be. The new time added to the medical course had been absorbed by the specialties, both medical and surgical, and by an extension of the work in the laboratories of the experimental medical sciences. The methods of teaching of internal medicine had not advanced to a development commensurate with that given in the laboratories or the specialties. Medicine was taught largely by theoretical and clinical lectures to whole classes in an amphitheater and in small groups at the bedside in the wards of a hospital and to a lesser extent in dispensary services. The students had a very limited opportunity to observe and examine the sick patient. Much of the best teaching of the students of these ten or twelve higher grade schools was still being done in 1900 in extra-mural classes of limited numbers by younger teachers who might also be connected with the medical school but who often had no academic standing whatever. These quiz-masters were a holdover from the days of the old proprietary school system in which they formed an important and valuable teaching agent. Conditions of education in all branches of medicine in the one hundred and forty odd poor schools of this period were so chaotic and their work of such miserable quality that it is not worth while to refer to this phase of the subject at all. Even the best characteristics of the proprietary school had disappeared entirely.

In 1900, medical specialties were receiving in these higher class schools greater attention than was being given to the basic subject of Medical

\* Read at the Meeting of the Council on Medical Education of the American Medical Association in Chicago March 9 1925

# BOOK REVIEWS

**ABT'S PEDIATRICS** Vols 4 and 5 By 150 Specialists  
 Edited by ISAAC A. ABT, M.D. Volume 4, containing 1271 pages with 271 illustrations (Set to be complete in eight octavo volumes) Phila. and London, W. B. Saunders Company, 1924 Cloth, \$10.00 per volume. Sold by subscription.

This fourth volume in the series of Pediatrics takes up in detail the Pleura, the Lungs, the Heart, the Mediastinum, the Blood, the Ductless Glands and the Kidneys. Each subject is covered in a complete manner, and as is inevitable from different authors covering different chapters, there is some repetition of subject, but even in the repetition, the subject is presented from a different angle, which makes it valuable. The chapter on the Surgery of the Thorax, by Everts A. Graham, and especially that dealing with empyema, is to be read for its wealth of detail and its conservative attitude.

Electrocardiography in children is more complete and has more supporting statistics than the reviewer has seen elsewhere. This is by Max Seham, who says "In the premature and during the first three months of life, the normal electrocardiogram indicates a right ventricular preponderance. At about the fourth month, R 1 becomes larger than S 1, and from then on the ventricular complex approaches the adult type of curve." And again "The S deflection is the most characteristic and distinctive of the ventricular complex in childhood. In lead I it is relatively and absolutely higher than in any other period of life, and in the other leads it is relatively higher than in the adult."

Transfusion of blood is covered by Lester J. Unger, and as is to be expected the two-way syringe method is recommended. There is, however, some discussion given to the citrate method of transfusion. He says "It is therefore superfluous to attempt a grouping of an infant's blood. One should rather test the blood directly against that of the prospective donor."

Infantilism, with its main divisions, type Lorain and type Brissaud, and their subdivisions, is very fully covered and in an interesting case history manner by Emil Goetsch.

After having picked some of the high spots as above, it occurred to the reviewer that there were a large number of other subjects that could well have been mentioned. In fact, nearly every subject treated can be used for reference. The printing and paper are excellent and the illustrations are frequent and clear, which makes for easy reading. For the physician dealing with children the completed work will be invaluable.

Volume the Fifth of Abt's Pediatrics 865 pages, 375 illustrations includes widely separated subjects, such as Diseases of the Face and Jaws, Orthopedic Surgery, Tuberculosis, Hereditary Syphilis, Erythema Infectiosum, Erythema Nodosum, Bubonic Plague, Actinomycosis, Glandular Fever, Dengue, the Trypanosomiasis, Malta Fever, Kala-azar in Children, Yellow Fever in Children, Malaria, and Infection and Immunity.

The care and treatment of healthy and painful feet is brimful of practical suggestions, some of which the pediatricist can employ with great advantage to his patients. I refer here to the prophylactic foot advice, which should be part of every pediatricist's stock in trade. Then again he should be able to diagnose the abnormalities which will respond to simple treatment and measures, and those which must be referred to the orthopedic surgeon for correction. These matters are made very plain.

The chapter on Hereditary Syphilis deserves special mention for the very good illustrations of the pathology, and the complete handling of treatment.

We cannot close this brief review without favorable comment on the chapters on Erythema Infectiosum, Malaria, and Infection and Immunity.

As the volumes come from the press one after another regard for this work as a practical every-day reference work and working guide rises higher.

ARCHIBALD D. SMITH

**OPERATIVE SURGERY** Covering the Operative Technique Involved in the Operations of General and Special Surgery By WARREN STONE BICKHAM, M.D., F.A.C.S. Vol 6, completing the set. Octavo, 989 pages, 1224 illustrations. General Index to Vols 1 to 6 Octavo, 189 pages. Phila. and London, W. B. Saunders Co., 1924 Cloth, \$10 per volume. Index volume free. sold by subscription only.

The sixth and final volume of this splendid set is just off the press. It deals in conclusion with operations upon the male genital organs. The approved operations are also described upon the female genito-urinary organs. A final chapter includes operations for deformities and disabilities not considered elsewhere.

As in the other volumes, Dr. Bickham has shown the same discriminating care in the selection of illustrations which the really purposeful, as well as the same accurate lucid descriptions of the various operative steps of surgical procedure. It is felt that this set of surgeries will be a monument to the author and that no practitioner who does surgical work should be without this splendid adjunct.

A separately bound index volume for handy reference has been added to the set.

R. H. FOWLER.

**COMMON INFECTIONS OF THE FEMALE URETHRA AND CERVIX** By FRANK KIDD, M.A., M.Ch., F.R.C.S., and A. MALCOLM SIMPSON, B.A., M.B., D.P.H. With additional chapters by GEORGE T. WESTERN, M.D., and M. S. MAYOU, F.R.C.S. Octavo of 191 pages illustrated (Oxford Medical Publications) London, Humphrey Milford, 1924 Cloth, \$2.50.

This small book is worthy of the attention of any doctor who has to deal with this particular branch of medicine.

There can be no doubt of what the authors wish to convey, as the style of the book is simple, clear and indeed forceful when dealing with controvertible matter.

Many old beliefs that are taught today by some of the leading gynecologists are ruthlessly destroyed, and even though the conclusions of the authors may not be taken *in toto*, yet the challenge remains and considerable work and painstaking observations must be made in order to refute the authors' conclusions.

Take but on instance—infection of the Bartholin's gland—the authors state that 38 per cent of the infections of this gland are non-gonorrheal. This conclusion is based not alone on observation but on thorough laboratory investigation as well.

The book is replete with such instances of old ideas destroyed. In treatment the authors again offer methods radically different to much that is taught.

In conclusion the reviewer feels that however much the reader may differ with the authors, they cannot refute the authors' conclusions unless backed by modern laboratory aid and a prolonged study of the subject in question.

G. W. P.

made for the Carnegie Foundation for the Advancement of Teaching and published in 1910. This report presented in great detail the shortcomings of the individual schools. It was a great help to every school which was in earnest to better the instruction given and to improve its own status. This report proved a moral force to help the Council in its work. The results of the work of the Council have been accomplished without any authority to enforce its suggestions, but entirely through its strength of organization and its power to influence public opinion and medical opinion and to persuade legislation in the states. The Council stands today as the representative body of physicians in their efforts to improve themselves.

The Association of Medical Colleges has undertaken to work out in detail the desires of its component schools to improve education. It also has become a great power to bring about reform under the leadership of the best educators in the profession. Its work is done as the representative of the schools rather than as that of the general profession.

The influence of the state licensing boards and the medical practice laws under which they act is of quite a different nature. It represents the state control of the professional education in medicine. The result on the whole curriculum of the medical schools has been a standardizing of a minimum requirement which any school may exceed but which no school may fail to meet without risking the exclusion of all its graduates from the licensing examination of the particular state whose law has been transgressed. Any large state, such as New York or Pennsylvania, influences medical education not only at home but in every other state, and the individual school to be accepted universally, must equal or exceed the maximum requirements of every state. As a matter of fact and in practice, the state departments have viewed minor infringements with broad toleration, and the best schools have always led and demanded of their students more than the requirements of any state law. The result of such control by law has raised the general standard of education without question, but it has not been entirely an unmixed benefit. The rigid and inelastic curriculum of today is the result of these laws which unite in demanding not only that a fixed number of hours be allotted to each subject but also that the total 3,600 or 4,000 hours of instruction be spread over four calendar years in four periods of eight months each. Some of these laws demand the addition of unusual subjects for instruction, which may be criticized in good faith as unwise or unnecessary. The state laws, therefore, prescribe not only a fixed number of hours of instruction, but also compel a fixed number of months of vacation each year for every student of medicine.

The result often is, however, that the more eager students undertake clinical work in hospitals during vacation, although they receive no credit for it either by state or university.

Under the influence of the forces just enumerated the present conditions in medical education have developed. The result is neither uniform nor finished. It probably never will be finished for medicine is a growing science and progress will be more sure and steady if the teaching of it never becomes uniform. Internal medicine has regained its merited place of chief prominence in the curriculum of most schools. This has been done either by devoting more hours than the legal requirement to it or by reducing the hours allotted to the specialties to the bare demands of the law. The system of clinical clerks has been introduced in the higher grade schools. The mere admission of students to hospital wards is not sufficient, it is essential that these students must be made to feel the responsibility of their privilege. This can be accomplished only by making their work a part of the permanent record of the hospital. Extra-mural courses as formerly given in internal medicine and in specialties have been practically abolished. The energy which formerly found expression in this way is now devoted to post graduate work. The hospitals have been largely reorganized so that an old fashioned rotating service is exceptional. The plan first put into practice in internal medicine by Osler at Johns Hopkins, of a pyramided staff consisting of a director, associates, assistants, residents, internes, and medical students, is generally recognized as the best that has been devised up to the present time even by those teachers who have not yet adopted it. The securing of an affiliated hospital is still the chief element of success in the organization of the medical department of every school. The education of the hospital trustee is still as important as it was when this question was discussed in the meeting of this Council ten years ago, in 1915. The correlation of internal medicine with previous training in work of the laboratory, is today one of the prominent problems of the medical educator. The report of the Council for 1923 calls attention to this question. It is recognized as of immediate importance, and though difficult of solution, it is the subject of study in every important school. The correlation of the subjects of a medical curriculum is usually understood to mean the proper sequence in which to present the numerous subjects to the students. Much worry has been caused to many teachers by the fear that the medical student who begins a new subject will not be properly instructed in those subjects necessary for him to understand his graded advance in the successive steps of his education. Such a correlation is important enough, but there is another phase to this interrelation of the subject matter of a medical educa-

Practice itself Neurology was presented fully, both as to clinical diagnosis and, so far as it was known, to the anatomical localization of the functional action of the nervous system Pediatrics, which embraces all that internal medicine does and in addition includes the special problems of diet for children and the greater incidence of contagious diseases in early life, had become a specialty of major importance Under the lead of such masters as Rotch in Boston, and of Jacobi and Holt in New York, the diseases and care of children were being impressed on the students of medicine in many schools even as early as 1900 The third medical specialty of dermatology and syphilology had not yet grown into its present day importance which resulted from the discoveries in therapeutics of Ehrlich and his followers In 1900, pediatrics and neurology each occupied as much time in the curriculum as did all the rest of internal medicine together At the beginning of the twentieth century internal medicine was a comparatively neglected subject This was due to the addition and growth of the newly discovered sciences of bacteriology and bio-chemistry, and of the operative branches of surgery and the surgical specialties

The one great outstanding event in medical education of the late 19th century was the founding of a medical school in Baltimore owning a large endowment, its own hospital, with no inherited prejudices of a proprietary nature, especially with no traditions as to hospital prerogatives The most important factor in the history of the teaching of internal medicine was the selection for the single head of this medical clinic of a remarkable man—William Osler It is a fact to note that Johns Hopkins built and equipped and opened its hospital several years before any medical students were admitted to the school This order of development was the same which signalized the origin of medical education in America in the early 18th century, when Samuel Bard, just returned from Edinburgh, founded the New York Hospital before he induced King's College to admit medical students to be taught in college and hospital The same procedure was true of the beginnings of the Pennsylvania Hospital and the medical department of the University of Philadelphia under the leadership of Thos Bond and John Morgan Osler re-established the English method of clinical clerks and surgical dressers in the wards of Johns Hopkins This real reform of clinical teaching in internal medicine was adopted slowly by other schools largely because of the difficulty of persuading the trustees of the available hospitals that such a plan was not only a duty but a distinct advantage to their own institutions It is not yet a universal method of instruction, although it ought to be at least until the addition of a fifth interne year to the curriculum, as

more recently proposed, has become an accomplished fact The influence of William Osler on the teaching of internal medicine was not limited to Baltimore Just before he left this country he called together twenty-four younger teachers from the four greater cities in the East and formed a "club" whose objective should be to visit each university represented in turn for the express purpose of studying not only the new research which was under way and unpublished, but also the methods of teaching in use in the different schools Through this medium the ward classes and laboratory methods of the University of Pennsylvania, the methods introduced at Johns Hopkins by Osler and his colleagues already referred to, the amplified system of using dispensary services especially in teaching therapeutics as distinguished from the use of hospital wards which had been forced on the schools of New York by the stupid stubbornness of the trustees of the metropolitan hospitals, and the case teaching methods and medical-pathological conferences as developed at Harvard under the leadership of Richard Cabot and Wright, all these became more universally known and were adopted by other schools The original members of this interurban clinical club and those subsequently elected have shifted their university connection and have carried the spirit and enthusiasm of Osler to Connecticut, Indiana, Michigan, Minnesota, Missouri, and other centers of medical education

The leaders in other branches of medical science were as keen as those working in internal medicine and the general tendency in all the high grade schools was for improvement The modern reform in medical education began within the profession itself It was in 1900 also that organized medicine began to notice medical education and the Journal of the American Medical Association to collect statistics on the education of medical students Under the initiative of this organization the Council on Medical Education and Hospitals began its epoch making work in 1904 During the past 21 years this Council, under its able chairman, has been a most potent force to elevate the standards of and to influence medical education favorably Its rating of medical schools, the intensive discussions on standards and on the school curriculum at its meetings, its annual reports on every phase of medical practice, its assistance and advice given to weaker schools, have accomplished much to improve education in every department of medicine Its chief credit lies in the reduction of the number of schools from 160 to 80 by the elimination of the hopelessly weak Of the eighty schools now left, only twelve lack universal recognition in every state in the Union

The results of the inspections of the Council and those of an independent investigation were embodied by Mr Abraham Flexner in a report

made for the Carnegie Foundation for the Advancement of Teaching and published in 1910. This report presented in great detail the shortcomings of the individual schools. It was a great help to every school which was in earnest to better the instruction given and to improve its own status. This report proved a moral force to help the Council in its work. The results of the work of the Council have been accomplished without any authority to enforce its suggestions, but entirely through its strength of organization and its power to influence public opinion and medical opinion and to persuade legislation in the states. The Council stands today as the representative body of physicians in their efforts to improve themselves.

The Association of Medical Colleges has undertaken to work out in detail the desires of its component schools to improve education. It also has become a great power to bring about reform under the leadership of the best educators in the profession. Its work is done as the representative of the schools rather than as that of the general profession.

The influence of the state licensing boards and the medical practice laws under which they act is of quite a different nature. It represents the state control of the professional education in medicine. The result on the whole curriculum of the medical schools has been a standardizing of a minimum requirement which any school may exceed but which no school may fail to meet without risking the exclusion of all its graduates from the licensing examination of the particular state whose law has been transgressed. Any large state, such as New York or Pennsylvania, influences medical education not only at home but in every other state, and the individual school to be accepted universally, must equal or exceed the maximum requirements of every state. As a matter of fact and in practice, the state departments have viewed minor infringements with broad toleration, and the best schools have always led and demanded of their students more than the requirements of any state law. The result of such control by law has raised the general standard of education without question, but it has not been entirely an unmixed benefit. The rigid and inflexible curriculum of today is the result of these laws which unite in demanding not only that a fixed number of hours be allotted to each subject but also that the total 3,600 or 4,000 hours of instruction be spread over four calendar years in four periods of eight months each. Some of these laws demand the addition of unusual subjects for instruction, which may be criticized in good faith as unwise or unnecessary. The state laws, therefore, prescribe not only a fixed number of hours of instruction, but also compel a fixed number of months of vacation each year for every student of medicine.

The result often is, however, that the more eager students undertake clinical work in hospitals during vacation, although they receive no credit for it either by state or university.

Under the influence of the forces just enumerated the present conditions in medical education have developed. The result is neither uniform nor finished. It probably never will be finished for medicine is a growing science and progress will be more sure and steady if the teaching of it never becomes uniform. Internal medicine has regained its merited place of chief prominence in the curriculum of most schools. This has been done either by devoting more hours than the legal requirement to it or by reducing the hours allotted to the specialties to the bare demands of the law. The system of clinical clerks has been introduced in the higher grade schools. The mere admission of students to hospital wards is not sufficient, it is essential that these students must be made to feel the responsibility of their privilege. This can be accomplished only by making their work a part of the permanent record of the hospital. Extra-mural courses as formerly given in internal medicine and in specialties have been practically abolished. The energy which formerly found expression in this way is now devoted to post graduate work. The hospitals have been largely reorganized so that an old fashioned rotating service is exceptional. The plan first put into practice in internal medicine by Osler at Johns Hopkins, of a pyramided staff consisting of a director, associates, assistants, residents, internes, and medical students, is generally recognized as the best that has been devised up to the present time even by those teachers who have not yet adopted it. The securing of an affiliated hospital is still the chief element of success in the organization of the medical department of every school. The education of the hospital trustee is still as important as it was when this question was discussed in the meeting of this Council ten years ago, in 1915. The correlation of internal medicine with previous training in work of the laboratory, is today one of the prominent problems of the medical educator. The report of the Council for 1923 calls attention to this question. It is recognized as of immediate importance, and though difficult of solution, it is the subject of study in every important school. The correlation of the subjects of a medical curriculum is usually understood to mean the proper sequence in which to present the numerous subjects to the students. Much worry has been caused to many teachers by the fear that the medical student who begins a new subject will not be properly instructed in those subjects necessary for him to understand his graded advance in the successive steps of his education. Such a correlation is important enough, but there is another phase to this interrelation of the subject matter of a medical educa-

Practice itself Neurology was presented fully, both as to clinical diagnosis and, so far as it was known, to the anatomical localization of the functional action of the nervous system Pediatrics, which embraces all that internal medicine does and in addition includes the special problems of diet for children and the greater incidence of contagious diseases in early life, had become a specialty of major importance Under the lead of such masters as Rotch in Boston, and of Jacoby and Holt in New York, the diseases and care of children were being impressed on the students of medicine in many schools even as early as 1900 The third medical specialty of dermatology and syphilology had not yet grown into its present day importance which resulted from the discoveries in therapeutics of Ehrlich and his followers In 1900, pediatrics and neurology each occupied as much time in the curriculum as did all the rest of internal medicine together At the beginning of the twentieth century internal medicine was a comparatively neglected subject This was due to the addition and growth of the newly discovered sciences of bacteriology and bio-chemistry, and of the operative branches of surgery and the surgical specialties

The one great outstanding event in medical education of the late 19th century was the founding of a medical school in Baltimore owning a large endowment, its own hospital, with no inherited prejudices of a proprietary nature, especially with no traditions as to hospital prerogatives The most important factor in the history of the teaching of internal medicine was the selection for the single head of this medical clinic of a remarkable man—William Osler It is a fact to note that Johns Hopkins built and equipped and opened its hospital several years before any medical students were admitted to the school This order of development was the same which signalized the origin of medical education in America in the early 18th century, when Samuel Bard, just returned from Edinburgh founded the New York Hospital before he induced King's College to admit medical students to be taught in college and hospital The same procedure was true of the beginnings of the Pennsylvania Hospital and the medical department of the University of Philadelphia under the leadership of Thos Bond and John Morgan Osler re-established the English method of clinical clerks and surgical dressers in the wards of Johns Hopkins This real reform of clinical teaching in internal medicine was adopted slowly by other schools largely because of the difficulty of persuading the trustees of the available hospitals that such a plan was not only a duty but a distinct advantage to their own institutions It is not yet a universal method of instruction, although it ought to be at least until the addition of a fifth interne year to the curriculum, as

more recently proposed, has become an accomplished fact The influence of William Osler on the teaching of internal medicine was not limited to Baltimore Just before he left this country he called together twenty-four younger teachers from the four greater cities in the East and formed a "club" whose objective should be to visit each university represented in turn for the express purpose of studying not only the new research which was under way and unpublished, but also the methods of teaching in use in the different schools Through this medium the ward classes and laboratory methods of the University of Pennsylvania, the methods introduced at Johns Hopkins by Osler and his colleagues already referred to, the amplified system of using dispensary services especially in teaching therapeutics as distinguished from the use of hospital wards which had been forced on the schools of New York by the stupid stubbornness of the trustees of the metropolitan hospitals, and the case teaching methods and medical-pathological conferences as developed at Harvard under the leadership of Richard Cabot and Wright, all these became more universally known and were adopted by other schools The original members of this interurban clinical club and those subsequently elected have shifted their university connection and have carried the spirit and enthusiasm of Osler to Connecticut, Indiana, Michigan, Minnesota, Missouri, and other centers of medical education

The leaders in other branches of medical science were as keen as those working in internal medicine and the general tendency in all the high grade schools was for improvement The modern reform in medical education began within the profession itself It was in 1900 also that organized medicine began to notice medical education and the Journal of the American Medical Association to collect statistics on the education of medical students Under the initiative of this organization the Council on Medical Education and Hospitals began its epoch making work in 1904 During the past 21 years this Council, under its able chairman, has been a most potent force to elevate the standards of and to influence medical education favorably Its rating of medical schools, the intensive discussions on standards and on the school curriculum at its meetings, its annual reports on every phase of medical practice, its assistance and advice given to weaker schools, have accomplished much to improve education in every department of medicine Its chief credit lies in the reduction of the number of schools from 160 to 80 by the elimination of the hopelessly weak Of the eighty schools now left, only twelve lack universal recognition in every state in the Union

The results of the inspections of the Council and those of an independent investigation were embodied by Mr Abraham Flexner in a report

made for the Carnegie Foundation for the Advancement of Teaching and published in 1910. This report presented in great detail the shortcomings of the individual schools. It was a great help to every school which was in earnest to better the instruction given and to improve its own status. This report proved a moral force to help the Council in its work. The results of the work of the Council have been accomplished without any authority to enforce its suggestions, but entirely through its strength of organization and its power to influence public opinion and medical opinion and to persuade legislation in the states. The Council stands today as the representative body of physicians in their efforts to improve themselves.

The Association of Medical Colleges has undertaken to work out in detail the desires of its component schools to improve education. It also has become a great power to bring about reform under the leadership of the best educators in the profession. Its work is done as the representative of the schools rather than as that of the general profession.

The influence of the state licensing boards and the medical practice laws under which they act is of quite a different nature. It represents the state control of the professional education in medicine. The result on the whole curriculum of the medical schools has been a standardizing of a minimum requirement which any school may exceed but which no school may fail to meet without risking the exclusion of all its graduates from the licensing examination of the particular state whose law has been transgressed. Any large state, such as New York or Pennsylvania, influences medical education not only at home but in every other state, and the individual school to be accepted universally, must equal or exceed the maximum requirements of every state. As a matter of fact and in practice, the state departments have viewed minor infringements with broad toleration, and the best schools have always led and demanded of their students more than the requirements of any state law. The result of such control by law has raised the general standard of education without question, but it has not been entirely an unmixed benefit. The rigid and inelastic curriculum of today is the result of these laws which unite in demanding not only that a fixed number of hours be allotted to each subject but also that the total 3,600 or 4,000 hours of instruction be spread over four calendar years in four periods of eight months each. Some of these laws demand the addition of unusual subjects for instruction, which may be criticized in good faith as unwise or unnecessary. The state laws, therefore, prescribe not only a fixed number of hours of instruction, but also compel a fixed number of months of vacation each year for every student of medicine.

The result often is, however, that the more eager students undertake clinical work in hospitals during vacation, although they receive no credit for it either by state or university.

Under the influence of the forces just enumerated the present conditions in medical education have developed. The result is neither uniform nor finished. It probably never will be finished for medicine is a growing science and progress will be more sure and steady if the teaching of it never becomes uniform. Internal medicine has regained its merited place of chief prominence in the curriculum of most schools. This has been done either by devoting more hours than the legal requirement to it or by reducing the hours allotted to the specialties to the bare demands of the law. The system of clinical clerks has been introduced in the higher grade schools. The mere admission of students to hospital wards is not sufficient, it is essential that these students must be made to feel the responsibility of their privilege. This can be accomplished only by making their work a part of the permanent record of the hospital. Extra-mural courses as formerly given in internal medicine and in specialties have been practically abolished. The energy which formerly found expression in this way is now devoted to post graduate work. The hospitals have been largely reorganized so that an old fashioned rotating service is exceptional. The plan first put into practice in internal medicine by Osler at Johns Hopkins, of a pyramided staff consisting of a director, associates, assistants, residents, internes, and medical students, is generally recognized as the best that has been devised up to the present time even by those teachers who have not yet adopted it. The securing of an affiliated hospital is still the chief element of success in the organization of the medical department of every school. The education of the hospital trustee is still as important as it was when this question was discussed in the meeting of this Council ten years ago, in 1915. The correlation of internal medicine with previous training in work of the laboratory, is today one of the prominent problems of the medical educator. The report of the Council for 1923 calls attention to this question. It is recognized as of immediate importance, and though difficult of solution, it is the subject of study in every important school. The correlation of the subjects of a medical curriculum is usually understood to mean the proper sequence in which to present the numerous subjects to the students. Much worry has been caused to many teachers by the fear that the medical student who begins a new subject will not be properly instructed in those subjects necessary for him to understand his graded advance in the successive steps of his education. Such a correlation is important enough, but there is another phase to this interrelation of the subject matter of a medical educa-



tion It is most important that a student may discover early in his career that the facts of anatomy, physiology and bacteriology are of the greatest use in surgery, and that his laboratory experiences in physiology, bacteriology, chemistry, pathology and pharmacology are of vital importance to the proper understanding of internal medicine and the medical specialties This is not merely a question of the sequence of the subjects of a curriculum There is a correlation of much greater significance in this matter It is necessary that the younger instructor in medicine and surgery has a keen interest in the details of the underlying subjects taught in the laboratories of his institution The appointment to a teaching position in internal medicine should presuppose a previous or contemporary service as an instructor in one or more of the laboratory subjects of physiology, pharmacology, chemistry or bacteriology, and a similar appointment in the department of surgery should lie through a service in anatomy, bacteriology and pathology, or even in all three

Ten schools, in California (3), Illinois (4), Minnesota (1), Michigan (1), and Wisconsin (1), have added a fifth year, to be spent by the student as an interne in an approved hospital Such an arrangement demands from the school a strict supervision to avoid the pitfalls incident to adding extra-mural work to the medical curriculum The majority of graduates voluntarily take a longer internship than one year if they can secure such a one, and most schools have not felt it desirable to adopt this innovation, although eleven states make the same demand as an essential qualification for the license to practice It is an interesting anomaly that only two states (Illinois and Michigan) are in accord with their own schools in making the demand The fifth interne year seems a logical sequence to the trend of medical education in internal medicine and general surgery during the past decade But an ideal scheme by which any school can control the personnel of a sufficient number of hospitals to place all its graduates seems too distant a goal to be reached in any measurable period of time The present advantage of the fifth year seems to be limited to an approval by his school of the hospitals to which a prospective graduate may go The fifth year is an advance, however, and properly administered will lead to greater usefulness in education of a larger number of hospitals than is now the case and will improve the opportunities for teaching in clinical work in the major subjects of medicine, surgery and pediatrics, and in some specialties as well, for the students of the third and fourth year classes

Whether a school adopts a five-year curriculum on some development of this innovation, or remains on a four-year basis and the well tried system of clinical clerks, it will be the number of hospital beds in general medicine and in sur-

gery under the control of the school which will determine the number of students that can be taken care of in each class and, therefore, the enrollment of medical students in that university There is an educational unit which is somewhere between 100 and 125 students which can be given an acceptable education with an equipment in hospital beds and personnel of a given size This minimum to teach 100 students in a class has been placed by the Council on Medical Education as six teachers for each subject, whether general or special, whether laboratory or clinical, and not less than 200 patients in hospital beds who can be utilized for clinical teaching If any university wishes to exceed this educational unit it should duplicate its hospital facilities and also its personnel in both laboratory and clinical subjects The hospital cannot be used for a second unit without detriment to the welfare of the patients, but the laboratories may well be so employed if the personnel be doubled

Medical education in the United States has reached a development during 25 years of which the profession may be proud The main objective as outlined by the general profession and directed by the Council on Medical Education has been the same as that demanded by the general public and enforced by the state legislatures It was that licensed physicians should have a careful training in the causation, diagnosis, therapeutics and pathology of general diseases, in pediatrics and in obstetrics and that an opportunity should exist for graduates to perfect themselves in surgery and the specialties Such a result has become more nearly a fact than has been the case during any time in the past The advance of the past 25 years has been the greatest of any previous period of twice its length

The course of progress has not been without disturbing factors during the past quarter century The World's War proved to be no help Even before April, 1917, there was a tendency for the teachers in American schools to wander off to Europe to secure personal experience of the unusual happenings in medicine and surgery which were going on in the world It was the sudden demand of an American Army of some 4,000,000 men to be supplied with a medical corps and the Federal draft law that so nearly wrecked medical education for the time being It is impossible for a young man to do full time service in two specialties The training of a soldier and the training of a physician are each full-time jobs The attempt to require both of the students of medicine was the stumbling block which caused much worry both in a bureau of the office of the Surgeon General and in the offices of the Deans of many medical schools It lasted only a short two years, after which medical education attempted to return to a quieter road to progress But



the war had changed a large number of the younger medical men. Two years in the Army or Navy had proved insufficient to teach these physicians a true appreciation of service discipline. They did not bring back from their military work any of the good points of the Army or Navy Medical Corps. But somewhere between their resignation from their schools and their discharge from the Army or Navy they had acquired the very bad habit of shirking responsibility and in the slang of the day of "passing the buck." Such a habit of thought and action has no place in the medical profession.

The second event of note is the much praised establishment of the full-time professorship. The claims set forth in support of this American experiment in medical education are so well known that a statement in great detail seems superfluous. It has been described by its most important advocate "as a protection and not as a restriction, not as an abridgement of liberty but as a permanent and effective protection against distraction in the interest of conditions desired by the scientist for the pursuit of his own highest ends." It is customary to compare the ideal full-time professor of internal medicine with the professor of Greek in the same university. In medical education this full-time idea is of special interest to the teaching of internal medicine which is the first department in every school to be drafted in this so-called reform. I admit that I have been opposed to the full-time idea from its very beginning. I believed that it would tend to diminish attention to the hospital wards rather than the reverse, that it would create a habit of thought that the sick were objects for research rather than subjects for cure, that it would limit the experience of the younger men trained in the isolation of a full-time clinic and that the ultimate product, the recent graduate, would acquire a very restricted view of medical diagnosis and therapeutic measures. It is no longer my duty to be a part of the organized education of medical men but as medical director of a hospital service I have an opportunity to study the results of the education of many schools by examination for hospital internships and by contact with the internes themselves. I have seen no reason to change my mind concerning the rigid full-time idea. From two sources I have received the opinion of the full-time professor concerning the undesirability of sharing the instruction of his students with any colleague of equal authority in clinical medicine. One of them has written: "The custom of 'giving instruction in three clinics differing considerably in their character leads to diffuseness, a lack of uniformity and widely varying

points of view, which tend to confuse the average student." This full-time professor at least does not possess a correct idea of clinical medicine. A correct diagnosis can often be reached only by sifting the varying opinions that will be drawn from a collection of clinical facts which are often necessarily incomplete. The sooner that a medical student awakes to the fact that a clinical diagnosis is only an hypothesis upon which to formulate treatment and which is subject to constant change as new facts are discovered so much the sooner will he be started on a successful career. I have observed that the full-time professor of medicine takes the same vacation as does his full-time colleague in the department of Greek, and that both are likely to have the same limited viewpoint and lack of touch with the economics and social needs of the community. This is often true in spite of the fact that one is ruler over a dead language which will remain in *statu quo* until the professor returns to his desk, while the other is in charge of a very living organism, the hospital, which works without vacation seven days in the week and 365 days in the year. I believe the future development of medical education will not be along the line of the full-time clinic with its long vacation, its cloister isolation and its ex-cathedra teaching. Backed as it is by millions this fallacious system has been able to buy its way into many places of prominence. It is a hectic educational disease which allowed to run to a logical conclusion will ruin the finances of any medical school now existing. Medical education will recover from it and will probably be uninjured by the experience.

I have recently examined for internships thirty high-grade students from ten schools, ranging from Massachusetts to South Carolina and from New York to Ohio. The outstanding characteristics of these young men was a very incompetent understanding of therapeutics. I was advised to use tartar emetic as a cathartic and aspidium for any intestinal parasite from hook worm to pin worm. Their advice in regard to digitalis was pharmacological and not clinical. Modern medical teaching neglects the essential point of instructing students how to mix and administer the simplest *materia medica* in the proper vehicle of brains. When it came to diagnosis only one of these thirty men used his ear applied to the chest in addition to his stethoscope. All of them gave the impression that they had not been taught to use their five senses, but would prefer to work with fifty-five instruments of more or less inaccurate precision. The modern education of the physician lays undue stress on the laboratory in diagnosis and neglects the study of the symptomatology of the onset and the

tion It is most important that a student may discover early in his career that the facts of anatomy, physiology and bacteriology are of the greatest use in surgery, and that his laboratory experiences in physiology, bacteriology, chemistry, pathology and pharmacology are of vital importance to the proper understanding of internal medicine and the medical specialties This is not merely a question of the sequence of the subjects of a curriculum There is a correlation of much greater significance in this matter It is necessary that the younger instructor in medicine and surgery has a keen interest in the details of the underlying subjects taught in the laboratories of his institution The appointment to a teaching position in internal medicine should presuppose a previous or contemporary service as an instructor in one or more of the laboratory subjects of physiology, pharmacology, chemistry or bacteriology, and a similar appointment in the department of surgery should lie through a service in anatomy, bacteriology and pathology, or even in all three

Ten schools, in California (3), Illinois (4) Minnesota (1), Michigan (1), and Wisconsin (1), have added a fifth year, to be spent by the student as an interne in an approved hospital Such an arrangement demands from the school a strict supervision to avoid the pitfalls incident to adding extra-mural work to the medical curriculum The majority of graduates voluntarily take a longer internship than one year if they can secure such a one, and most schools have not felt it desirable to adopt this innovation, although eleven states make the same demand as an essential qualification for the license to practice It is an interesting anomaly that only two states (Illinois and Michigan) are in accord with their own schools in making the demand The fifth interne year seems a logical sequence to the trend of medical education in internal medicine and general surgery during the past decade But an ideal scheme by which any school can control the personnel of a sufficient number of hospitals to place all its graduates seems too distant a goal to be reached in any measurable period of time The present advantage of the fifth year seems to be limited to an approval by his school of the hospitals to which a prospective graduate may go The fifth year is an advance, however, and properly administered will lead to greater usefulness in education of a larger number of hospitals than is now the case and will improve the opportunities for teaching in clinical work in the major subjects of medicine, surgery and pediatrics, and in some specialties as well, for the students of the third and fourth year classes

Whether a school adopts a five-year curriculum on some development of this innovation, or remains on a four-year basis and the well tried system of clinical clerks, it will be the number of hospital beds in general medicine and in sur-

gery under the control of the school which will determine the number of students that can be taken care of in each class and, therefore, the enrollment of medical students in that university There is an educational unit which is somewhere between 100 and 125 students which can be given an acceptable education with an equipment in hospital beds and personnel of a given size. This minimum to teach 100 students in a class has been placed by the Council on Medical Education as six teachers for each subject, whether general or special, whether laboratory or clinical, and not less than 200 patients in hospital beds who can be utilized for clinical teaching If any university wishes to exceed this educational unit it should duplicate its hospital facilities and also its personnel in both laboratory and clinical subjects The hospital cannot be used for a second unit without detriment to the welfare of the patients, but the laboratories may well be so employed if the personnel be doubled

Medical education in the United States has reached a development during 25 years of which the profession may be proud The main objective as outlined by the general profession and directed by the Council on Medical Education has been the same as that demanded by the general public and enforced by the state legislatures It was that licensed physicians should have a careful training in the causation, diagnosis, therapeutics and pathology of general diseases, in pediatrics and in obstetrics and that an opportunity should exist for graduates to perfect themselves in surgery and the specialties Such a result has become more nearly a fact than has been the case during any time in the past The advance of the past 25 years has been the greatest of any previous period of twice its length

The course of progress has not been without disturbing factors during the past quarter century The World's War proved to be no help Even before April, 1917, there was a tendency for the teachers in American schools to wander off to Europe to secure personal experience of the unusual happenings in medicine and surgery which were going on in the world It was the sudden demand of an American Army of some 4,000,000 men to be supplied with a medical corps and the Federal draft law that so nearly wrecked medical education for the time being It is impossible for a young man to do full time service in two specialties The training of a soldier and the training of a physician are each full-time jobs The attempt to require both of the students of medicine was the stumbling block which caused much worry both in a bureau of the office of the Surgeon General and in the offices of the Deans of many medical schools It lasted only a short two years, after which medical education attempted to return to a quieter road to progress But

straints, it went through the world war on the "thou shalt nots" of its President. This country is ruled by and loves its prohibitions, whether it be the prohibition of cigarettes or the prohibition of medical education, which denies to any student, however capable or diligent, the privilege of learning his profession any faster than is possible for the laziest and dullest student who can scrape through in four years, the minimum requirements of the university and licensing board of his State.

It is customary to condemn *in toto* the old proprietary system of medical education. But it turned out good doctors and it could not have been all bad. In fact, the course system of teaching on which the proprietary school was organized has in it a greater possibility for development for the capable student than is possessed by any hard and fast arrangement of courses of instruction with fixed hours of attendance and of duration and fixed content of subject. American medical schools were founded on the best traditions of the 18th century as learned at the schools of England and Edinburgh under Hunter, Munro and Cullen. They were developed in the 19th century by adding to the work in hospital and deadhouse of Bright, Hodgkin, Walsh, Stokes and Addison, the best methods of the French schools brought home from the Clinics of Laennec, Bichat, Andral, Corvissart and Louis. American medicine produced results under the leadership in internal medicine of such men as Alonzo Clark, DaCosta, Delafield, Fitz, Janeway, Leidy, Loomis, Minot, Osler, Pepper, Shattuck, Stille, in spite of the handicaps of the proprietary system under which they labored. In 1900, the younger generation of American graduates had come under the influence of the German Universities and the reforms of the past 25 years show the result. The influence of Pasteur in France, and Lister

in England were supplemented by a new influence.

The German University grew into a power in medical education when, about 1870, it became a purely scientific force and lost, for the time, its political taint. The German system under Skoda, Billroth, Virchow, Bamberger, Neusser, Nothnagle, Leyden, Gerhardt and others developed several new ideas of organization and procedure. First, that advancement in university rank should depend on achievement in scientific work and research, also that each university chair and control of hospital service or clinical institute should be combined on a single appointee and finally that the central authority of the state should recognize any course in any recognized university as of equal value so far as it constituted a part of the education of the individual student and was offered by him for credit in the State examination for licensure. Such a system gave an elasticity to medical education, a power of choice to the students enabling them to wander from university to university in periods of semester attendance, which have never been known to the American system of university organization. Such a plan puts each university at the mercy of the critical and stern judgment of the young, earnest and thoughtful students of the whole country. If such a system had been applied under State supervision to the proprietary medical schools of America, it is conceivable that a better result would have followed than is the case today. In any event and under any organization, the success or failure of American, or any other system of medical education, will depend not on the details enforced or self-imposed, but on the personality of the Billroths, the Oslers, the Virchows and the Pasteurs, on the leaders of the profession and on no other condition.

---

## VACCINATION AND SMALLPOX

By FREDERICK W SEARS, M.D.,

SYRACUSE N. Y.

**M**Y purpose in presenting this paper tonight is to call attention to certain facts regarding the increased prevalence of smallpox throughout the United States and to some of the causes responsible for its spread, and to urge the more general adoption of the improved methods in vaccination.

There has been a considerable increase in the incidence of smallpox throughout the United States during the last ten years which is undoubtedly due to a general relaxation in the

enforcement of present laws on vaccination and in many states the repeal of compulsory vaccination laws. This relaxation is probably due to the mild character of the disease which has prevailed up to within the last two or three years.

In 1923 the United States ranked third among the civilized nations in the number of smallpox cases reported, being only exceeded by India and Russia. From incomplete reports received for 1924, the indications are that the United States will rank second. This is quite a shock to our pride

course of a disease. The teaching of older clinicians has been forgotten in the worship of faithless idols and the present day is searching for new specifics to cure and for easy short cuts to diagnosis. It was Christian Fenger, of Chicago, who said that the microscope is only a symptom, and Edward G. Janeway, of New York, that the only value of the Widal reaction was to give him when it was absent a certain number more of consultations for diagnosis. The physician of today has forgotten that typhoid and the pox were well-known and diagnostic long before Widal and Wassermann were born, and before the causative germs of these diseases were discovered by Eberth and Schaudinn. The teachers of these recent graduates in medicine seem to me to miss the special needs of their followers. They are forever hunting the snark and lecturing on the ichthyosaurus while their pupils are unable to recognize the cimex lectuarius, or a common cold.

It is impossible to close this discussion without some reference to the recently published article by Dr. Wm. A. Pusey on "Medical Education and Medical Service." An attack on the expensiveness of medical education by the President of the American Medical Association is likely to be misinterpreted as an attack on education itself and reactionary influences may try to lean on this article to bring about a reduction in the instruction in every branch of medicine. Whether President Pusey has hit on the remedy for the faulty distribution of physicians in rural communities or not is not a point to be discussed in this report. It is important that President Pusey has called attention to the question that the expense of time and money in getting a modern medical education is the cause of the exclusion of poorer boys of the best minds from the profession of medicine. It is not so much the large cost in money that is important but the excessive cost in time that demands serious consideration and correction. Nor is it a question of medical education alone. The whole system of education is at fault. The child is taught to make of his education a play or game. The boy is filled full of facts to be forgotten, and is not given a real knowledge of how to study or a habit of concentration of effort. The youth at college is given too much choice and selection in his education. He is not compelled to carry everything begun to a conclusion. The course in high school and college should be so graded and taught that the average age of a bachelor of arts should not exceed 21 years. During all this time from 13 up to 21 years of age, the student should live a routine of work and play in a proportion of one to one and a half as to time consumed. At the age of 21 he should be ready to go to work in earnest, he

should have his bachelor's degree, and if he will be a medical student he should have an opportunity to fulfil the requirements of 4000 curriculum hours with 4000 hours of extra curriculum reading within three years of 264 working days each instead of spreading the same work as now required by law over four years of 156 days each. His ratio of work to play is still kept in the medical curriculum of today at the college ratio of one to one and a half. The medical student is a man, he can be no weakling. His ratio of work to play should be that of other men or about two and a half of work to one of play. This would mean eight weeks of vacation and 44 weeks of six days each of work, and each day would be of ten working hours duration. Dr. Pusey's claim for a reduction of expenditure should apply to the reduction of vacation time and not to a reduction in the required amount of instruction or of study. To accomplish this end, state control of medical education must give up its present double method of measurement both by length of each subject course and by total length of the whole course, as well. The state will still remain the final judge of the results and by examination can determine who is fit and who unfit to be admitted to the license to practice within its borders. Educators and legislators both must appreciate that medical education is a life's work for men and women over 21 years of age and not a job for boys and girls. It is not to be measured in periods of calendar time, but by the yardstick of hours of accomplishment.

Such a change in the medical curriculum was formulated as a possible war measure and presented on this platform in 1918 by Commissioner Downing, of New York. Some of the New York Schools at that time held continuous sessions for their 3rd and 4th year students and graduated the classes of 1918 and 1919 in February instead of in June. The regular organization of the University of Chicago for continuous sessions dividing the calendar year into four terms of three months each, is a demonstration of what can be done in this direction. But the law, with its restrictions of time and its enforced vacations for medical students, has always prevented the students of Rush Medical College from securing the full benefit of the curriculum of their own institution and thereby saving material time during their education. It will not be easy to undo the fixed habits of administration and of the legal processes of a quarter century. It is easier to make laws than it is to unmake or even to reform them, especially when the law demands some form of restriction. This country was founded on the decalogue of Moses, it adopted a constitution of checks and re-

straints, it went through the world war on the "thou shalt nots" of its President. This country is ruled by and loves its prohibitions, whether it be the prohibition of cigarettes or the prohibition of medical education, which denies to any student, however capable or diligent, the privilege of learning his profession any faster than is possible for the laziest and dullest student who can scrape through in four years, the minimum requirements of the university and licensing board of his State.

It is customary to condemn *in toto* the old proprietary system of medical education. But it turned out good doctors and it could not have been all bad. In fact, the course system of teaching on which the proprietary school was organized has in it a greater possibility for development for the capable student than is possessed by any hard and fast arrangement of courses of instruction with fixed hours of attendance and of duration and fixed content of subject. American medical schools were founded on the best traditions of the 18th century as learned at the schools of England and Edinburgh under Hunter, Munro and Cullen. They were developed in the 19th century by adding to the work in hospital and deadhouse of Bright, Hodgkin, Walsh, Stokes and Addison, the best methods of the French schools brought home from the Clinics of Laennec, Bichat, Andral, Corvissart and Louis. American medicine produced results under the leadership in internal medicine of such men as Alonzo Clark, DaCosta, Delafield, Fitz, Janeway, Leidy, Loomis, Minot, Osler, Pepper, Shattuck, Stille, in spite of the handicaps of the proprietary system under which they labored. In 1900, the younger generation of American graduates had come under the influence of the German Universities and the reforms of the past 25 years show the result. The influence of Pasteur in France, and Lister

in England were supplemented by a new influence.

The German University grew into a power in medical education when, about 1870, it became a purely scientific force and lost, for the time, its political taint. The German system under Skoda, Billroth, Virchow, Bamberger, Neusser, Nothnagle, Leyden, Gerhardt and others, developed several new ideas of organization and procedure. First, that advancement in university rank should depend on achievement in scientific work and research, also that each university chair and control of hospital service or clinical institute should be combined on a single appointee and finally that the central authority or the state should recognize any course in any recognized university as of equal value so far as it constituted a part of the education of the individual student and was offered by him for credit in the State examination for licensure. Such a system gave an elasticity to medical education, a power of choice to the students enabling them to wander from university to university in periods of semester attendance, which have never been known to the American system of university organization. Such a plan puts each university at the mercy of the critical and stern judgment of the young, earnest and thoughtful students of the whole country. If such a system had been applied under State supervision to the proprietary medical schools of America, it is conceivable that a better result would have followed than is the case today. In any event and under any organization, the success or failure of American, or any other system of medical education, will depend not on the details enforced or self-imposed, but on the personality of the Billroths, the Oslers, the Virchows and the Pasteurs, on the leaders of the profession and on no other condition.

---

## VACCINATION AND SMALLPOX

By FREDERICK W. SEARS, M.D.,

SYRACUSE, N. Y.

**M**Y purpose in presenting this paper tonight is to call attention to certain facts regarding the increased prevalence of smallpox throughout the United States and to some of the causes responsible for its spread, and to urge the more general adoption of the improved methods in vaccination.

There has been a considerable increase in the incidence of smallpox throughout the United States during the last ten years which is undoubtedly due to a general relaxation in the

enforcement of present laws on vaccination and in many states the repeal of compulsory vaccination laws. This relaxation is probably due to the mild character of the disease which has prevailed up to within the last two or three years.

In 1923 the United States ranked third among the civilized nations in the number of smallpox cases reported, being only exceeded by India and Russia. From incomplete reports received for 1924, the indications are that the United States will rank second. This is quite a shock to our pride.

course of a disease. The teaching of older clinicians has been forgotten in the worship of faithless idols and the present day is searching for new specifics to cure and for easy short cuts to diagnosis. It was Christian Fenger, of Chicago, who said that the microscope is only a symptom, and Edward G. Janeway, of New York, that the only value of the Widal reaction was to give him when it was absent a certain number more of consultations for diagnosis. The physician of today has forgotten that typhoid and the pox were well-known and diagnostic long before Widal and Wassermann were born, and before the causative germs of these diseases were discovered by Eberth and Schaudinn. The teachers of these recent graduates in medicine seem to me to miss the special needs of their followers. They are forever hunting the snark and lecturing on the ichthyosaurus while their pupils are unable to recognize the *cimex lectuarius*, or a common cold.

It is impossible to close this discussion without some reference to the recently published article by Dr. Wm. A. Pusey on "Medical Education and Medical Service." An attack on the expensiveness of medical education by the President of the American Medical Association is likely to be misinterpreted as an attack on education itself and reactionary influences may try to lean on this article to bring about a reduction in the instruction in every branch of medicine. Whether President Pusey has hit on the remedy for the faulty distribution of physicians in rural communities or not is not a point to be discussed in this report. It is important that President Pusey has called attention to the question that the expense of time and money in getting a modern medical education is the cause of the exclusion of poorer boys of the best minds from the profession of medicine. It is not so much the large cost in money that is important but the excessive cost in time that demands serious consideration and correction. Nor is it a question of medical education alone. The whole system of education is at fault. The child is taught to make of his education a play or game. The boy is filled full of facts to be forgotten, and is not given a real knowledge of how to study or a habit of concentration of effort. The youth at college is given too much choice and selection in his education. He is not compelled to carry everything begun to a conclusion. The course in high school and college should be so graded and taught that the average age of a bachelor of arts should not exceed 21 years. During all this time from 13 up to 21 years of age, the student should live a routine of work and play in a proportion of one to one and a half as to time consumed. At the age of 21 he should be ready to go to work in earnest, he

should have his bachelor's degree, and if he will be a medical student he should have an opportunity to fulfil the requirements of 4000 curriculum hours with 4000 hours of extra curriculum reading within three years of 264 working days each instead of spreading the same work as now required by law over four years of 156 days each. His ratio of work to play is still kept in the medical curriculum of today at the college ratio of one to one and a half. The medical student is a man, he can be no weakling. His ratio of work to play should be that of other men or about two and a half of work to one of play. This would mean eight weeks of vacation and 44 weeks of six days each of work, and each day would be of ten working hours duration. Dr. Pusey's claim for a reduction of expenditure should apply to the reduction of vacation time and not to a reduction in the required amount of instruction or of study. To accomplish this end, state control of medical education must give up its present double method of measurement both by length of each subject course and by total length of the whole course, as well. The state will still remain the final judge of the results and by examination can determine who is fit and who unfit to be admitted to the license to practice within its borders. Educators and legislators both must appreciate that medical education is a life's work for men and women over 21 years of age and not a job for boys and girls. It is not to be measured in periods of calendar time, but by the yardstick of hours of accomplishment.

Such a change in the medical curriculum was formulated as a possible war measure and presented on this platform in 1918 by Commissioner Downing, of New York. Some of the New York Schools at that time held continuous sessions for their 3rd and 4th year students and graduated the classes of 1918 and 1919 in February instead of in June. The regular organization of the University of Chicago for continuous sessions dividing the calendar year into four terms of three months each, is a demonstration of what can be done in this direction. But the law, with its restrictions of time and its enforced vacations for medical students, has always prevented the students of Rush Medical College from securing the full benefit of the curriculum of their own institution and thereby saving material time during their education. It will not be easy to undo the fixed habits of administration and of the legal processes of a quarter century. It is easier to make laws than it is to unmake or even to reform them, especially when the law demands some form of restriction. This country was founded on the decalogue of Moses, it adopted a constitution of checks and re-

straints, it went through the world war on the "thou shalt nots" of its President. This country is ruled by and loves its prohibitions, whether it be the prohibition of cigarettes or the prohibition of medical education, which denies to any student, however capable or diligent, the privilege of learning his profession any faster than is possible for the laziest and dullest student who can scrape through in four years, the minimum requirements of the university and licensing board of his State.

It is customary to condemn *in toto* the old proprietary system of medical education. But it turned out good doctors and it could not have been all bad. In fact, the course system of teaching on which the proprietary school was organized has in it a greater possibility for development for the capable student than is possessed by any hard and fast arrangement of courses of instruction with fixed hours of attendance and of duration and fixed content of subject. American medical schools were founded on the best traditions of the 18th century as learned at the schools of England and Edinburgh under Hunter, Munro and Cullen. They were developed in the 19th century by adding to the work in hospital and deadhouse of Bright, Hodgkin, Walsh, Stokes and Addison, the best methods of the French schools brought home from the Clinics of Laennec, Bichat, Andral, Corvissart and Louis. American medicine produced results under the leadership in internal medicine of such men as Alonzo Clark, DaCosta, Delafield, Fitz, Janeway, Leidy, Loomis, Minot, Osler, Pepper, Shattuck, Stille, in spite of the handicaps of the proprietary system under which they labored. In 1900, the younger generation of American graduates had come under the influence of the German Universities and the reforms of the past 25 years show the result. The influence of Pasteur in France, and Lister

in England were supplemented by a new influence.

The German University grew into a power in medical education when, about 1870, it became a purely scientific force and lost, for the time, its political taint. The German system under Skoda, Billroth, Virchow, Bamberger, Neusser, Nothnagle, Leyden, Gerhardt and others, developed several new ideas of organization and procedure. First, that advancement in university rank should depend on achievement in scientific work and research, also that each university chair and control of hospital service or clinical institute should be combined on a single appointee and finally that the central authority of the state should recognize any course in any recognized university as of equal value so far as it constituted a part of the education of the individual student and was offered by him for credit in the State examination for licensure. Such a system gave an elasticity to medical education, a power of choice to the students enabling them to wander from university to university in periods of semester attendance, which have never been known to the American system of university organization. Such a plan puts each university at the mercy of the critical and stern judgment of the young, earnest and thoughtful students of the whole country. If such a system had been applied under State supervision to the proprietary medical schools of America, it is conceivable that a better result would have followed than is the case today. In any event and under any organization, the success or failure of American, or any other system of medical education, will depend not on the details enforced or self-imposed, but on the personality of the Billroths, the Oslers, the Virchows and the Pasteurs, on the leaders of the profession and on no other condition.

---

## VACCINATION AND SMALLPOX

By FREDERICK W SEARS, M.D.,

SYRACUSE, N. Y.

**M**Y purpose in presenting this paper tonight is to call attention to certain facts regarding the increased prevalence of smallpox throughout the United States and to some of the causes responsible for its spread, and to urge the more general adoption of the improved methods in vaccination.

There has been a considerable increase in the incidence of smallpox throughout the United States during the last ten years which is undoubtedly due to a general relaxation in the

enforcement of present laws on vaccination and in many states the repeal of compulsory vaccination laws. This relaxation is probably due to the mild character of the disease which has prevailed up to within the last two or three years.

In 1923 the United States ranked third among the civilized nations in the number of smallpox cases reported, being only exceeded by India and Russia. From incomplete reports received for 1924, the indications are that the United States will rank second. This is quite a shock to our pride



as medical men and public health workers, and a reflection upon the intelligence of our legislators. In this respect I wish to exempt the City of Syracuse from any such reflection. Were all communities as diligent in enforcement of the vaccination laws and as careful in the methods of vaccination as Syracuse has been for the last quarter of a century, there would be little cause for anxiety. Our chief concern in the prevention of smallpox is among adults who have adopted Syracuse as their home, coming from sections of the country where compulsory vaccination has not been carried out in their schools. It is among these people that all of our initial cases occur, however, during the fifteen years in which I have been more or less closely associated with the health work of Syracuse these outbreaks have been confined to the homes of the initial case which is undoubtedly due to the compulsory vaccination which is so thoroughly carried on by our local health department. The serious epidemic which this City went through in 1875 and 1876 was a lesson in vaccination which Syracuse has never forgotten.

Incomplete reports for the United States for the year 1924 gives the total number of cases of smallpox reported that year as 49,819. From January 1st to July 1st, 1924, there were reported in the States of Michigan 3,999 cases of smallpox. From January 1st to November 1st, 1924, Detroit alone reported 1,592 cases with 164 deaths. From January 1st to August 1st, 1924, Minnesota reported 1,613 cases, 193 of which were of the malignant type with 40 deaths, compulsory vaccination was given up in that State in 1903. The case mortality rate for smallpox in Arizona in 1922 was 28.6 per cent, in Colorado for the same year it was 24.9 per cent.

At the beginning of the outbreak in Detroit last year 26 per cent of its population was unvaccinated and 44 per cent was in need of revaccination. During 1924 New York State had the largest number of cases of smallpox recorded for many years (488 cases, 451 of them had never been vaccinated), some were of the malignant type.

A severe type of smallpox may convey a mild attack to a person vaccinated a number of years previously who in turn may transmit the severe type. It is plainly evident that unless laws are more stringently enforced and new laws enacted where needed, the situation will soon become a most serious one, and it is our duty as physicians to urge our legislators to do their duty along these lines.

The question as to the value of vaccination and the possibility of eradicating smallpox by this means was settled by Jenner once for all time a century and a quarter ago. However, careless methods in vaccination and ignorance

or neglect in its after-care has been the chief weapon in the hands of anti-vaccinationists in securing adverse legislation. Greater refinement in the manufacture of vaccine virus which has been under government supervision since 1902 and the more careful and sane methods employed in vaccination has rendered this a perfectly safe and harmless procedure.

There are three recognized methods for efficient and safe vaccination. In all of these methods we should confine the vaccination area with in a surface not to exceed one-eighth of an inch in diameter. The proper site for vaccination is the one which Jenner himself selected, that is, at the insertion of the deltoid muscle on the left arm. With all methods the arm should be cleansed with soap and water or by some volatile antiseptic liquid and allowed to dry. A small drop of the virus is placed on the site for vaccination. The three methods are, first, a one-eighth of an inch linear incision through the virus not sufficiently deep to cause bleeding. Second, three or four superficial punctures with a sharp needle through the virus. Third, the so-called drill method of the same depth. In all methods the surface should be allowed to dry in the air and no dressings applied until a take is assured when either a very thin covering of sterile gauze is placed over the wound or what is equally efficient the pinning of sterile gauze on the lining of the sleeve which covers the vaccination wound. In no case should we use a shield or a tight bandage. These methods used with potent vaccine should give one hundred per cent takes in all primary cases and no disfiguring scar. The physician who consents to vaccinate on the leg is courting trouble unless the patient consents to remain in bed during the active course of the vaccination. Vaccine virus should be stored at as near the freezing temperature as possible, as freezing does not injure it. It rapidly loses its potency when kept at room temperatures. When we consider that successful vaccination performed within three days after exposure to smallpox will prevent the disease and from the fourth to the seventh day of exposure successful vaccination will modify the course of the disease in unprotected persons, and that after the eighth day following exposure it has no effect upon the disease the importance of using potent vaccine in checking an outbreak of smallpox becomes very evident.

What are the contra-indications to vaccination? In the presence of an epidemic I know of none. In the recent Detroit epidemic 3,346 hospital patients were vaccinated. Of these patients 90 were cases of erysipelas, 773 were obstetric cases, 876 were new born babies, 21 were venereal cases, also numerous cases of diphtheria, scarlet fever, measles and tuberculosis and no untoward results occurred. In normal times it



is unwise to vaccinate in the presence of an open infection for fear of infecting the wound. Among careless people who have the care of horses it is advisable to give a prophylactic dose of tetanus antitoxin at the time of vaccination. Owing to an outbreak of a serious form of the disease in Rochester last summer 103,000 people were vaccinated within the last few months with no serious results. Rochester uses the drill method.

During the recent epidemic in Detroit 817,000 vaccinations were performed, 500,000 of which were done during May and the early part of June. Dr. Vaughan writes that there were a few sore arms but not one of which in any way could be called serious. The epidemic ended the last of June. The vaccine was delivered fresh every two hours. At one period of the work 75,000 points were delivered daily. The method used in Detroit was two linear incisions. No case of smallpox occurred in Detroit among exposed people who had a vaccination scar which was five years old or less. There were twelve cases among exposed persons who had vaccination scars from six years to ten years old, thirty-five with scars from eleven to twenty-five years standing and sixty-six with scars over twenty-five years old. Only seven per cent of the cases and no deaths among the people who had a typical vaccination scar.

Dr. John Simon, the famous London Health official, brought out the fact many years ago that vaccination gives a greater protection against smallpox than does having the disease itself.

Should a case of smallpox occur following a successful vaccination the disease is nearly always of the mild type. Among the secondary cases of smallpox occurring in individuals who have had the disease earlier in life a large percentage are fatal. This was borne out in a recent outbreak in Minnesota, in which outbreak there were two fatal cases of smallpox in persons who had had the disease in childhood and no deaths occurring among those who had ever been successfully vaccinated.

Failure to get a take on repeated vaccination does not indicate that the person will not take smallpox, neither does a secondary successfully vaccination indicate that the individual would have taken smallpox had he been exposed to it.

In people who have been successfully vaccinated an immunity reaction can usually be seen at the site of revaccination in the form of a small red pimple which develops within twenty-four hours after vaccination and fades out in about forty-eight hours. This reaction is useful in the presence of outbreaks in determining the period of isolation.

A large percentage of the outbreaks which occur are due to errors in diagnosis of the initial

case. This was true of the recent outbreak in Johnson City and in many other outbreaks in New York State. The outbreak of the more serious cases in Detroit was thought to be due to a hemorrhagic case which occurred in Windsor and which was not diagnosed. In the absence of an epidemic hemorrhagic cases are rarely diagnosed.

In my opinion one of the chief causes of failure in making a diagnosis of smallpox is in giving too much attention to the appearance of the eruption and not sufficient to the history of the case. There is little difficulty in making a diagnosis of smallpox if a suitable history of the case can be obtained. In the order of their importance I should place first, the history of four days of more or less severe constitutional symptoms, including an initial chill, nausea, fever, severe headache and backache and frequently delirium, the temperature ranging from 102 or 105 or more, second, the almost complete cessation of the constitutional symptoms on the appearance of the eruption, the temperature going to 98 degrees, and in the majority of cases if properly cared for, not again going above the normal point, third, the eruption begins on the forehead and extends rapidly downward over the surface of the body, selecting chiefly the exposed surfaces, as the face, forearms, wrists, legs, palms of the hands and the soles of the feet. The eruption reaches its height of development about the end of a week, and is always of the same stage of development on that portion of the body on which it may appear. In chickenpox, the disease most commonly confused with smallpox, the eruption is preceded by only one day of illness, the temperature gradually rising with the development of the successive crops of the eruption, which is most profuse on the chest and other covered portions of the body. I have never seen a case of chickenpox without a rise of temperature in its early eruptive stage, and I have never seen a case of smallpox with a rise of temperature during the early stage of the eruption. The eruption of chickenpox always shows the mixed variety of lesions in any particular location and tends to dry down and form crusts at the end of four or five days.

To those who are unacquainted with smallpox the tendency is to consider the case as one of smallpox if the eruption is profuse and the patient seems very ill, notwithstanding the fact that a case of smallpox may exist with fewer lesions than would ever occur in any case of adult chickenpox.

I wish to show a few slides to illustrate some of the points spoken of in the paper.

## OBSERVATIONS ON CHRONIC OTORRHEA IN THE INSANE

By JAY DASHIEL WHITHAM, M.D.,

NEW YORK CITY

MUCH has been written in recent years regarding the role focal infections play in the production of certain forms of mental diseases. There is no doubt that severe infectious processes always produce temporary derangements of the sensorium. When such processes are long continued or exhausting, in many cases the result is a prolonged or permanent psychiatric condition. It seems possible that extensive necrosis in the temporal bone with continuous absorption of virulent toxic products in a mentally unstable individual is an important factor in aggravating a psychosis. With this idea in mind the writer has operated on seven mental cases, with the object in each of curing a chronic discharging ear.

These were selected from scores of mental cases who had chronic ears, for, generally speaking, only those were operated on who had a very foul discharge with granulations indicating the presence of an extensive necrosis in the temporal bone. After examining the ears of many hundred insane the writer has been astonished at the relative frequency of chronic suppuration.

The writer wishes to take this opportunity to thank Dr. William C. Garvin, former Superintendent of Kings Park State Hospital for the Insane, for his co-operation in this work and to give credit to Dr. Milton M. Grover for the skillful post-operative care the following cases received.

Case 1. Frank W., age 24. On admission to the hospital, July 22, 1922, this man showed a well-marked hebephrenic type of dementia praecox. He was voluble, confused and rambling in speech. His memory and orientation were intact. His mental age was eleven years. He had constant auditory hallucinations. Physical examination was practically negative except for a foul discharge from the right ear. The ear showed an almost complete destruction of the drum and a large quantity of granulation tissue. He had had this condition as long as he could remember.

On August 27, 1922, a radical mastoid operation was performed on this ear.

On September 18, 1922, the ear was almost healed, but no mental improvement was apparent.

October 20, 1923. The right ear has remained clean and dry. He has shown a marked mental improvement. He is pleasant and agreeable in manner and is no longer troubled with hearing voices. He co-operates readily and is clean and neat in appearance.

On that date he was sent home from the hospital on parole.

Case 2. Florence M., age 35. This woman was admitted to the hospital on March 4, 1922, with the diagnosis of psychopathic personality with excited episodes. She was restless, childish, voluble and dangerous at times. Her age level was nine years. She apparently had no insight into her mental condition. From a relative it was learned that the discharge she had from her left ear had been present since early childhood. This discharge was fairly profuse, and on removing it, a large posterior marginal perforation was seen.

On October 8, 1922, a radical mastoid operation was performed.

December 16, 1922, the cavity was healed and dry. The patient was neat, clean and alert. Mentally she was so far improved that she was sent home.

Case 3. James L. This man was suffering from paresis. He had a copious foul discharge from his left ear about which he complained a great deal.

On December 31, 1921, a radical mastoid operation was performed. Following this the patient had a permanent facial paralysis, although the writer was not conscious of exposing or touching the nerve during the operation. His ear healed perfectly, but his mental condition grew steadily worse until his death eight months later from general paresis.

Case 4. George T. This patient had dementia praecox, associated with a foul, scanty discharge from his left ear. It was ascertained that he had had this discharge for at least four years. Examination of the ear showed a posterior marginal perforation involving Shrapnell's membrane. A probe passed through this perforation toward the antrum. It seemed to touch exposed rough bone.

On June 25, 1922, a radical mastoid operation was performed.

This resulted in a dry ear after many weeks of treatment, including a re-administration of ether and removal of granulations through the meatus. This patient was paroled to his home greatly improved mentally several months later.

Case 5. R. H., male, age 43. This patient had dementia praecox, paranoid type. At the time of operation he had numerous ideas of persecution, auditory hallucinations, and obsessions. His speech was rambling and incoherent. The duration of these symptoms was doubtful. He had a continuous scanty dis-

charge from his left ear with a marginal perforation

On November 11, 1923, a radical mastoid operation was performed. The entire mastoid was ivory-like without cell structure. The antrum was apparently entirely obliterated. The operation was completed by using the horizontal canal as a landmark.

On January 21, 1924, the ear was healed. His memory, orientation and grasp of current topics was defective. Since then he has been working in the hospital dining hall and is in good general physical condition. He no longer reacts to hypochondriacal trends as before, but complains at times of pain in his left ear.

Case 6 M. H., female, age 32. Former occupation, dictaphone operator.

Diagnosis Dementia praecox, paranoid type. In July, 1923, she lost her way returning home from work and for several days after this she had a headache, which felt like a tight band pressing on her forehead. At first she slept a great deal, but after a few days she grew restless and felt that some great harm was coming to her. According to relatives she then became unmanageable, refused food, alleging it was poisoned.

On admission it was noted that she was obstructive and showed emotional instability. It was noted that she had a moderately large thyroid gland and a fine tremor of her fingers. She weighed 187 pounds. The left ear showed a scanty foul discharge. The canal was narrow and the perforation was covered with granulations. She had an O. M. P. C. residual in the right ear with good hearing. The discharge from the left ear had been present since childhood.

On October 28, 1923, a left radical mastoid operation was performed and extensive necrosis was found about the antrum and adjacent bone.

February 18, 1924. The ear was dry and healed. Her appearance was quite natural. Although her insight into her previous condition was not complete she was wonderfully improved and was sent home on parole.

Case 7 Mary T., age 26. Diagnosis Dementia praecox, hebephrenic type. This patient was simple, childish, destructive, and very dull. Her physical condition was very poor. Haemoglobin 60%. Albumin was present in the urine.

On August 6, 1921, she complained of pain

in right lower jaw. A swelling was noted below the angle of the jaw. Her temperature was 104. The next day the swelling had greatly increased in size and involved the neck and parotid region. Great quantities of pus then began to flow continually through the right auditory meatus. Culture showed staphylococci streptococci and Gram positive encapsulated diplococci. A paralysis of the right facial nerve was then noted for the first time.

On August 9th an effort was made to examine the ear, but the drum could not be seen owing to the continual discharge from the abscess in the neck, which had grown very large.

It was thought the pus was flowing from a perforation in the floor of the cartilaginous canal. Under light anaesthesia two large incisions were made in the neck, a great quantity of thick white pus was evacuated and through and through drainage was established. Within a month the neck had healed, but the aural discharge and the facial paralysis had persisted.

On October 17, 1921, a right radical mastoid operation was performed. At this operation a large sequester was found which included the entire posterior canal wall and part of the mastoid tip.

On February 10, 1922, the ear was dry and healed, the facial paralysis, however, persisted. Evidence of pulmonary tuberculosis was present in both lungs.

On July 14, 1922, death occurred from pulmonary tuberculosis. No autopsy was permitted. It seems probable that the ear condition was tuberculous, although no tubercle bacilli could be found in the smears.

To summarize, four of the seven cases showed marked mental improvement, two showed considerable improvement, and in two patients the operation did nothing to arrest the progress of the disease. In all cases the operation cured the aural suppuration.

One of the failures was a case of general paresis, which should not have been operated upon, and would not have been touched had the diagnosis been certain at the time of the operation, the other failure died of pulmonary tuberculosis ten months later. There is no intention to claim directly or by inference that any patients were cured of insanity, but the mental improvement after operation was so striking in some of our patients that we feel amply rewarded for our efforts.

## OBSERVATIONS ON CHRONIC OTORRHEA IN THE INSANE

By JAY DASHIEL WHITHAM, M.D.,  
NEW YORK CITY

MUCH has been written in recent years regarding the role focal infections play in the production of certain forms of mental diseases. There is no doubt that severe infectious processes always produce temporary derangements of the sensorium. When such processes are long continued or exhausting, in many cases the result is a prolonged or permanent psychiatric condition. It seems possible that extensive necrosis in the temporal bone with continuous absorption of virulent toxic products in a mentally unstable individual is an important factor in aggravating a psychosis. With this idea in mind the writer has operated on seven mental cases, with the object in each of curing a chronic discharging ear.

These were selected from scores of mental cases who had chronic ears, for, generally speaking, only those were operated on who had a very foul discharge with granulations indicating the presence of an extensive necrosis in the temporal bone. After examining the ears of many hundred insane the writer has been astonished at the relative frequency of chronic suppuration.

The writer wishes to take this opportunity to thank Dr. William C. Garvin, former Superintendent of Kings Park State Hospital for the Insane, for his co-operation in this work and to give credit to Dr. Milton M. Grover for the skillful post-operative care the following cases received.

Case 1 Frank W., age 24. On admission to the hospital, July 22, 1922, this man showed a well-marked hebephrenic type of dementia praecox. He was voluble, confused and rambling in speech. His memory and orientation were intact. His mental age was eleven years. He had constant auditory hallucinations. Physical examination was practically negative except for a foul discharge from the right ear. The ear showed an almost complete destruction of the drum and a large quantity of granulation tissue. He had had this condition as long as he could remember.

On August 27, 1922, a radical mastoid operation was performed on this ear.

On September 18, 1922, the ear was almost healed, but no mental improvement was apparent.

October 20, 1923. The right ear has remained clean and dry. He has shown a marked mental improvement. He is pleasant and agreeable in manner and is no longer troubled with hearing voices. He co-operates readily and is clean and neat in appearance.

On that date he was sent home from the hospital on parole.

Case 2 Florence M., age 35. This woman was admitted to the hospital on March 4, 1922, with the diagnosis of psychopathic personality with excited episodes. She was restless, childish, voluble and dangerous at times. Her age level was nine years. She apparently had no insight into her mental condition. From a relative it was learned that the discharge she had from her left ear had been present since early childhood. This discharge was fairly profuse, and on removing it, a large posterior marginal perforation was seen.

On October 8, 1922, a radical mastoid operation was performed.

December 16, 1922, the cavity was healed and dry. The patient was neat, clean and alert. Mentally she was so far improved that she was sent home.

Case 3 James L. This man was suffering from paresis. He had a copious foul discharge from his left ear about which he complained a great deal.

On December 31, 1921, a radical mastoid operation was performed. Following this the patient had a permanent facial paralysis, although the writer was not conscious of exposing or touching the nerve during the operation. His ear healed perfectly, but his mental condition grew steadily worse until his death eight months later from general paresis.

Case 4 George T. This patient had dementia praecox, associated with a foul, scanty discharge from his left ear. It was ascertained that he had had this discharge for at least four years. Examination of the ear showed a posterior marginal perforation involving Shrapnell's membrane. A probe passed through this perforation toward the antrum. It seemed to touch exposed rough bone.

On June 25, 1922, a radical mastoid operation was performed.

This resulted in a dry ear after many weeks of treatment, including a re-administration of ether and removal of granulations through the meatus. This patient was paroled to his home greatly improved mentally several months later.

Case 5 R. H., male, age 43. This patient had dementia praecox, paranoid type. At the time of operation he had numerous ideas of persecution, auditory hallucinations, and obsessions. His speech was rambling and incoherent. The duration of these symptoms was doubtful. He had a continuous scanty dis-

charge from his left ear with a marginal perforation

On November 11, 1923, a radical mastoid operation was performed. The entire mastoid was ivory-like without cell structure. The antrum was apparently entirely obliterated. The operation was completed by using the horizontal canal as a landmark.

On January 21, 1924, the ear was healed. His memory, orientation and grasp of current topics was defective. Since then he has been working in the hospital dining hall and is in good general physical condition. He no longer reacts to hypochondriacal trends as before, but complains at times of pain in his left ear.

Case 6 M H, female, age 32. Former occupation, dictaphone operator.

Diagnosis Dementia praecox, paranoid type. In July, 1923, she lost her way returning home from work and for several days after this she had a headache, which felt like a tight band pressing on her forehead. At first she slept a great deal, but after a few days she grew restless and felt that some great harm was coming to her. According to relatives she then became unmanageable, refused food, alleging it was poisoned.

On admission it was noted that she was obstructive and showed emotional instability. It was noted that she had a moderately large thyroid gland and a fine tremor of her fingers. She weighed 187 pounds. The left ear showed a scanty foul discharge. The canal was narrow and the perforation was covered with granulations. She had an O M P C residual in the right ear with good hearing. The discharge from the left ear had been present since childhood.

On October 28, 1923, a left radical mastoid operation was performed and extensive necrosis was found about the antrum and adjacent bone.

February 18, 1924. The ear was dry and healed. Her appearance was quite natural. Although her insight into her previous condition was not complete she was wonderfully improved and was sent home on parole.

Case 7 Mary T, age 26. Diagnosis Dementia praecox, hebephrenic type. This patient was simple, childish, destructive, and very dull. Her physical condition was very poor. Haemoglobin 60%. Albumin was present in the urine.

On August 6, 1921, she complained of pain

in right lower jaw. A swelling was noted below the angle of the jaw. Her temperature was 104. The next day the swelling had greatly increased in size and involved the neck and parotid region. Great quantities of pus then began to flow continually through the right auditory meatus. Culture showed staphylococci streptococci and Gram positive encapsulated diplococci. A paralysis of the right facial nerve was then noted for the first time.

On August 9th an effort was made to examine the ear, but the drum could not be seen owing to the continual discharge from the abscess in the neck, which had grown very large.

It was thought the pus was flowing from a perforation in the floor of the cartilaginous canal. Under light anaesthesia two large incisions were made in the neck, a great quantity of thick white pus was evacuated and through and through drainage was established. Within a month the neck had healed, but the aural discharge and the facial paralysis had persisted.

On October 17, 1921, a right radical mastoid operation was performed. At this operation a large sequester was found which included the entire posterior canal wall and part of the mastoid tip.

On February 10, 1922, the ear was dry and healed, the facial paralysis, however, persisted. Evidence of pulmonary tuberculosis was present in both lungs.

On July 14, 1922, death occurred from pulmonary tuberculosis. No autopsy was permitted. It seems probable that the ear condition was tuberculous, although no tubercle bacilli could be found in the smears.

To summarize, four of the seven cases showed marked mental improvement, two showed considerable improvement, and in two patients the operation did nothing to arrest the progress of the disease. In all cases the operation cured the aural suppuration.

One of the failures was a case of general paresis, which should not have been operated upon, and would not have been touched had the diagnosis been certain at the time of the operation, the other failure died of pulmonary tuberculosis ten months later. There is no intention to claim directly or by inference that any patients were cured of insanity, but the mental improvement after operation was so striking in some of our patients that we feel amply rewarded for our efforts.

## OBSERVATIONS ON CHRONIC OTORRHEA IN THE INSANE

By JAY DASHIEL WHITHAM, M.D.,  
NEW YORK CITY

MUCH has been written in recent years regarding the role focal infections play in the production of certain forms of mental diseases. There is no doubt that severe infectious processes always produce temporary derangements of the sensorium. When such processes are long continued or exhausting, in many cases the result is a prolonged or permanent psychiatric condition. It seems possible that extensive necrosis in the temporal bone with continuous absorption of virulent toxic products in a mentally unstable individual is an important factor in aggravating a psychosis. With this idea in mind the writer has operated on seven mental cases, with the object in each of curing a chronic discharging ear.

These were selected from scores of mental cases who had chronic ears, for, generally speaking, only those were operated on who had a very foul discharge with granulations indicating the presence of an extensive necrosis in the temporal bone. After examining the ears of many hundred insane the writer has been astonished at the relative frequency of chronic suppuration.

The writer wishes to take this opportunity to thank Dr. William C. Garvin, former Superintendent of Kings Park State Hospital for the Insane, for his co-operation in this work and to give credit to Dr. Milton M. Grover for the skillful post-operative care the following cases received.

Case 1 Frank W., age 24. On admission to the hospital, July 22, 1922, this man showed a well-marked hebephrenic type of dementia praecox. He was voluble, confused and rambling in speech. His memory and orientation were intact. His mental age was eleven years. He had constant auditory hallucinations. Physical examination was practically negative except for a foul discharge from the right ear. The ear showed an almost complete destruction of the drum and a large quantity of granulation tissue. He had had this condition as long as he could remember.

On August 27, 1922, a radical mastoid operation was performed on this ear.

On September 18, 1922, the ear was almost healed, but no mental improvement was apparent.

October 20, 1923. The right ear has remained clean and dry. He has shown a marked mental improvement. He is pleasant and agreeable in manner and is no longer troubled with hearing voices. He co-operates readily and is clean and neat in appearance.

On that date he was sent home from the hospital on parole.

Case 2 Florence M., age 35. This woman was admitted to the hospital on March 4, 1922, with the diagnosis of psychopathic personality with excited episodes. She was restless, childish, voluble and dangerous at times. Her age level was nine years. She apparently had no insight into her mental condition. From a relative it was learned that the discharge she had from her left ear had been present since early childhood. This discharge was fairly profuse, and on removing it, a large posterior marginal perforation was seen.

On October 8, 1922, a radical mastoid operation was performed.

December 16, 1922, the cavity was healed and dry. The patient was neat, clean and alert. Mentally she was so far improved that she was sent home.

Case 3 James L. This man was suffering from paresis. He had a copious foul discharge from his left ear about which he complained a great deal.

On December 31, 1921, a radical mastoid operation was performed. Following this the patient had a permanent facial paralysis, although the writer was not conscious of exposing or touching the nerve during the operation. His ear healed perfectly, but his mental condition grew steadily worse until his death eight months later from general paresis.

Case 4 George T. This patient had dementia praecox, associated with a foul, scanty discharge from his left ear. It was ascertained that he had had this discharge for at least four years. Examination of the ear showed a posterior marginal perforation involving Shrapnell's membrane. A probe passed through this perforation toward the antrum. It seemed to touch exposed rough bone.

On June 25, 1922, a radical mastoid operation was performed.

This resulted in a dry ear after many weeks of treatment, including a re-administration of ether and removal of granulations through the meatus. This patient was paroled to his home greatly improved mentally several months later.

Case 5 R. H., male, age 43. This patient had dementia praecox, paranoid type. At the time of operation he had numerous ideas of persecution, auditory hallucinations, and obsessions. His speech was rambling and incoherent. The duration of these symptoms was doubtful. He had a continuous scanty dis-

charge from his left ear with a marginal perforation

On November 11, 1923, a radical mastoid operation was performed. The entire mastoid was ivory-like without cell structure. The antrum was apparently entirely obliterated. The operation was completed by using the horizontal canal as a landmark.

On January 21, 1924, the ear was healed. His memory, orientation and grasp of current topics was defective. Since then he has been working in the hospital dining hall and is in good general physical condition. He no longer reacts to hypochondriacal trends as before, but complains at times of pain in his left ear.

Case 6 M. H., female, age 32. Former occupation, dictaphone operator.

Diagnosis: Dementia praecox, paranoid type. In July, 1923, she lost her way returning home from work and for several days after this she had a headache, which felt like a tight band pressing on her forehead. At first she slept a great deal, but after a few days she grew restless and felt that some great harm was coming to her. According to relatives she then became unmanageable, refused food, alleging it was poisoned.

On admission it was noted that she was obstructive and showed emotional instability. It was noted that she had a moderately large thyroid gland and a fine tremor of her fingers. She weighed 187 pounds. The left ear showed a scanty foul discharge. The canal was narrow and the perforation was covered with granulations. She had an O M P C residual in the right ear with good hearing. The discharge from the left ear had been present since childhood.

On October 28, 1923, a left radical mastoid operation was performed and extensive necrosis was found about the antrum and adjacent bone.

February 18, 1924. The ear was dry and healed. Her appearance was quite natural. Although her insight into her previous condition was not complete she was wonderfully improved and was sent home on parole.

Case 7 Mary T., age 26. Diagnosis: Dementia praecox, hebephrenic type. This patient was simple, childish, destructive, and very dull. Her physical condition was very poor. Haemoglobin 60%. Albumin was present in the urine.

On August 6, 1921, she complained of pain

in right lower jaw. A swelling was noted below the angle of the jaw. Her temperature was 104. The next day the swelling had greatly increased in size and involved the neck and parotid region. Great quantities of pus then began to flow continually through the right auditory meatus. Culture showed staphylococci streptococci and Gram positive encapsulated diplococci. A paralysis of the right facial nerve was then noted for the first time.

On August 9th an effort was made to examine the ear, but the drum could not be seen owing to the continual discharge from the abscess in the neck, which had grown very large.

It was thought the pus was flowing from a perforation in the floor of the cartilaginous canal. Under light anaesthesia two large incisions were made in the neck, a great quantity of thick white pus was evacuated and through and through drainage was established. Within a month the neck had healed, but the aural discharge and the facial paralysis had persisted.

On October 17, 1921, a right radical mastoid operation was performed. At this operation a large sequester was found which included the entire posterior canal wall and part of the mastoid tip.

On February 10, 1922, the ear was dry and healed, the facial paralysis, however, persisted. Evidence of pulmonary tuberculosis was present in both lungs.

On July 14, 1922, death occurred from pulmonary tuberculosis. No autopsy was permitted. It seems probable that the ear condition was tuberculous, although no tubercle bacilli could be found in the smears.

To summarize, four of the seven cases showed marked mental improvement, two showed considerable improvement, and in two patients the operation did nothing to arrest the progress of the disease. In all cases the operation cured the aural suppuration.

One of the failures was a case of general paresis, which should not have been operated upon, and would not have been touched had the diagnosis been certain at the time of the operation, the other failure died of pulmonary tuberculosis ten months later. There is no intention to claim directly or by inference that any patients were cured of insanity, but the mental improvement after operation was so striking in some of our patients that we feel amply rewarded for our efforts.

## OBSERVATIONS ON CHRONIC OTORRHEA IN THE INSANE

By JAY DASHIEL WHITHAM, M.D.,

NEW YORK CITY

MUCH has been written in recent years regarding the role focal infections play in the production of certain forms of mental diseases. There is no doubt that severe infectious processes always produce temporary derangements of the sensorium. When such processes are long continued or exhausting, in many cases the result is a prolonged or permanent psychiatric condition. It seems possible that extensive necrosis in the temporal bone with continuous absorption of virulent toxic products in a mentally unstable individual is an important factor in aggravating a psychosis. With this idea in mind the writer has operated on seven mental cases, with the object in each of curing a chronic discharging ear.

These were selected from scores of mental cases who had chronic ears, for, generally speaking, only those were operated on who had a very foul discharge with granulations indicating the presence of an extensive necrosis in the temporal bone. After examining the ears of many hundred insane the writer has been astonished at the relative frequency of chronic suppuration.

The writer wishes to take this opportunity to thank Dr. William C. Garvin, former Superintendent of Kings Park State Hospital for the Insane, for his co-operation in this work and to give credit to Dr. Milton M. Grover for the skillful post-operative care the following cases received.

Case 1. Frank W., age 24. On admission to the hospital, July 22, 1922, this man showed a well-marked hebephrenic type of dementia praecox. He was voluble, confused and rambling in speech. His memory and orientation were intact. His mental age was eleven years. He had constant auditory hallucinations. Physical examination was practically negative except for a foul discharge from the right ear. The ear showed an almost complete destruction of the drum and a large quantity of granulation tissue. He had had this condition as long as he could remember.

On August 27, 1922, a radical mastoid operation was performed on this ear.

On September 18, 1922, the ear was almost healed, but no mental improvement was apparent.

October 20, 1923. The right ear has remained clean and dry. He has shown a marked mental improvement. He is pleasant and agreeable in manner and is no longer troubled with hearing voices. He co-operates readily and is clean and neat in appearance.

On that date he was sent home from the hospital on parole.

Case 2. Florence M., age 35. This woman was admitted to the hospital on March 4, 1922, with the diagnosis of psychopathic personality with excited episodes. She was restless, childish, voluble and dangerous at times. Her age level was nine years. She apparently had no insight into her mental condition. From a relative it was learned that the discharge she had from her left ear had been present since early childhood. This discharge was fairly profuse, and on removing it, a large posterior marginal perforation was seen.

On October 8, 1922, a radical mastoid operation was performed.

December 16, 1922, the cavity was healed and dry. The patient was neat, clean and alert. Mentally she was so far improved that she was sent home.

Case 3. James L. This man was suffering from paresis. He had a copious foul discharge from his left ear about which he complained a great deal.

On December 31, 1921, a radical mastoid operation was performed. Following this the patient had a permanent facial paralysis, although the writer was not conscious of exposing or touching the nerve during the operation. His ear healed perfectly, but his mental condition grew steadily worse until his death eight months later from general paresis.

Case 4. George T. This patient had dementia praecox, associated with a foul, scanty discharge from his left ear. It was ascertained that he had had this discharge for at least four years. Examination of the ear showed a posterior marginal perforation involving Shrapnell's membrane. A probe passed through this perforation toward the antrum. It seemed to touch exposed rough bone.

On June 25, 1922, a radical mastoid operation was performed.

This resulted in a dry ear after many weeks of treatment, including a re-administration of ether and removal of granulations through the meatus. This patient was paroled to his home greatly improved mentally several months later.

Case 5. R. H., male, age 43. This patient had dementia praecox, paranoid type. At the time of operation he had numerous ideas of persecution, auditory hallucinations, and obsessions. His speech was rambling and incoherent. The duration of these symptoms was doubtful. He had a continuous scanty dis-



charge from his left ear with a marginal perforation

On November 11, 1923, a radical mastoid operation was performed. The entire mastoid was ivory-like without cell structure. The antrum was apparently entirely obliterated. The operation was completed by using the horizontal canal as a landmark.

On January 21, 1924, the ear was healed. His memory, orientation and grasp of current topics was defective. Since then he has been working in the hospital dining hall and is in good general physical condition. He no longer reacts to hypochondriacal trends as before, but complains at times of pain in his left ear.

Case 6 M. H., female, age 32. Former occupation, dictaphone operator.

Diagnosis Dementia praecox, paranoid type. In July, 1923, she lost her way returning home from work and for several days after this she had a headache, which felt like a tight band pressing on her forehead. At first she slept a great deal, but after a few days she grew restless and felt that some great harm was coming to her. According to relatives she then became unmanageable, refused food, alleging it was poisoned.

On admission it was noted that she was obstructive and showed emotional instability. It was noted that she had a moderately large thyroid gland and a fine tremor of her fingers. She weighed 187 pounds. The left ear showed a scanty foul discharge. The canal was narrow and the perforation was covered with granulations. She had an O. M. P. C. residual in the right ear with good hearing. The discharge from the left ear had been present since childhood.

On October 28, 1923, a left radical mastoid operation was performed and extensive necrosis was found about the antrum and adjacent bone.

February 18, 1924. The ear was dry and healed. Her appearance was quite natural. Although her insight into her previous condition was not complete she was wonderfully improved and was sent home on parole.

Case 7 Mary T., age 26. Diagnosis Dementia praecox, hebephrenic type. This patient was simple, childish, destructive, and very dull. Her physical condition was very poor. Haemoglobin 60%. Albumin was present in the urine.

On August 6, 1921, she complained of pain

in right lower jaw. A swelling was noted below the angle of the jaw. Her temperature was 104. The next day the swelling had greatly increased in size and involved the neck and parotid region. Great quantities of pus then began to flow continually through the right auditory meatus. Culture showed staphylococci streptococci and Gram positive encapsulated diplococci. A paralysis of the right facial nerve was then noted for the first time.

On August 9th an effort was made to examine the ear, but the drum could not be seen owing to the continual discharge from the abscess in the neck, which had grown very large.

It was thought the pus was flowing from a perforation in the floor of the cartilaginous canal. Under light anaesthesia two large incisions were made in the neck, a great quantity of thick white pus was evacuated and through and through drainage was established. Within a month the neck had healed, but the aural discharge and the facial paralysis had persisted.

On October 17, 1921, a right radical mastoid operation was performed. At this operation a large sequester was found which included the entire posterior canal wall and part of the mastoid tip.

On February 10, 1922, the ear was dry and healed, the facial paralysis, however, persisted. Evidence of pulmonary tuberculosis was present in both lungs.

On July 14, 1922, death occurred from pulmonary tuberculosis. No autopsy was permitted. It seems probable that the ear condition was tuberculous, although no tubercle bacilli could be found in the smears.

To summarize, four of the seven cases showed marked mental improvement, two showed considerable improvement, and in two patients the operation did nothing to arrest the progress of the disease. In all cases the operation cured the aural suppuration.

One of the failures was a case of general paresis, which should not have been operated upon, and would not have been touched had the diagnosis been certain at the time of the operation, the other failure died of pulmonary tuberculosis ten months later. There is no intention to claim directly or by inference that any patients were cured of insanity, but the mental improvement after operation was so striking in some of our patients that we feel amply rewarded for our efforts.

## THE TREATMENT OF CONGENITAL DEFORMITIES

By RICHMOND STEPHENS, M.D.,

NEW YORK CITY

**I**N commencing I wish to state briefly that Orthopædic Surgery has probably changed more in the last twenty years than any other branch of Medicine. Formerly it was considered merely "strap and buckle" work and was limited to very few conditions and practiced by comparatively few men. Lately the scope of the work has broadened and the specialty has become better known to the profession at large and I believe now that the general public is beginning to know what it means, although unfortunately the title is extremely unsatisfactory. Many people are confused and think that it is something like osteopathy, chiropractic or some of the other cults.

A few years ago the field of orthopædic surgery was practically limited to tuberculosis of bones and joints, certain paralyses, a few congenital deformities and some of the postural conditions. The treatment was always by means of braces or plaster-of-Paris and the only operations were tenotomies for the correction of contractures and simple evacuation of abscesses. Now a great deal of our work is operative and we are doing more along the line of bone and joint surgery. Fractures and dislocations, particularly the difficult ones or those with poor late results, such as mal or non-union, ankylosed joints, etc., are among the problems which we are handling.

At the present time we are doing a great deal of prophylactic work as is the case in all branches of medicine. At this time I would like to add my word of approval to the campaigns that are being carried on for routine periodic examinations. In this way many orthopædic conditions could be prevented or at least discovered early and treated before they become serious. Such conditions as weak foot, spinal curvature, mild paralyses, early tuberculosis and many others might be checked and the usual prolonged treatment and often deforming results might be eliminated.

In considering congenital deformities it is of the utmost importance that all infants should be thoroughly examined at birth as practically all of the conditions should have treatment instituted early.

There are several conditions of congenital origin which may not be discovered during infancy such as, anomalies of the vertebrae and cervical ribs which we will not discuss at this time. In passing I might also mention several conditions such as spina bifida deformities caused by amniotic bands, supernumerary bones or digits, syndactylism, etc. most of which require operative correction and many in which it is preferable to defer the treatment for some time. There is also a group of congenital deformities such as elevation of the Scapula (Sprengel's

shoulder), radioulna synostosis, Madelung's deformity, club hand, etc., which are infrequently seen and which require rather individual and highly specialized forms of treatment.

The more common congenital deformities which I do wish to cover are wry-neck or Torticollis, club foot or talipes and dislocation of the hip. These are seen relatively frequently and in the first two conditions there are many cases that can be relieved without the services of a specialist. It is impossible in a short time to go very deeply into the treatment but I will endeavor to outline it for all except the most resistant or extreme cases.

*Torticollis*—Although the congenital type is less common than the acquired, nevertheless we see it quite frequently. In making the diagnosis we must be certain that it is true muscular contraction and not secondary to some affection of the cervical spine or glands. It may be caused by an injury at birth and often one can see or feel an enlargement in the neck due to a hæmatoma or a muscle injury. In this type of case the treatment consists of light massage and frequent gentle manipulations to overcome the deformity. In the cases of real contracture the sterno-cleido-mastoid is always involved and with it there may be shortening of other structures. Sometimes the condition is not noticed until the child sits up or at least holds the head. The deformity is that which is produced by approximating the mastoid process to the sterno-clavicular joint. For example, in a right torticollis the head is tilted toward the right shoulder with the face to the left and the chin pointed up to the left. In infants we are able to cure most cases by simple stretching. The method is by holding the shoulder and stretching the sterno-mastoid to increase the distance between our two fixed points. The child will usually lie in its bed facing the left in a case of right torticollis. We find that because this seems to be the tendency the mother will place the bed so that the child can look out into the room which is the natural thing. Therefore, we may help the condition by having the bed so placed that in order to look out into the room the baby will have to turn the head in the opposite direction. In the average case this along with manipulations done to the count about twenty times, four or five times a day will give a complete cure. In obstinate or neglected cases we will find a resulting condition of asymmetry of the head and neck which will increase with age and which decreases the chances of an ultimate cure. We can only resort to operation by a subcutaneous tenotomy of the contracted muscle fibres or an open operation. Of course,

nobody desires a scar on his or her neck but the subcutaneous method is such blind surgery, much like the old methods of tonsillotomy that we should always avoid it except in the simplest cases. By the open method we do not run the risk of injury to the important structures in the neck and with a subcuticular stitch we can usually avoid an unsightly scar.

The after treatment consists of retaining the overcorrected position by means of plaster-of-Paris for a short time and then frequent manipulations to prevent a recurrence of the deformity. Formerly we used the plaster for several weeks but I now believe that the results are better by removing it in about two weeks and then starting manipulations and exercises. The after treatment should be continued for several months and the patient carefully observed to make certain that the deformity does not tend to recur.

*Lalipes*—Congenital club foot is easily recognized at birth and if treated early and efficiently can be cured in about ninety per cent of all cases in from a few weeks to a year. The proper time to start treatment is about the tenth day at which time the baby has usually regained birth weight, is feeding well and the skin is slightly tougher than at birth. Whatever the deformity may be, the aim is to stretch the foot into the directly opposed position. The most common type is equinovarus and we will make our remarks for such a case. In the mild cases simple stretching several times a day may be sufficient. In more severe cases it is necessary to stretch the foot and maintain it in the over-corrected position. Plaster-of-Paris is preferable to adhesive plaster as it maintains the position better and is not so liable to cause skin injury. One must be careful to avoid a tight plaster and at the same time to have one that can not be kicked off. The plaster should be reapplied every week. At each reapplication the foot is stretched and further correction should be obtained. This is continued until the foot remains in the over-corrected position. Then the plaster may be omitted and the foot held in an over-corrected attitude with adhesive strapping and then manipulations. As the child begins to walk we may have the shoes altered, by raising the outer border for equino-varus, etc. The patient must be watched for a long time. If there is any sign of recurrence, treatment should be reinstituted.

In older or relapsed cases the same method may be tried but these and the most serious cases may need operation such as wrenching, fasciotomy, tenotomy, capsulotomy, wedge, astraglectomy, etc. Untreated cases in older children or adults are difficult and results can not be expected to be so good.

*Congenital Dislocation of the Hip*—Congenital dislocation of the hip may be diagnosed at birth but usually is not found until the child begins to walk. Then the parents notice that there is a limp and an exaggerated lumbar lordosis. I can not say what the result would be in cases diagnosed before walking as we do not see them but it is my belief that they could be very easily reduced and in many cases would stay in place without any plaster or other support.

In the usual case we start treatment when the baby is trained sufficiently to dispense with diapers for in the use of plaster it is essential that they should not be wet. The chances of reduction are very good from this time up to about seven years. After seven we can rarely reduce a dislocated hip without an open operation. In all cases, however, we can usually determine the outcome, for if the head of the femur is not too high and if there is a good acetabulum we may expect to get a cure.

The common variety of dislocation is the one in which the head of the femur is above and behind the acetabulum and the treatment outlined here is for this type of case. Other forms of dislocation require special treatment. Let us consider a case of the most frequent sort. I will not go into the details of the operation but will describe the treatment briefly. The child must be anesthetized sufficient for complete relaxation. The hamstrings, adductors and flexors are stretched and the hip manipulated into place. A plaster spica is then applied to hold the hip in place, this usually being with the thigh rotated outward, abducted and hyper-extended into what is frequently called the "frog" position. The after treatment consists of maintaining the reduction with a change of plaster every six or eight weeks, each time bringing the thigh down a little toward the normal position. In the average case the treatment covers a period of about nine months.

If a hip can not be reduced in two or three attempts or if it can not be held in place after adequate reduction it is best to let it wait until the patient is a little older and then reduce it by an open operation. Such cases will usually show a shallow acetabulum or one filled with connective tissue or a so-called hour-glass constriction of the capsule.

I have endeavored to cover a lot of ground in a short time and have tried to outline the treatment of these congenital deformities in such a way that it would be of interest to all. I am of the opinion that we can all get a great deal more out of our County Medical Society meetings if we can take up subjects that will not be too special, and that can be discussed by all of the members.

## THE TREATMENT OF CONGENITAL DEFORMITIES

By RICHMOND STEPHENS, M.D.,

NEW YORK CITY

**I**N commencing I wish to state briefly that Orthopædic Surgery has probably changed more in the last twenty years than any other branch of Medicine. Formerly it was considered merely "strap and buckle" work and was limited to very few conditions and practiced by comparatively few men. Lately the scope of the work has broadened and the specialty has become better known to the profession at large and I believe now that the general public is beginning to know what it means, although unfortunately the title is extremely unsatisfactory. Many people are confused and think that it is something like osteopathy, chiropractic or some of the other cults.

A few years ago the field of orthopædic surgery was practically limited to tuberculosis of bones and joints, certain paralyses, a few congenital deformities and some of the postural conditions. The treatment was always by means of braces or plaster-of-Paris and the only operations were tenotomies for the correction of contractures and simple evacuation of abscesses. Now a great deal of our work is operative and we are doing more along the line of bone and joint surgery. Fractures and dislocations, particularly the difficult ones or those with poor late results, such as mal or non-union, ankylosed joints, etc., are among the problems which we are handling.

At the present time we are doing a great deal of prophylactic work as is the case in all branches of medicine. At this time I would like to add my word of approval to the campaigns that are being carried on for routine periodic examinations. In this way many orthopædic conditions could be prevented or at least discovered early and treated before they become serious. Such conditions as weak foot, spinal curvature, mild paralyses, early tuberculosis and many others might be checked and the usual prolonged treatment and often deforming results might be eliminated.

In considering congenital deformities it is of the utmost importance that all infants should be thoroughly examined at birth as practically all of the conditions should have treatment instituted early.

There are several conditions of congenital origin which may not be discovered during infancy such as, anomalies of the vertebrae and cervical ribs which we will not discuss at this time. In passing I might also mention several conditions such as spina bifida deformities caused by amniotic bands, supernumerary bones or digits syndactylism etc. most of which require operative correction and many in which it is preferable to defer the treatment for some time. There is also a group of congenital deformities such as elevation of the Scapula (Sprengel's

shoulder), radioulna synostosis, Madelung's deformity, club hand, etc., which are infrequently seen and which require rather individual and highly specialized forms of treatment.

The more common congenital deformities which I do wish to cover are wry-neck or Torticollis, club foot or talpes and dislocation of the hip. These are seen relatively frequently and in the first two conditions there are many cases that can be relieved without the services of a specialist. It is impossible in a short time to go very deeply into the treatment but I will endeavor to outline it for all except the most resistant or extreme cases.

*Torticollis*—Although the congenital type is less common than the acquired, nevertheless we see it quite frequently. In making the diagnosis we must be certain that it is true muscular contraction and not secondary to some affection of the cervical spine or glands. It may be caused by an injury at birth and often one can see or feel an enlargement in the neck due to a hematoma or a muscle injury. In this type of case the treatment consists of light massage and frequent gentle manipulations to overcome the deformity. In the cases of real contracture the sterno-cleido-mastoid is always involved and with it there may be shortening of other structures. Sometimes the condition is not noticed until the child sits up or at least holds the head. The deformity is that which is produced by approximating the mastoid process to the sterno-clavicular joint. For example, in a right torticollis the head is tilted toward the right shoulder with the face to the left and the chin pointed up to the left. In infants we are able to cure most cases by simple stretching. The method is by holding the shoulder and stretching the sterno-mastoid to increase the distance between our two fixed points. The child will usually lie in its bed facing the left in a case of right torticollis. We find that because this seems to be the tendency the mother will place the bed so that the child can look out into the room which is the natural thing. Therefore, we may help the condition by having the bed so placed that in order to look out into the room the baby will have to turn the head in the opposite direction. In the average case this along with manipulations done to the count about twenty times, four or five times a day will give a complete cure. In obstinate or neglected cases we will find a resulting condition of asymmetry of the head and neck which will increase with age and which decreases the chances of an ultimate cure. We can only resort to operation by a subcutaneous tenotomy of the contracted muscle fibres or an open operation. Of course,

nobody desires a scar on his or her neck but the subcutaneous method is such blind surgery, much like the old methods of tonsillotomy, that we should always avoid it except in the simplest cases. By the open method we do not run the risk of injury to the important structures in the neck and with a subcuticular stitch we can usually avoid an unsightly scar.

The after treatment consists of retaining the overcorrected position by means of plaster-of-Paris for a short time and then frequent manipulations to prevent a recurrence of the deformity. Formerly we used the plaster for several weeks but I now believe that the results are better by removing it in about two weeks and then starting manipulations and exercises. The after treatment should be continued for several months and the patient carefully observed to make certain that the deformity does not tend to recur.

*Talipes*—Congenital club foot is easily recognized at birth and if treated early and efficiently can be cured in about ninety per cent of all cases in from a few weeks to a year. The proper time to start treatment is about the tenth day at which time the baby has usually regained birth weight, is feeding well and the skin is slightly tougher than at birth. Whatever the deformity may be, the aim is to stretch the foot into the directly opposed position. The most common type is equinovarus and we will make our remarks for such a case. In the mild cases simple stretching several times a day may be sufficient. In more severe cases it is necessary to stretch the foot and maintain it in the over-corrected position. Plaster-of-Paris is preferable to adhesive plaster as it maintains the position better and is not so liable to cause skin injury. One must be careful to avoid a tight plaster and at the same time to have one that can not be kicked off. The plaster should be reapplied every week. At each reapplication the foot is stretched and further correction should be obtained. This is continued until the foot remains in the over-corrected position. Then the plaster may be omitted and the foot held in an over-corrected attitude with adhesive strapping and then manipulations. As the child begins to walk we may have the shoes altered, by raising the outer border for equinovarus, etc. The patient must be watched for a long time. If there is any sign of recurrence, treatment should be reinstituted.

In older or relapsed cases the same method may be tried but these and the most serious cases may need operation such as wrenching, fasciotomy, tenotomy, capsulotomy, wedge, astraglectomy, etc. Untreated cases in older children or adults are difficult and results can not be expected to be so good.

*Congenital Dislocation of the Hip*—Congenital dislocation of the hip may be diagnosed at birth but usually is not found until the child begins to walk. Then the parents notice that there is a limp and an exaggerated lumbar lordosis. I can not say what the result would be in cases diagnosed before walking as we do not see them but it is my belief that they could be very easily reduced and in many cases would stay in place without any plaster or other support.

In the usual case we start treatment when the baby is trained sufficiently to dispense with diapers for in the use of plaster it is essential that they should not be wet. The chances of reduction are very good from this time up to about seven years. After seven we can rarely reduce a dislocated hip without an open operation. In all cases, however, we can usually determine the outcome, for if the head of the femur is not too high and if there is a good acetabulum we may expect to get a cure.

The common variety of dislocation is the one in which the head of the femur is above and behind the acetabulum and the treatment outlined here is for this type of case. Other forms of dislocation require special treatment. Let us consider a case of the most frequent sort. I will not go into the details of the operation but will describe the treatment briefly. The child must be anesthetized sufficient for complete relaxation. The hamstrings, adductors and flexors are stretched and the hip manipulated into place. A plaster spica is then applied to hold the hip in place, thus usually being with the thigh rotated outward, abducted and hyper-extended into what is frequently called the "frog" position. The after treatment consists of maintaining the reduction with a change of plaster every six or eight weeks, each time bringing the thigh down a little toward the normal position. In the average case the treatment covers a period of about nine months.

If a hip can not be reduced in two or three attempts or if it can not be held in place after adequate reduction it is best to let it wait until the patient is a little older and then reduce it by an open operation. Such cases will usually show a shallow acetabulum or one filled with connective tissue or a so-called hour-glass constriction of the capsule.

I have endeavored to cover a lot of ground in a short time and have tried to outline the treatment of these congenital deformities in such a way that it would be of interest to all. I am of the opinion that we can all get a great deal more out of our County Medical Society meetings if we can take up subjects that will not be too special, and that can be discussed by all of the members.

## INFANT FEEDING

By RALPH SHELDON, M D

LYONS N Y

I HAVE been asked to read a paper on infant feeding, the time allotted me being twenty minutes. No living person can write any kind of a paper on infant feeding and only be allowed twenty minutes. It is a subject which covers a lifetime of a physician, and at the end of that time there is much for him to learn.

I am not giving you gentlemen anything new in the line of infant feeding but rather to point out possibly where many of us fail in the caring for our babies. The fault of most physicians in the care and treatment of infants, especially those in the rural districts, is that they do not spend enough time in obtaining the history of their case and thoroughly looking over their patient. They are not careful enough in writing out formulas for mothers to follow, but simply give directions and leave it to the mother's memory to prepare. Thus in a few days the patient is brought back reporting "no improvement."

To me the greatest measure of success in feeding bottle-fed infants, one must pay attention not only to the minutest details of the infant's life but also to the most careful carrying out of all directions in connection with it. You frequently hear the complaint that mothers will not follow the directions. I believe when this is so, quite frequently the trouble lies with the physician. It is an art to take a good history and when one does take a complete history he is familiar with all of the details of feeding and thus inspires confidence.

It is almost impossible to get a correct idea of symptoms and existing conditions from the voluntary information of any mother, and it is left to the physician to tactfully obtain from her the information necessary for successful treatment of his case. It is quite necessary to ascertain the number of children born to the mother, how many living and if any died in infancy to ascertain cause of death, for oftentimes those dying during the bottle period has a direct bearing upon the prognosis of the individual case.

Then comes the question of how long the infant has been breast fed and with what success, for oftentimes a breast fed baby is not obtaining the proper nourishment and is becoming a weakling.

If a bottle baby, a knowledge of the composition of the food used is of the utmost importance in prescribing a new food for an infant.

If food containing cow's milk has been given it is very necessary to guard against giving too large an amount of it and against too rapidly

increasing the same. The same is also true in the use of sugar.

To get the information relating to previous foods it is generally necessary to ask many questions. To the first question asked, What are you feeding the baby? The answer will be usually cow's milk, barley gruel or some proprietary food. It is advisable in such instances to ask, Tell me just how you make this food? It is an exceptional mother who will explain in detail the making of the food and the exact amount of each ingredient used.

After having ascertained the kind of food being taken the next step is to find out the quantity given at each feeding and the interval at which the infant is being fed.

There is a great diversity of opinion as to the intervals of feeding, but I believe that the better men have come to the idea that a three hour feeding with one feeding at night is the best for the infant, although under some conditions a two hour feeding is necessary.

One should be very particular as to the inquiry regarding the condition of the bowels and whether the baby is vomiting. It is oftentimes very hard to obtain this information, as invariably the mother will say, "The bowels are all right and that the baby vomits." That may mean that the baby has only vomited once during the day which is not of any particular moment and bowels moved but once.

One should ascertain and be particular as to the amount of sleep which the child obtains, both during day and night. Also as to whether the child is gaining. The latter is of great importance as it notifies the physician as to the health of the child. The normal infant usually doubles its weight in six months, and trebles it in one year. The loss of weight of an infant after birth should be regained by the end of the second week, and the gain from then on up to six months of age should be from four to six ounces a week.

Do not neglect taking temperature. Oftentimes you are told that the baby feels warm. I have known physicians to dispute the mother simply by placing their hands on the head of the child. No one can tell whether a child has fever or not in that manner.

The examination of the abdomen is of great importance. Invariably infants who have been improperly fed come to you with a marked abdominal distension, and one of the first indications of the improvement of the child under the proper dietetic treatment is a decrease in the distension. A sunken abdomen is usually an in-

dication of a severe or prolonged diarrhoea or a long period of under feeding

When it comes to the proper food for the feeding of a baby, one is oftentimes in a quandary what to do, for there is one set of men who believe, and all of them headliners in their specialty believe, in feeding only modified cow's milk. Another, equally distinctive, are believers in the feeding of unsweetened evaporated milk, and then there is the new set just coming into prominence who believe that is nothing better or quite so good as the feeding of lactic acid milk, or lobbered milk.

Whatever form of feeding you prescribe it must contain three main points. First, it should contain the proper elements to maintain nutrition and to allow growth. Secondly, it should be digestible, and third, it should contain the proper quantity of food, which is best estimated by caloric standards.

The ideal bottle food would be the one that imitates breast milk and would therefore contain three to four per cent of fat, six to seven per cent of sugar and one to two per cent of protein. Such a food when made of cow's milk is not well borne except by infants with the strongest digestive capacity, and therefore it is not practicable to feed these mixtures to difficult feeding cases, and these are the kind of cases that a physician is usually called upon to treat. The reason is obvious. The fat, sugar and protein of cow's milk are of a different kind than those of breast milk.

Since cow's milk contains over three per cent protein and breast milk has only one per cent or two per cent, this element of the food can be made to closely approach breast milk as far as the percentages are concerned, by diluting the milk one-third or one-half. One-third milk will give one per cent protein. One-half milk will give one and a half per cent protein. Cow's milk diluted three times contains only one and a third per cent of sugar, in the form of lactose and when diluted half it contains only two per cent, thus it is necessary to add sugar to bottle feedings in order to bring the sugar content of the food up to that of breast milk. The sugars most often used are cane sugar, milk sugar and malt sugar in the form of maltose and dextrin.

It has been the custom for many years to overcome the acid of the stomach to add an alkali, and the alkali was usually lime water used one ounce to twenty parts of food. Lime water in this proportion will have absolutely no effect upon the acids of the gastric juice, and most pediatricians nowadays use either sodium bicarbonate or sodium citrate or potassium carbonate, two grains to every ounce of milk.

Sugar is the most frequent source of indi-

gestion of any of the elements. It is usually a laxative, though it has not been settled which of the three sugars (cane sugar, milk sugar or malt sugar) is the most laxative. I would advise the use of cane sugar for older infants and those with no intestinal or gastric indigestion. Malt sugar for infants having much intestinal trouble. Milk sugar not at all. Malt soup extracts and wheat flour in those cases that do not do well upon any other kind of sugar. No sugar whatever (temporarily) in infants with diarrhoea or severe vomiting. What is the quantity of sugar that an infant should take within twenty-four hours? A well infant under ten pounds in weight should receive one ounce of sugar in twenty-four hours. A well infant over ten pounds in weight may have one and a half ounces of sugar in twenty-four hours.

This gives in the mixture six or seven per cent of sugar, the same as in breast milk.

The proper quantity of food which supplies the caloric need depends upon the age and condition of the child.

Food may be compared with fuel in a furnace. A furnace requires so many tons of coal to run the engine. An individual infant needs a certain amount of food to use up in heat, energy and growth, and an ounce of milk or an ounce of sugar represents a definite number of calories, the term used to express food value. One ounce of milk equals twenty calories. An ounce of sugar represents one hundred and twenty calories. Babies do not all require the same number of calories. Fat infants over four months of age need forty to forty-five calories per pound per day. The average infant under four months of age and who are moderately thin babies need fifty to fifty-five calories per pound per day. Emaciated babies need sixty to sixty-five calories per pound per day.

As an example—an average infant three months of age weighing twelve pounds, needs fifty calories per pound. Twelve times fifty equals six hundred caloric requirements in twenty-four hours.

The best method of complementing the breast with artificial feeding is to give five or ten minutes feeding from the breast, then complete each feeding with the bottle, using one-third milk and two-thirds water to start with, gradually increasing to one-half milk and one-half water, and if the bowels are constipated add one quarter ounce of sugar in a twenty-four hour mixture, increasing this amount as the weight and condition of the bowels seem to warrant.

From the foregoing it is easy to see that an infant requires a definite number of ounces of milk every day for each pound of weight to

which is added one or one and a half ounces of sugar

A rough rule for estimating the quantity of cow's milk that an infant needs is as follows. The average infant having no digestive disturbances requires in twenty-four hours twice as many ounces of milk as it weighs in pounds provided it can take care of one or one and a half ounces of sugar. Fat, well nourished infants, older than four months, need less than this, while emaciated infants often need much more.

A sour odor of a stool is due to fermentation of the carbohydrates within the intestinal canal. This does not necessarily mean that sugar is being given in too great an excess nor that it is the entire cause of the diarrhoea. The fat may be the original cause of the indigestion and the sugar fermentation a later development. A foul, putrefactive odor like that of decayed meat indicates a putrefactive diarrhoea. The reaction of a stool is of very little importance, except in cases of diarrhoea or in infants who have recently recovered from diarrhoea.

Simple intestinal indigestion is caused by feeding mixtures containing more fat, sugar, protoid or starch than the individual infant is capable of digesting, or by feeding these elements in a form that cannot be digested by the infant.

Indigestion caused by fat is due to the use of top milk or cream. Sugar indigestion is caused by giving an excess of sugar. Gruels are undoubtedly a contributing factor in the cause of diarrhoea in very young infants when given in milk and sugar mixtures.

As to the feeding of dry milk. It is only of value or useful in cases of sickly infants who, while unable to digest milk in other forms, yet oftentimes take dry milk readily and make good progress. The dry milk which has no sugar or any other ingredients is the one best adapted to these cases, especially so where vomiting has been persistent.

The best of the dry milks is Laracen and Caasec.

The remainder of my paper will be devoted to the diarrhoeas of infancy which is oftentimes most obstinate and trying to the physician. The great majority of all diarrhoeas in infancy are the result of one of two things, either the taking of too much sugar or too much fat. I believe it is unwise to treat all cases of diarrhoea by first giving a cathartic. The treatment is usually entirely dietetic. Drugs are of minor importance and even when they are employed a proper feeding must still be instituted. There are usually three different methods of treating diarrhoea and each has its own indications.

The first is giving a protein diet. Stop all sugar, usually feed one-third milk and two-thirds water. The water and milk should be boiled and under this heading cathartics should be avoided. In this type of diarrhoea we get what is known as fermentation. Do not simply reduce the sugar but stop it entirely. You will get diarrhoea in this form as well from under feeding as over feeding. In this type of case barley gruel does not usually act as well as plain water. The boiling of milk and water together, formerly it was believed, was more difficult to digest than raw milk. This is not a fact for it has been proved most conclusively that if properly boiled no tough curds or hard curds form in the stomach and is most easily digested. To properly boil water and milk one should take the proper amount of water, bring it to a boil, then add the milk, stirring constantly until it has boiled three minutes. Then taken from the fire and cooled at once.

The second method of treating diarrhoea is a carbohydrate method. Here we use barley gruel made without milk, thick gruels of various kinds such as corn starch, arrowroot, fed with a spoon. Also gruels cooked with part fat-free milk.

For small infants under four months of age the barley gruel should be made weak. One level tablespoon usually to a quart of water. For the average infants over four months old two to three level tablespoons to the quart of water may be used. Usually in these cases the barley flour is the best to use. Pearl barley, such as Robinson's Pearl Barley, can be used, but it requires three to four hours' cooking instead of the twenty minutes for the flour.

The third method of treating diarrhoea is where we have the mild types of infectious diarrhoea, dysentery, cholera infantum, sugar intoxication and mechanical diarrhoea. In these types of conditions a cathartic should be used, castor oil probably being the best, followed by from twelve to twenty-four hours of starvation, with only water to be taken. After this starvation period a gruel or starch diet should follow.

The differential diagnosis of fermentative and putrefactive diarrhoea is oftentimes difficult. However, it is easy to distinguish either of the two from simple indigestion by the fact that a low grade of temperature usually ranging from ninety-nine to one hundred two degrees F, is present in the fermentative and putrefactive type. The onset of fermentative diarrhoea is more sudden than that of simple intestinal indigestion. The stools of intestinal indigestion have no abnormal odor, while those of the fermentative or putrefactive are either



sour or foul smelling, but in fermentative diarrhoeas we usually meet the foamy stool

Cholera infantum is of a more serious type and probably should come under the head of diarrhoea as no separate classification of bacteria has ever been discovered as its direct cause. Here we have a very rapid depletion of the patient due to diarrhoea and vomiting. Cathartics are of little use, as they are immediately vomited. The washing of bowels by high irrigation should be done. The fluids must be supplied by intravenous or subcuta-

neous injections of saline solution. Give as much as one pint in twenty-four hours. Hypodermic injections of 1-300 of strychnine to 1-50 every four hours. The fever reduced by friction baths and cold applications. Quite often we meet with acidosis accompanying intestinal intoxication, constipation in bottle fed babies, the vomiting of bottle fed babies, the complications of breast fed babies, all of which must be and are met with but time prevents going into same, into their care and treatment of them.

## FRACTURES OF THE UPPER END OF THE HUMERUS\*

By JAMES N WORCESTER, M D,

NEW YORK CITY

THIS subject has been chosen because it has in the past presented a problem particularly of interest from the economical and functional side of the treatment of fractures. The disabilities following fractures or even simple contusions in this region have been out of all proportion to the anatomical changes demonstrable by the present methods of diagnosis in a large percentage of cases. When real anatomical difficulties are added, such as gross malposition of fragments, the problem is still greater.

The shoulder joint is a very complex mechanical problem. It offers in its normal state an extreme range of motion, every one of which motions is of great value in the ordinary pursuits of daily life. When any one of these is limited the disability occasioned seems to incapacitate the individual more than a similar degree of limitation in other joints.

The lines of fracture commonly met with fall into the following groups:

1 Anatomical neck. In my experience, not at all common. The head of the humerus severed from any muscular control may assume any position even turning completely around.

2 Epiphyseal separation.—The same factors are present as in the preceding fractures.

3 Surgical neck.—In this fracture the upper fragment is controlled by the predominating muscles attached to the greater tuberosity and if completely separated from the shaft assumes the position of external rotation and abduction. The lower fragment, under the muscular control of the pectoralis major, is adducted and internally rotated. Any degree of deformity may exist, varying from the so-called "impacted fracture" in which there is no apparent rotary displacement, to that in which the upper

end of the lower fragment is displaced markedly inward and the shaft of necessity rotated internally. However, a careful study of the so-called "impacted fracture" of the surgical neck of the humerus will reveal the fact that stereoscopic X-ray plates show that the head of the humerus is most often in a position of external rotation while the shaft is in internal rotation, for the first X-ray pictures of shoulder fractures are practically always taken for diagnostic purposes with the arm in an adducted and internally rotated position. Union with this altered rotary deformity explains the very common limitation of external rotation. In other words this means that any impaction which occurs is a result of continuance of the trauma after the fracture has been caused and that a rotary deformity is present.

4 External tuberosity.—This may be associated with a fracture of the surgical neck or an independent lesion. In either condition the external rotators of the shoulder control this fragment, and this of necessity is pulled outward.

5 Fracture associated with dislocation. Any of the above fractures may be complicated by dislocation of the head of the humerus.

It is obviously impossible to deal in a paper of this scope with all of the complications concerned in fractures about the shoulder joint. The one object is to attempt to bring the complicated cases into the anatomical possibility of being treated on the same principles as the uncomplicated cases.

This comes down to one common principal. The fractured surfaces of the two fragments must be brought into contact. In the fractures of the anatomical neck and epiphyseal separations, if the lower controllable fragment cannot be put in a position which brings about this result, operative treatment is indicated.

\*Read at the Annual Meeting of the Medical Society of the State of New York at Rochester April 22 1924

with a suture of the fragments to maintain the contact in the proper position. The same is true of the fractures complicated by dislocation of the head of the humerus.

Of the fractures of the upper end of the humerus those having the line of fracture passing through the surgical neck either involving the separation of the greater tuberosity or not, are by far the most frequent. The other complicated fractures having been brought into a condition where the same mechanical problems exist can be treated on the same basis.

The routine treatment as originally proposed by Dr. Joseph A. Blake, in 1916, is based on the following principles:

1. That in the fractures of the surgical neck the upper fragment is almost invariably externally rotated and abducted. This fragment is uncontrollable and the lower fragment must be brought into the same line of rotation and axial deviation.

2. That when a fracture of the greater tuberosity is present this fragment must be externally displaced. If it heals in this position the power exerted by the short external rotators must of necessity be very limited. Therefore, the lower controllable fragment must be brought into external rotation.

These two factors explain the disability present in almost all of the fractures about the shoulder joint treated by methods, which do

not take into consideration the position during treatment, of abduction and external rotation. It has been found that this disability is the one which requires the long period of after treatment. When this position is maintained from the start, it has been my experience, that the natural gravity of the arm furnishes the mechanical forces necessary for the return of the other motions, i.e., internal rotation and adduction.

The maintenance of the position of external rotation and adduction can be maintained by two methods:

1. Immobilization, by plaster. This presupposes the fact that apposition of the fractured surfaces can be accomplished by traction and manipulation. The advantage of this treatment lies only in the maintenance of a proper primary position and possibility of a certain amount of ambulatory freedom. The disadvantages of this so-called immobilization treatment are, that very few people would care to follow their ordinary pursuits with the heavy plaster encircling their chest and with their arm in the required position. Massage, physiotherapy, active motions of the other joints are impossible. A prolonged after treatment to restore the muscular power is still necessary, and in my experience the total period of disability is prolonged over the second method proposed.

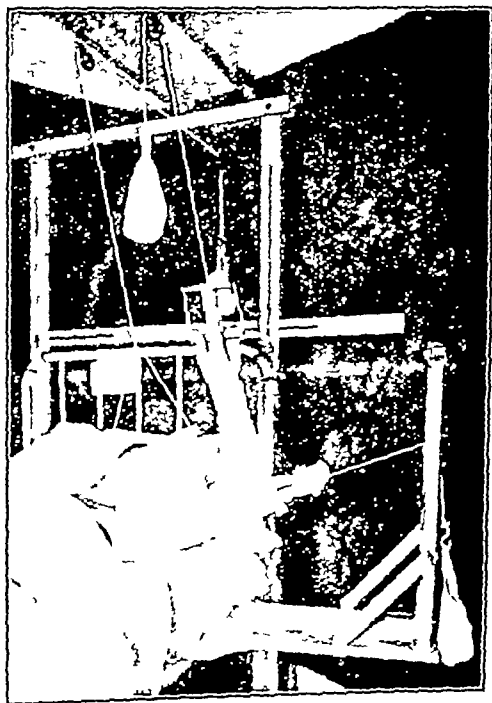


FIG. 1 Traction and suspension by Hennequin Band.

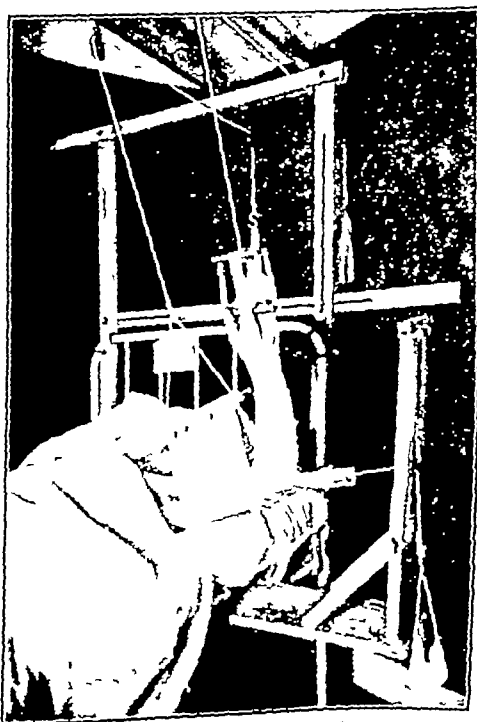


FIG. 2 Traction and suspension by means of adhesive plaster



FIG 3 Showing application of Hennequin Band for traction

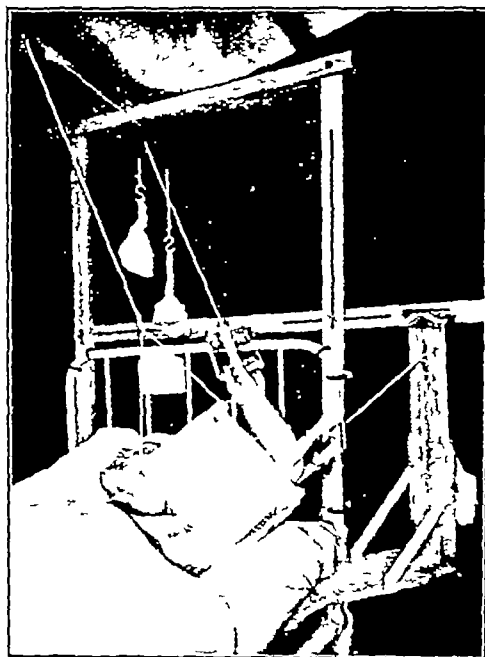


FIG 4 Illustrating traction and suspension with arm in extreme abduction and external rotation.

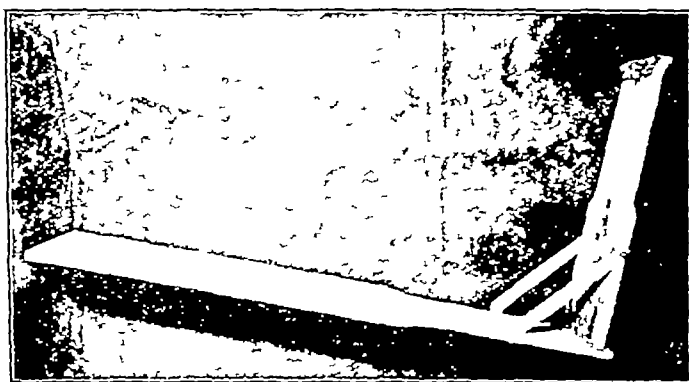


FIG. 5 Convenient apparatus for obtaining traction

2 Treatment by the traction and suspension method. The theory of this has been so fully described and its application can be so much better explained by illustration that these two factors will be passed over very briefly and a summary of the results obtained and advantages from a functional and economic standpoint emphasized.

The method necessitates a confinement to bed of twenty-eight days. The apparatus necessary is not extensive and should be at the disposal of anybody treating fractures, and especially available in any hospital. A sense

of the mechanical problems involved is much more important than fancy apparatus.

From the theoretical standpoint the one main consideration is that of bringing the lower controllable fragment into line with the upper uncontrollable one, by traction in the proper line, and at the same time keeping it in the same position of rotation. This necessitates, of course, a portable X-ray apparatus, to check up on these factors. When this reduction has been accomplished, as is usual in the first 48 hours in fresh fractures, not involving the complications mentioned in the first part of this paper it is possible to institute early mo-

with a suture of the fragments to maintain the contact in the proper position. The same is true of the fractures complicated by dislocation of the head of the humerus.

Of the fractures of the upper end of the humerus those having the line of fracture passing through the surgical neck either involving the separation of the greater tuberosity or not, are by far the most frequent. The other complicated fractures having been brought into a condition where the same mechanical problems exist can be treated on the same basis.

The routine treatment as originally proposed by Dr. Joseph A. Blake, in 1916, is based on the following principles:

1 That in the fractures of the surgical neck the upper fragment is almost invariably externally rotated and abducted. This fragment is uncontrollable and the lower fragment must be brought into the same line of rotation and axial deviation.

2 That when a fracture of the greater tuberosity is present this fragment must be externally displaced. If it heals in this position the power exerted by the short external rotators must of necessity be very limited. Therefore, the lower controllable fragment must be brought into external rotation.

These two factors explain the disability present in almost all of the fractures about the shoulder joint treated by methods, which do

not take into consideration the position during treatment, of abduction and external rotation. It has been found that this disability is the one which requires the long period of after treatment. When this position is maintained from the start, it has been my experience, that the natural gravity of the arm furnishes the mechanical forces necessary for the return of the other motions, i.e., internal rotation and adduction.

The maintenance of the position of external rotation and adduction can be maintained by two methods:

1 Immobilization, by plaster. This presupposes the fact that apposition of the fractured surfaces can be accomplished by traction and manipulation. The advantage of this treatment lies only in the maintenance of a proper primary position and possibility of a certain amount of ambulatory freedom. The disadvantages of this so-called immobilization treatment are, that very few people would care to follow their ordinary pursuits with the heavy plaster encircling their chest and with their arm in the required position. Massage, physiotherapy, active motions of the other joints are impossible. A prolonged after treatment to restore the muscular power is still necessary, and in my experience the total period of disability is prolonged over the second method proposed.



FIG 1 Traction and suspension by Hennequin Band.

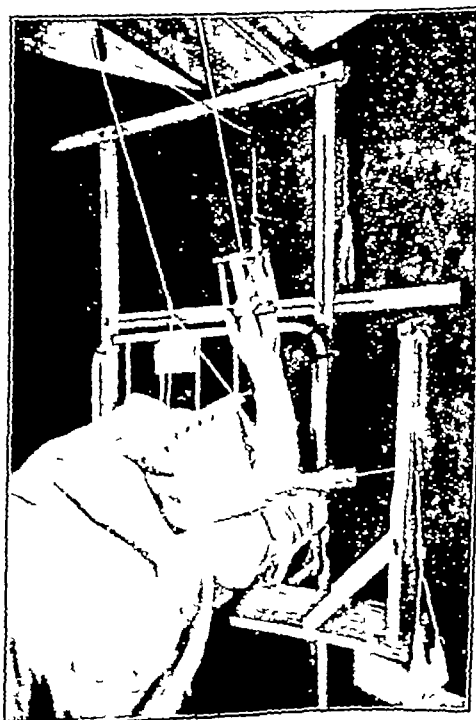


FIG 2. Traction and suspension by means of adhesive plaster

# EDITORIALS

The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

**Editor-in-Chief**—NATHAN B VAN ETEN, M.D.,  
New York  
**Associate Editor**—ORRIN SAGE WIGHTMAN, M.D.,  
New York  
**Executive Editor**—FRANK OVERTON, M.D.  
Patchogue

### COMMITTEE ON PUBLICATION

E. ELIOT HARRIS, M.D., *Chairman* . . . New York  
ORRIN SAGE WIGHTMAN, M.D. . . . New York  
EDWARD LIVINGSTON HUNT, M.D. . . . New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

**President**—OWEN E. JONES, M.D.  
Rochester  
**First Vice-President**—GEORGE A. LEITCHER, M.D.  
Piermont  
**Second Vice-President**—LUZERN COVILLE, M.D.  
Ithaca  
**Speaker**—E. ELIOT HARRIS, M.D.  
New York  
**Vice-Speaker**—GEORGE M. FISHER, M.D.  
Utica  
**Secretary**—EDWARD LIVINGSTON HUNT, M.D.  
New York  
**Assistant Secretary**—WILBUR WARD, M.D.  
New York  
**Treasurer**—CHARLES GORDON HAYD, M.D.  
New York

### CHAIRMAN, STANDING COMMITTEES

**Arrangements**—FREDERICK H. FLAHERTY, M.D.  
Syracuse  
**Public Health and Medical Education**  
JOSHUA M. VAN COTT, M.D., Brooklyn  
**Scientific Work**—ANDREW MACFARLANE, M.D.  
Albany  
**Medical Economics**—HENRY LYLE WINTER, M.D.  
Cornwall  
**Legislation**—JAMES N VANDER VEER, M.D.  
Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex-President and the Controllers of the District Branches.

**First District**—EDWARD C. RUSHMORE, M.D.  
Tuxedo Park  
**Second District**—FRANK H LASHER, M.D.  
Brooklyn  
**Third District**—ARTHUR J BEDDLE, M.D.  
Albany  
**Fourth District**—CHARLES C TREMBLEY, M.D.  
Saratoga Lake  
**Fifth District**—NELSON O BROOKS, M.D.  
Oneida  
**Sixth District**—GEORGE H FOX, M.D.  
Binghamton  
**Seventh District**—WILLIAM I. DEAN, M.D.  
Rochester  
**Eighth District**—HARRY R. TRICK, M.D.  
Buffalo

### COUNSEL

GEORGE W. WHITEHEAD, Esq., 27 William St.  
Telephone, Broad 1744  
New York

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St.  
New York

### EXECUTIVE OFFICER

JOSEPH S. LAWRENCE, M.D.  
51 Chapel Street, Albany

### SECTION OFFICERS

**Medicine**  
**Chairman**—ROBERT L. LEVY, M.D.  
New York  
**Secretary**—L. WHITTINGTON GORHAM, M.D.  
Albany  
**Surgery**  
**Chairman**—MARSHALL CLINTON, M.D.  
Buffalo  
**Secretary**—EDWARD S. VAN DYKE, M.D.  
Syracuse  
**Obstetrics and Gynecology**  
**Chairman**—HAROLD C. BAILEY, M.D.  
New York  
**Secretary**—NATHAN P. SEARS, M.D.  
Syracuse  
**Pediatrics**  
**Chairman**—JOSEPH C. PALMER, M.D.  
Syracuse  
**Vice-Chairman**—ROGER H. DENNETT, M.D.  
New York  
**Secretary**—ARTHUR W. BENSON, M.D.  
Troy  
**Eye, Ear, Nose and Throat**  
**Chairman**—ARTHUR G. BENNETT, M.D.  
Buffalo  
**Secretary**—EUGENE E. HIRMAN, M.D.  
Albany  
**Public Health, Hygiene and Sanitation**  
**Chairman**—PAUL B. BROOKS, M.D.  
Albany  
**Secretary**—ARTHUR D. JACQUES, M.D.  
Lynbrook  
**Neurology and Psychiatry**  
**Chairman**—EUGENE N. BOUDREAU, M.D.  
Syracuse  
**Secretary**—CLARENCE O. CHERRY, M.D.  
Utica

For a list of the officers of the county medical societies, see this issue, advertising page v

## OUR PRESIDENT

What is the ideal that you think the President of the Medical Society of the State of New York should be?

Each of us sees another through our own eyes, and interprets his character and peculiarities in terms of our own. The editorial "We" passes an editor's judgment on the President and compares the work of the presidential office with that of the editor's sanctum.

It is our editorial duty to make ourselves familiar with the inner workings of the State and County Medical Societies, but our duty is done when we have recorded conditions and expressed our opinion of them. The President must get more information than will be revealed to

us, and in addition he must take another big step and secure action based on that information.

We are expected to discern the signs of the times, and know what other medical societies and health organizations are doing, in order to judge their adaptability to our own societies. If we make a fanciful suggestion, no particular notice is taken of it, but let the President make a miscalculation and gravely put forth an impractical suggestion, and then see what the doctors say about him! The President is denied the editor's prerogative of license in speech, and must weigh his silver words against a standard of golden silence.

Publication days come round to us with a

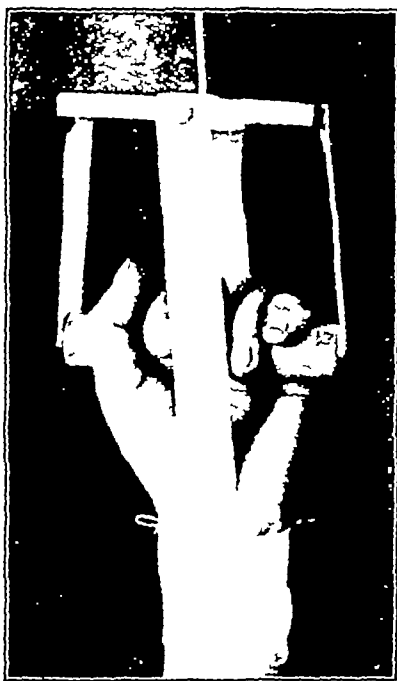


FIG 6 Hand Rest. Strips connecting round bar with spreader are made of elastic.

tion in the shoulder joint, as well as in the elbow joint. The application of heat and light massage may be started very early and the atrophy of the deltoid, produced by the stretching of this muscle in the treatment of fractures of this region in an adducted position, is avoided.

Union is, as a rule, present much earlier than in any other form of treatment. Twenty-eight days has through experience, been almost arbitrarily set for the removal from the apparatus.

At this date the shoulder presents in most cases a complete range of passive motion. Active motion is limited only at this period by a moderate amount of muscular weakness, and is quickly regained by systematic exercises.

The result has been that in cooperative patients the return to their previous occupations have been uninterrupted by a long course of treatment. The ordinary pursuit of their work unless it is of the heaviest type is an advantage.

The routine treatment of the uncomplicated cases has been as follows:

- 1 A careful X-ray study, insisting on stereoscopic plates.

- 2 The application of traction and suspension in a position of external rotation and abduction, the degree of both of these depending on the mechanical problem involved. The traction used is usually eight pounds and is applied through adhesive straps placed on both sides of the arm with the elbow flexed at right angles and the forearm suspended also by adhesive straps. The arm above the elbow is supported by a sling, balanced by weights as is also the forearm. This is modified in many ways as is shown in the slides to follow.

In the fresh cases the position of external rotation and abduction is assumed as soon as possible. In the cases over 48 hours old, it is often inadvisable to attempt this and the position desired must be reached by more gradual means. In the cases in which the lower fragment is displaced inward, it is frequently necessary by traction to pull this fragment down before the position of abduction can be reached. The ultimate aim in all cases is, however, to reach a position of abduction and external rotation as soon as possible. This is maintained through the whole treatment.

Active motion is encouraged from the start. This has in no case interfered with union, but has, on the other hand, seemed to hasten it.

The after results have been almost without exception good, even when anatomically perfect alignment has not been secured. The maintenance from the start of the position which gives the shoulder joint its maximum range of usefulness, and which when lacking, gives it its greatest disability, seems to be the object sought for, and the traction and suspension treatment accomplishes this.

## MONEY RAISING

We recently ran across an advertisement in a health journal in which a firm offers to raise money for hospitals by correspondence "at less cost than by any other means." We know that the firm can do what it says it can do. It has found that a certain number of form letters, sent to a certain selected list of business men in a town, and followed up by a certain number of reminding letters, will produce a certain amount of money. You turn the crank of the machine and the system does the rest. The organization is entirely impersonal, and is run by strangers. Lists of business firms, tax books, church rolls, every list that is readily available are used. Many mistakes and duplications are made, many good givers are overlooked and many are dunned twice and three times. The final result looks good, and the hospital managers are relieved of an immense amount of personal work and worry.

Now let us look on the opposite side of the picture. These canvassers are like strange revivalists who turn a town upside down for a week or two and then leave all the unstable converts on the hands of the local pastors and church officers.

A local hospital depends on the good will and support of all the people in a town. It is not

sufficient that "business" methods are followed and enough money raised to pay running expenses. A store can prosper if only twenty-five per cent of the people of a town patronize it. A politician will prosper if only fifty-one per cent of the voters support him. The business man and the politician can ignore the minority. But a small hospital prospers only as practically all the people take an interest in it.

Each of us gets out of a thing just what we put in it, and very little more. Hospital managers may hire strangers to canvass a town in an impersonal way, but the personal touch is what counts for real success. If the managers do not work for a hospital, neither will the people.

There is a system by which a firm will supply an expert or two and the materials, and then the local people do the canvassing by personal solicitation. This method not only raises the money but it enables those interested in the hospital to make friends for the hospital and to explain its work.

We are impelled to write these thoughts by the observation of the workings of an impersonal canvass. We prefer the personal system.

F O

## FEET AND BACKS

Two of the most common conditions from which people seek relief are painful feet and backache. Doctors don't like to treat these conditions because they say "Folks will not do as they are told." Rest is usually advised, and it will nearly always relieve both painful feet and backache, but of course that is a prescription that most people will not take.

Rubbing and massage and manipulations and baking will usually relieve both conditions, but few doctors care to give the treatments, and so the patients go to chiropractors, who are quite likely to give them relief, at least temporarily. It is just these patients that bring credit to the quacks and discredit to the doctors who fail to treat them.

What are the conditions that cause foot pains? They are those which are associated with flat feet, fallen arches, muscular flabbiness, overweight, and other conditions which bring an unusually severe strain on the feet. Foot pain may be compared to an eye pain that is caused by strain of the eye muscles. It is present when the organs are used, and absent when they are rested.

There is nothing mysterious in foot pains. The parts can readily be seen, and their functions tested. Their treatment is standardized and any physician can readily learn both to diagnose and to treat the condition.

The tendency to painful feet can be recognized

at an early age. The report of the examinations of school children in New York City shows that from five to ten per cent of all children have serious foot conditions that vary from "wiggly" ankles, to complete flat foot. These children will suffer from painful feet when they do work which requires them to stand or walk.

The detection of these foot conditions in school children is easy. The treatment is equally simple and consists in exercises to strengthen the muscles that hold the arch of the foot tense and rigid.

When we consider the causes of backache, the condition is not so simple, although strains of ligaments and muscles are the usual causes. Orthopedists are now recognizing the fact that trouble with the sacroiliac joint is frequent, and when this trouble is present, chiropractic treatment aggravates the condition.

So long as little was definitely known regarding the cause and treatment of foot pain and backache, physicians were excusable in failing to take any deep interest in the cases, but now that orthopedists are able to relieve the conditions, it is time that general practitioners should take up their study, and give the patients the relief to which they are entitled. If physicians do not do this, are they practicing modern medicine? One of the best ways of dealing with chiropractors is that physicians give satisfaction to the cases that leave the doctors and go to chiropractors. And why do they leave the physicians? The patients

whirr and often find our mind as blank as the paper before us. But somehow, one word suggests a thought that calls for more words, and getting started seems to be our hardest task. And then we still have the comforting assurance that we will get another chance at expression when we read the proof.

Appointments come thick and fast to our President, and he is even denied the privilege of sitting on the back seat and enjoying the show. He must sit on the platform and look interested in the speaker while he wonders what possible thing he will be expected to say. But a proper shyness pleases an audience immensely, and a studied search for the appropriate word gives an impression of numberless others in the rich storehouse of the brain. It is not so much what the President says off-hand, as the impression that he is suppressing much more that he could say if he were less considerate of his audience.

The editor is constantly learning something new. He cannot live in the past or repeat him-

self, but accurate information is the meat and drink on which he thrives and grows. The President can neither bind himself to conventionalized ideas, nor shut his eyes to evolving conditions. He will be judged by the items of progress and growth which he has added to the life of the Society.

We, the editor, must do our full daily stint promptly, fearlessly, conscientiously, without undue timidity lest our hat may not be on straight. We get our ideas from others, but their clothes are ours.

The President has a huge array of daily tasks to perform, and many excellent advisors to give him new ideas, but action is his.

We started out to be impersonal and to compare the practical editor with the ideal president. We end by being personal and confessing that Dr. Owen E. Jones supplied the model and the inspiration on which we based our impersonal picture of the presidency. F O

## THE WEEKLY JOURNAL

This issue of the JOURNAL is the last of the weekly numbers that have been planned for the year 1925. We have printed fifteen weekly issues this year, while last year we issued twelve.

We will mail the May number on May 7th, one week earlier than usual on account of the annual meeting which will fill the following week. We will issue the succeeding numbers as near the middle of the month as possible.

We have had our ear to the ground in an honest effort to find out how the members like the JOURNAL. Almost the only criticism that we have heard was that the JOURNAL had too much legislative matter in it. Our reply is that the JOURNAL has been issued weekly in order to carry full information about legislation in Albany. We wish we did not have to put all the legislative news into a few issues, but we have to adapt our plans to those of lay legislators.

Some think we could compress and condense the legislative news. Yes, we could if we actually had a week to edit each issue. But here is the schedule which we follow. Friday noon, adjournment of the Legislature for the week. Saturday afternoon late, receive the official report of actions taken on all bills. Sunday, spend the day checking up the bills and the previous comments in the JOURNAL, dictating new comments and writing editorials,—all of which must be ready for mailing that evening. Monday, the account is received in the editorial office and prepared for the printer, a copy is sent to the printer. Tuesday,—some galley proof is received from the printer, and used in making up some of the pages of the week's JOURNAL. Wednesday the

morning is spent in the printer's office making up the pages of the JOURNAL, reading proof, and making indexes. About one o'clock the printer says "We positively must put the JOURNAL on the press at four o'clock, and there is no time for you to make any more changes." Thursday, we recall a lot of good things which we have failed to say as well as we might, and ruefully consider half an article which had been cut in two owing to lack of space. Friday noon, we receive the first copies off the press, and see our editorial mistakes glaring at us.

The point is that we have only one day in which to get out our legislative matter. So far as the department of legislation is concerned, we work as we would on a daily newspaper.

But don't let anyone get the idea that we are complaining. On the contrary we thoroughly enjoy the hurry and the rapid writing, and the sense of doing things. We like to try out ourselves and see what we can do. We find that we can write an editorial in the printer's office and have it back in type form in half an hour,—and that is as quick as it is done on a daily paper during rush hours, and then the final thrill comes when a medical friend tells us how that editorial showed careful thought and preparation.

We flatter ourselves that our weekly issues were better than those last year, and we are so egotistical as to feel that next year's will be still better. Possibly we may even try to do the impossible task of preparing a three-page legislative summary that shall contain every detail about every medical bill. F O





# LEGAL



By GEORGE W. WHITESIDE, Esq  
Counsel Medical Society of the State of New York

## PROTECTION AGAINST LAW SUITS

The past twenty years have worked great changes in the political, economic and social life of this country, during this time our capacity to assimilate vast hordes of European immigrants has been taxed to the breaking point. The strangers in our midst have come here seeking the land of opportunity and many of them have brought energies, traits and qualities which, when properly assimilated, will be of permanent value to the land of their adoption. But they have brought, also, standards and traditions, conceptions and points of view quite alien to our American teachings. In no part of the country is this more apparent than in the great city of New York, the counties of Long Island, Westchester and Rockland, which comprise what is known as the metropolitan district.

In this area are splendid hospitals, completely equipped and manned and rendering a scientific, diversified and conscientious service to mankind. No other section possesses a more conscientious, better trained, more generous or public-spirited class of professional men than those who practice medicine in this territory. Nevertheless, within the past four and one-half years in this metropolitan district, where but sixty-one per cent of the State Society's membership practices, there have been instituted five times as many malpractice suits as were brought in the remainder of the State. The damages claimed in actions now pending against doctors in this district aggregate the staggering total of upwards of two and one-half millions of dollars. Those who are engaged in the alleviation of pain and suffering, in the care of the injured and the sick, and whose time, whose skill and whose knowledge are so largely given gratuitously to that part of mankind which is unable to pay for the services received, find themselves engaged in what may be truly termed an extra hazardous profession.

Large numbers of suits are instituted in this district by patients who have been the recipients of charity, who do not speak English, and who are wholly unacquainted with the ways, standards and traditions of the country which they have sought as a refuge from the oppressions and injustices of Europe. Many of these cases are devoid of any merit whatever. Some of them are built up on testimony quite incapable of withstanding the scrutiny of a court of justice. Yet all of these assaults upon the good name of some doctor present hazards and risks fully understood and appreciated only by those doctors who have

been sued in malpractice suits. Quite often the case, wholly destitute of merit, presents the gravest cause of concern to the doctor and to your counsel who defends him. Sometimes these cases rest upon the faulty understanding of the English language by the plaintiff who has lately come to these shores or who, having been here a long time, has never learned to speak our language. Sometimes these cases are founded upon testimony largely fabricated by those who have failed to assimilate the standards of decency, fairness and good faith which underlie American institutions. In such cases the capacity of your counsel to unearth and expose either ignorance or fraud is the sole reliance of the honest medical man. Those for whom most has been done often become the most unreasonable critics.

In a case recently tried in New York City a woman had been the recipient for many weeks of the skill, care and attention of the doctors and nurses of one of the best equipped metropolitan hospitals. She was suffering from arthritis. After she had been treated for many weeks, had been the subject of the best possible attention, had had innumerable analyses made, had been the beneficiary of X-ray diagnosis, she contended that one of the doctors on the staff came into her room and by a forceful manipulation of her leg, dislocated her hip. Only through the weapon of cross-examination was it developed that the dislocation claimed did not occur until many months after the supposed manipulation of the defendant doctor, and that in the meantime her limb had been massaged and manipulated by a masseur. At the close of the plaintiff's case the judge dismissed the complaint. Yet this action consumed four days of the defendant-doctor's time and presented a serious risk and danger both to his good name and pocketbook.

In no section of the State are there more lawyers willing to take cases against doctors, in no section of the State are there more potential plaintiffs, in no section of the State are there more doctors of a certain type who are ready to express an opinion of condemnation upon mere slender and inadequate premises, than in this metropolitan district.

No medical man thoroughly appreciates the hazards of his profession until he has been sued. Your counsel has observed the psychology of countless doctors who have been forced for days at a time to drop their practice and to hear themselves presented in court as the villain of the

often say, "The doctor did not understand my case" Let the doctor take the time and trouble to understand those cases Let him take an interest in the prevention of the trouble by attention to school children, both in the school and in his office If doctors generally do this, they will retain a large percentage of the cases that now go to chiropractors

We believe that the subjects of painful feet and backache are neither too difficult for a general practitioner to understand nor too unimportant and impractical to be ignored We have asked an orthopedist to prepare a series of simple articles on these subjects to be published next summer or fall  
F O

## CHIROPRACTIC LITERATURE

The chiropractors are using wise tactics to promote their own interests They are capitalizing remarks that were made at the hearing before the Legislative Committees on Public Health on March 4th, and are frequently inserting letters in the daily press calling attention to alleged errors on the part of medical men Physicians should consider these arguments of the chiropractors in order to meet them effectively

The New York *Herald-Tribune* of March 25th, contains the following statement from Lyndon E Lee, President of the New York State Chiropractic Society

"We are deeply impressed by the statistics from the Massachusetts General Hospital, published by Dr Richard C Cabot, in which he says that medical diagnosis varies in error from 30 to 80 per cent in ordinary, every-day illnesses, and the general average of error is in excess of 50 per cent In the interest of public health and the efficiency of our practitioners we have no desire to employ methods as fallible as these

"The chiropractic schools teach a thorough course in chiropractic analysis, which is a system of arriving at the cause of disease and its character through a knowledge of the nerve centers

involved, as well as the general symptoms considered by the ordinary physician

"'Physician' feels deeply concerned for the public health if chiropractors are allowed to treat contagious diseases May we direct attention of this doctor to the fact that during the influenza epidemic of 1920 the Board of Health statistics show the death loss of the medical men to have been one in every 17 cases, while the chiropractor lost only one out of every 886

"The plea of 'Physician' that the state 'make chiropractors show their qualifications in the same way that physicians have shown theirs' is made somewhat ridiculous when it is remembered that at the public hearing on the chiropractic and medical bills at Albany this same argument was advanced by a medical advocate and was met instantly by an offer on the part of the chiropractors to submit at once to examination under the State Medical Board if the medical representatives would do likewise The argument ended abruptly with a flat refusal on the part of the learned medicos"

Think over these arguments, and prepare your answer You will run across some chiropractic admirer who will use these arguments Prepare yourself to meet them  
F O

## MEDICAL LANGUAGE

One of the duties of an editor is to edit The word edit carries a variety of concepts By the contributor it is often interpreted as a deliberate attempt on the part of the editor to change the meaning of his sentences—and that is our intention when the contributor says what he does not mean

Sometimes our editing seems to our contributors to be an attempt to embellish their plain statements with grammatical flourishes, and they are sometimes right We wish every contributor would recall that English grammar exists in order to render language clear

Sometimes our contributors accuse us of "stringing out" their thoughts Sometimes we

add a few unessential details or comments just to lend attractiveness to dry, dull, uninteresting statements

We try to make the notices of meetings interesting, and in order to do so, we frequently have to do a lot of editing—usually in the way of additions of interesting details

We sometimes write out a doctor's abbreviations, when we can, but now and then we run across a poser If our readers cannot tell what the abbreviation means, they ascribe the obscurity to the editor's poor proof reading, and we accept the charge rather than expose our ignorance When we receive an obscure, ungrammatical announcement, we accept the implied compliment that the editor can do anything  
F O



# State Department of Health



## ADULT DIES OF UNCOMPLICATED MEASLES

A supplementary report on a measles death recently received by the Division of Communicable Diseases stated that the patient, a young woman of 22, was in excellent health up to the time of her infection which was contracted from exposure to the case of her brother. According to this report, the rash appeared one day after the first symptoms and she died three days after the appearance of the rash. The temperature when first seen by the physician was 102, but diminished to 99  $\frac{4}{5}$  on the morning of the day she died. The physician stated that the patient did not complain of feeling bad in any

way except itching of the skin until the first symptoms subsided, and felt in good condition up to two hours before death. The physician arrived about 11 P. M. and found her in a comatose state—temperature 108, pulse 150, lungs clear, no complications except that the rash had taken on a hemorrhagic appearance, the patient died about twenty minutes after the physician arrived. A peculiar feature of the case was that the patient had expressed a dread of the disease during her brother's illness, although there was no apparent reason why she should not make a good recovery.

## ADULT PARALYZED FOLLOWING DIPHTHERIA

One of the District State Health Officers was recently called to see a patient, age 36, who is a Russian. This man gives a history of having had a sore throat about the tenth of January, at which time a physician treated him for tonsillitis. Two weeks later he called a second physician on account of paralysis of his arms and legs. The second physician took a culture of the throat, which was found to be positive for diphtheria. The patient was taken to a hospital and had been there up to the time the last report was made

to the Department. It was stated that he still has wrist drop of the right wrist and considerable paralysis of both arms and legs and is unable to be out of bed. On March 25, positive cultures were still being obtained.

An interesting point in this case is that the patient owns the house in which two children died from diphtheria in January and February. One of them died from diphtheritic paralysis. The man probably received his infection from this family.

## DEATH REPORTED FROM MUMPS

The death of a girl baby, eight months old, from mumps, was recently reported from Gouverneur. On March 21, this child was suddenly taken ill with fever and vomiting. The next morning the left parotid gland began to swell. In the evening the mother noticed that the swelling over the parotid was dusky in hue. The physician who called found the temperature 102, respiration 40, heart too fast to count. The legs were reported to be purple in places, but there was no cough or respiratory symptoms.

The District State Health Officer was called in consultation in this case two days later. At this time the temperature was 101, respiration 45, pulse imperceptible, heart action distinct and

regular, but so rapid that one could not attempt to estimate the rate. Pupils were normal, reflexes equal but slow, no stiffness of neck, face slightly flushed, skin over the parotid was purple, the color disappearing on pressure, both legs were dusky purple, which would disappear on rubbing, no purpuric eruption, throat negative, abdomen soft. The child died shortly afterwards.

The District State Health Officer feels that the reported cause of death, namely mumps, was the true one in this case, as the whole family had the same disease and none of them had influenza. He believes that the mumps infection may have been sufficiently virulent to set up a general septicemia.

## DEATH REPORTED FROM ACUTE EXACERBATION OF MASTOIDITIS DUE TO PARA-TYPHOID BACILLUS

The patient in this case was admitted to the Vassar Hospital, Poughkeepsie, with an acute ear condition, para-typhoid bacilli were found in the

discharge from the ear, blood showed a negative Widal and there was no history of para-typhoid fever. The patient was a man, age 38.

piece, watching with chagrin, amazement and concern the unfolding of their alleged shortcomings. The possession of insurance, under such circumstances, in addition to the knowledge that their rights will be safeguarded in court, is a source of assurance, confidence and consolation which only those who have been sued fully understand and appreciate.

Despite all this, the amazing fact remains that only forty-nine per cent of the doctors eligible for our group plan of insurance within the metropolitan district have availed themselves of its benefits. It is an amazing fact that 3,241 doctors

in this territory are not carriers of the group insurance protection. After the action has been begun it is too late to procure insurance covering that action. Many doctors who have neglected to obtain the benefits of the plan which the State Society has inaugurated for them, come to us after suit has been brought literally wringing their hands at their own neglect.

The question fairly arises for all doctors, both those with years of experience and those who are just embarking upon their professional career: Is it safe to practice medicine without being insured?

### CLAIMED INFECTION FROM RETAINED PLACENTA

It was charged that the defendant as a physician was engaged to attend the plaintiff in confinement, that he was careless and negligent and failed to use the proper care and skill in his attention to the plaintiff in that he permitted the placenta to remain within the plaintiff for a period of twenty-eight hours after the delivery of her child, and by reason of this fact the plaintiff claimed that the womb, ovaries, fallopian tubes and appendix of the plaintiff became inflamed and diseased and it was necessary that she submit to an operation for the removal of the tubes, ovaries and neck of the womb and appendix, that she was confined in a hospital for about a month and suffered permanent injury by the removal of the genital organs.

The defendant had been the family physician of the plaintiff and had attended her in a previous confinement. In the particular case he attended the plaintiff for about a month prior to her confinement, made urine examinations and gave her the necessary pre-natal care. She resided in a small village about five miles from the defendant's office and the birth occurred in the winter when the roads were rendered impassable by reason of a recent snowstorm. On the day of the birth he went to the plaintiff's home about noon and remained in attendance until after delivery about five P. M. The patient was extremely irritable, the labor being rather difficult, and the physician remained with her for about an hour after delivery and administered ergot. The proper attempts were made by the physician to express the placenta, but without success. Upon examination he found a little contraction at the end of the uterus. He then applied a pack soaked in a lysol solution and left instructions that he would return on the following morning, but to

telephone if anything occurred. About noon of the following day he returned to the patient's home and endeavored manually to express the placenta, again without success. After this attempt he administered ether and with a sterile glove removed the placenta by hand. For the next ten days the patient was seen by the defendant every second or third day and her condition gradually improved until about the tenth day, when she was up and about the house. At about the fourteenth day after the birth she visited the defendant at his office. During this time there was no complaint by the plaintiff. About seven months after this attendance upon the plaintiff by the defendant, he was called to her home, she at that time complaining of distress at the stomach. He prescribed for and treated the condition and made several visits to the plaintiff's home. Nothing further was heard from the patient until the institution of this action about a year and a half later.

It was ascertained that about twenty-two months after the defendant's last visit to the plaintiff, her appendix, tubes and ovaries were removed, due to an inflammatory condition. It was also ascertained that about a year after the delivery of the plaintiff by the defendant, she was delivered of another child and that the operation which plaintiff claimed was due to the alleged carelessness of the defendant in his care of her, was performed about ten months after the birth of this child.

The plaintiff's attorney strenuously sought to procure a settlement of the action, but when forced to trial abandoned the case and the suit resulted in a dismissal of the complaint in favor of the defendant.

of the hospital needs of the country as a guide in future planning and building

Suffolk County has a general hospital in each corner of the County, and a Tuberculosis Hospital near the geographic center. The hospitals are as follows

Name	Location	Number of Beds
South Side	Bay Shore	50
Southampton	Southampton	65
Eastern Long Island	Greenport	25
Huntington	Huntington	35
Tuberculosis Sanatorium	Holtsville	90
		<hr/> 265

The ratio of beds is about two and one-half for each one thousand of population

The Suffolk County Medical Society conducted a confidential study of the management of the four general hospitals, and made the information available to the officials of the hospitals. The studies and comparisons were of great value in improving the economy and efficiency of the hospitals. One hospital reduced its expenses twenty-five per cent as the result of observations of the methods used in the other hospitals

The four general hospitals of Suffolk County are open to practically all the physicians in the vicinity. Two hold regular monthly staff meetings, and conform to the standards of the American College of Surgeons, and the other two are approaching those standards

*Medical Societies*—The membership of the county medical societies on Long Island, and the percentage of physicians belonging to them, are shown by the following table

County Society	Number of Members	Percentage of Physicians
Kings	1,578	60
Queens	249	53
Nassau	154	70
*Suffolk	110	95

\*Exclusive of State Hospital staffs.

Every county medical society on Long Island is active, and is doing original work along some lines. The activities of the Kings County Medical Society are described on page 664 of our last week's issue

The methods of carrying on the work of the three other societies are governed largely by transportation facilities. The public transportation lines run east and west, for New York City is their principal objective. Travel east and west is easy while that of north and south has been difficult. However, the automobile now solves the transportation problem, and the result is that now the meetings are well attended. The meetings of the Queens and Nassau Societies are held in the evening, and a social supper is served

The physicians of Suffolk County meet and

dine together at noon, for distances are too great for an evening meeting

*Queens County Medical Society*—The Medical Society of the County of Queens is undergoing a rapid evolution and development in keeping with the growth of the County. It meets monthly, and the programs of its meetings are frequently on civic topics. The attendance at each meeting is about one hundred. It owns a lot with 200 feet frontage on the Boulevard in Forest Hill, in the center of the County, and is now raising a fund for the erection of a large building which shall be the medical center of Queens County. The building will be of a size sufficient to meet the future needs of the Society, but the rental of the present excess space will be sufficient to provide for maintenance and a sinking fund. It is planned to develop the County Society along the lines of the Kings County Society, and to unify all the medical organizations of the County in the County Society

*The Bulletin*—The Queens County Medical Society has recently established a monthly Bulletin of twelve pages which carries announcements of coming events, and descriptions of previous meetings, and news of medical activities in the County. It is also printing the Principles of Medical Ethics of the Medical Society of the State of New York—an excellent idea, for while physicians know there is a code, they can seldom quote it accurately

The Bulletin carries a few advertisements which are sufficient to pay the printer's bills

*Nassau County Society*—The Nassau County Medical Society holds eight monthly meetings and one social outing each year. The regular meetings are held in the center of the County, and begin with a social supper at about seven o'clock. The programs of the meetings are about equally divided between scientific and civic subjects. The Society has made intensive studies of the hospital needs of Nassau County, and of the management of the work of the Tuberculosis Committee. It has promoted all phases of tuberculosis work in the County, and is now planning a series of teaching clinics in pediatrics and other subjects as an extension of the graduate courses of the Medical Society of the County of Kings

*Suffolk County*—The Suffolk County Medical Society holds only two meetings a year, owing to the difficulties of travel. The County is 75 miles long and 20 wide, and its sections are separated by either broad arms of salt water or immense stretches of poorly roaded woodland. Yet the Society is one of the most active in the State. It has undergone an evolution along unusual lines which may be classi-



# MEDICAL SURVEY



## MEDICAL SURVEY, NUMBER 10—MEDICINE ON LONG ISLAND

**EDITOR'S NOTE** The subjects of Surveys Numbers 8 and 9 have been the two largest counties which compose Greater New York. We have shown that the differences in the Medical Societies of the Counties of New York and of Kings arise largely from the natural evolution of the two organizations. The medical profession of each county of Greater New York forms a natural unit that is surprisingly individual and distinct, but the Medical Society of the County of Kings has a direct and extensive influence on the medical organizations of the other counties of Long Island. The counties of Kings, Queens, Nassau, and Suffolk are therefore closely related medically, and a consideration of this relationship will form a part of this Survey.

The data for this Survey have been derived largely from the same sources as those for the Survey of Kings County. We are also indebted to Dr. Henry C. Courten, President of the Medical Society of the County of Queens, to Dr. Arthur D. Jaques, Secretary of the Medical Society of the County of Nassau, and to Dr. George H. Schenck, President of the Medical Society of the County of Suffolk.

Long Island is 110 miles long and 20 wide. It has an area of 1,373 square miles, and a population of 2,723,764 people, according to the census of 1920, but the five year increase makes the 1925 population over three millions.

The Island is divided into four counties whose population is an inverse ratio to their areas, as is shown by the following table:

County	Area Sq. Mile	Population 1920	Population 1925 Estimated
Kings	71	2,018,356	2,235,886
Queens	108	469,042	578,851
Nassau	274	126,120	175,000
Suffolk	920	110,246	125,000
Total	1,373	2,723,764	3,114,737

*Area and population of the four counties on Long Island*

The distribution of population on Long Island is the direct result of waves of emigration which start from the Metropolitan Center and spread in all directions with a speed which is governed by the facilities for rapid transit. Queens County is rapidly being built up as closely as Kings County. The fringe of dense population is now invading Nassau County, although the most of the County remains rural. Suffolk is entirely rural, half of its area is still unsettled, and the greater part of its population is collected in a fringe of villages along its southern coast line.

**Physicians**—The number of physicians on Long Island and their distribution by counties is indicated by the following table:

County	Number of Physicians	Ratio to Population
Kings	2,631	1 to 835
Queens	472	1 to 1,200
Nassau	154	1 to 1,100
*Suffolk	110	1 to 1,100

\*Exclusive of 37 on the staffs of two State Hospitals.

The physicians on Long Island are fairly evenly distributed according to population, and the average number of people served by each doctor is large as compared with the rest of the State. The population is rapidly increasing, and the doctors share the general prosperity of the Island.

**Hospitals**—Queens County has six hospitals, as follows:

Name	Location	Number of Beds
Flushing	Flushing	120
St. John's	Long Island City	200
Jamaica	Jamaica	140
St. Mary's	Jamaica	90
St. Joseph's	Far Rockaway	100
Queensboro Contagious	Jamaica	50
		<hr/> 700

The proportion of hospital beds in Queens County is slightly over one bed per thousand of population. This small ratio is due to the rapid growth of the County, and the nearness and availability of the hospitals of Brooklyn and Manhattan.

The hospitals are well organized and conform to the standards of the American College of Surgeons.

Nassau has four hospitals as follows:

Name	Location	Number of Beds
Nassau	Mineola	120
Mercy	Hempstead	20
Glen Cove	Glen Cove	30
Tuberculosis Sanatorium	Farmingdale	110
		<hr/> 280

Nassau County has about one and one-half hospital beds for every one thousand of population, but additions which are already planned will double the hospital capacity.

The Nassau Hospital is conducted after the manner of the Metropolitan hospitals. Two internes are employed, staff meetings are held, and the standards of the American College of Surgeons are observed. The Nassau County Medical Society conducted an extensive survey

of the hospital needs of the country as a guide in future planning and building

Suffolk County has a general hospital in each corner of the County, and a Tuberculosis Hospital near the geographic center. The hospitals are as follows

Name	Location	Number of Beds
South Side	Bay Shore	50
Southampton	Southampton	65
Eastern Long Island	Greenport	25
Huntington	Huntington	35
Tuberculosis Sanatorium	Holtsville	90
		<hr/> 265

The ratio of beds is about two and one-half for each one thousand of population

The Suffolk County Medical Society conducted a confidential study of the management of the four general hospitals, and made the information available to the officials of the hospitals. The studies and comparisons were of great value in improving the economy and efficiency of the hospitals. One hospital reduced its expenses twenty-five per cent as the result of observations of the methods used in the other hospitals

The four general hospitals of Suffolk County are open to practically all the physicians in the vicinity. Two hold regular monthly staff meetings, and conform to the standards of the American College of Surgeons, and the other two are approaching those standards

*Medical Societies*—The membership of the county medical societies on Long Island, and the percentage of physicians belonging to them, are shown by the following table

County Society	Number of Members	Percentage of Physicians
Kings	1,578	60
Queens	249	53
Nassau	154	70
*Suffolk	110	95

\*Exclusive of State Hospital staffs

Every county medical society on Long Island is active, and is doing original work along some lines. The activities of the Kings County Medical Society are described on page 664 of our last week's issue

The methods of carrying on the work of the three other societies are governed largely by transportation facilities. The public transportation lines run east and west, for New York City is their principal objective. Travel east and west is easy while that of north and south has been difficult. However, the automobile now solves the transportation problem, and the result is that now the meetings are well attended. The meetings of the Queens and Nassau Societies are held in the evening, and a social supper is served

The physicians of Suffolk County meet and

dine together at noon, for distances are too great for an evening meeting

*Queens County Medical Society*—The Medical Society of the County of Queens is undergoing a rapid evolution and development in keeping with the growth of the County. It meets monthly, and the programs of its meetings are frequently on civic topics. The attendance at each meeting is about one hundred. It owns a lot with 200 feet frontage on the Boulevard in Forest Hill, in the center of the County, and is now raising a fund for the erection of a large building which shall be the medical center of Queens County. The building will be of a size sufficient to meet the future needs of the Society, but the rental of the present excess space will be sufficient to provide for maintenance and a sinking fund. It is planned to develop the County Society along the lines of the Kings County Society, and to unify all the medical organizations of the County in the County Society

*The Bulletin*—The Queens County Medical Society has recently established a monthly Bulletin of twelve pages which carries announcements of coming events, and descriptions of previous meetings, and news of medical activities in the County. It is also printing the Principles of Medical Ethics of the Medical Society of the State of New York—an excellent idea, for while physicians know there is a code, they can seldom quote it accurately

The Bulletin carries a few advertisements which are sufficient to pay the printer's bills

*Nassau County Society*—The Nassau County Medical Society holds eight monthly meetings and one social outing each year. The regular meetings are held in the center of the County, and begin with a social supper at about seven o'clock. The programs of the meetings are about equally divided between scientific and civic subjects. The Society has made intensive studies of the hospital needs of Nassau County, and of the management of the work of the Tuberculosis Committee. It has promoted all phases of tuberculosis work in the County, and is now planning a series of teaching clinics in pediatrics and other subjects as an extension of the graduate courses of the Medical Society of the County of Kings

*Suffolk County*—The Suffolk County Medical Society holds only two meetings a year owing to the difficulties of travel. The County is 75 miles long and 20 wide, and its sections are separated by either broad arms of salt water or immense stretches of poorly roaded woodland. Yet the Society is one of the most active in the State. It has undergone an evolution along unusual lines which may be classi-

fied as 1, group societies, 2, the practice of civic medicine, 3, a periodical news letter, and 4, teaching clinics

Geographic peculiarities have caused the population of Suffolk County to be grouped in four distinct sections, each of which maintains a general hospital. The physicians in each section form a natural group which were brought together through a common interest in the hospital. Out of this association has grown four group medical societies which are practically branches of the County Medical Society. Some of the groups are better organized than others. The South Side Clinical Society is the oldest and best organized, and is composed of the group of physicians who live in the south west corner of the County, and are on the staff of the South Side Hospital in Bay Shore. It has thirty-five members and an average attendance of twenty-five at its monthly meetings. The program of each meeting begins with a social supper at 7 o'clock, which is followed by a scientific meeting.

Other group societies are centered about the hospitals in Southampton, Greenport, and Huntington.

The Suffolk County Medical Society has been active in the practice of civic medicine for many years. It originated and conducted a successful campaign which resulted in the establishment of a county tuberculosis hospital in 1916. It has continuously agitated the establishment of a general county hospital for chronic cases to be built as soon as the needs of the tuberculosis hospital are fully met. It has developed a practical system of field work in tuberculosis, and has been the means of unifying the methods of hospital management throughout the county.

*The News Letter*—The Suffolk County Medical Society publishes an eight-page News Letter each month. This publication is the natural development from small bulletins of information which were sent to the members at irregular intervals. Its object is to carry notices and descriptions of meetings, and to inform the members regarding medical matters throughout the County. Some of the articles are written with the object of having them quoted in the local press, and editors usually consider the contents of the News Letters to be good news for reproduction or comment.

About 300 copies of the News Letter are printed each month, at a cost of about \$250 annually. The publication is sent free to every member of the Society and to a large list of physicians and organizations outside of the County. About half of the dues of the Society are used in producing the News Letter, but the members unanimously desire its continuance.

*Teaching Clinics*—The Suffolk County Medical Society has sponsored a series of teaching clinics for physicians as an extension of the graduate education courses of the Medical Society of the County of Kings. A demonstration course in pediatrics is held weekly in the South Side Hospital at four o'clock on every Tuesday afternoon (See this Journal, April 3, 1925, page 587). Plans are being made to hold similar clinics in other hospitals.

*Tuberculosis*—The official anti-tuberculosis work in Queens County is under the Department of Health of Greater New York, and cases needing hospital care are sent to institutions supported by the Greater City. It also has an active citizens' committee.

Nassau and Suffolk Counties each have a County Sanatorium with about 100 beds. The superintendent of each sanatorium conducts diagnostic clinics and directs the activities of two field nurses. One special feature of the tuberculosis work in each county is that it is done with the cooperation and assistance of the physicians.

The field work of the discovery and visitation of cases is carried on as a medical problem in epidemiology in the same way that outbreaks of scarlet fever or typhoid fever are handled. New cases are sought among those in contact with previously known cases, with the result that the number of known cases per annual death is fully equal to the number discovered by the Framingham demonstration, which has been the best known standard for comparison. The cases are not merely discovered and listed, but the system of visitation and advice is efficient as is shown by the unusual fall in the death rate from tuberculosis.

*Health Departments*—The official public health work in the Counties of Kings and Queens is under the Department of Health of Greater New York City. That in both Nassau and Suffolk Counties is conducted by the local boards of health of its two cities, thirty-six villages, and thirteen townships. The character of the public health work done is as variable as the populations of the units. One village is credited by the 1920 census with a population of three, another with eleven, and another with seventy-one. On the other hand, the township of Hempstead contains 40,000 people, besides 40,000 more in its ten incorporated villages. In general the public health work in the larger units is very well done.

*The Associated Physicians of Long Island*—The physicians of all Long Island are closely associated together by an organization called the Associated Physicians of Long Island. This organization was formed on April 14th, 1898, eight years before the present organization of the Medical Society of the State of New York was perfected. When the Second District Branch of



the Medical Society of the State of New York was organized in 1906, its functions were already being well performed by the Associated Physicians. There has been harmony between the two bodies, the same leaders have been active in both, and still closer cooperation is planned for the future.

The Associated Physicians has a membership of about 1,000, drawn from all four counties on Long Island. About two thirds of the members live in Kings County and one-third in the other three counties. The annual dues are five dollars. Three meetings are held each year—an annual meeting in January in Brooklyn, a meeting in early summer and another in the fall in the other counties. The summer and fall meetings are largely social, and are instrumental in promoting good fellowship among the physicians of Long Island. The winter meeting is scientific, and is followed by an evening supper.

*The Long Island Medical Journal*—Next to its meetings, the principal activity of the Associated Physicians is the publication of a monthly periodical—*The Long Island Medical Journal*—which goes to all the members. Each issue consists of forty pages, which record the activities of all the medical organizations on the Island. It has made a specialty of articles that present the fundamentals of the art and science of medicine from the standpoint of the general practitioner. The last issue, for example, contained a series of articles on tuberculosis from the standpoint of family doctors, and the preceding number recorded a series of papers on focal infection which had been read before the Second District Branch Medical Society. The Journal has also prepared and printed abstracts of papers which have been read before local medical societies, and which have had a strong appeal to the members.

The Journal has been the means of informing the physicians of Long Island regarding the major activities of the County Medical Societies, and especially of the work of the Committee on Graduate Medical Education of the Medical Society of the County of Kings. It has been a great factor in stimulating the activities of the local medical societies, and the interest of the members in the Medical Society of the State of New York.

The Journal makes regular exchanges with over 400 medical journals from all over the world, and is widely sought as representing the medical thought of a great medical center. The exchanges are given to the Library of the Medical Society of the County of Kings, where they are available to any physician who comes to consult them.

The Journal also conducts a book review department in which reviews are carefully prepared by the best critics on the Island. This department is carefully edited and the opinions of its readers are widely quoted by publishers. The books which are received for review are added to the Library of the Kings County Medical Society.

*In Conclusion*—Long Island is a section that is set off by natural boundaries. It contains about one-fifth of the population of New York State, and is largely self sufficient in a medical way. Its several sections include every phase of medical practice among every variety of people. Its medical organizations have evolved in a natural manner, and have been unified by an influential central organization. The outstanding features of its medicine are the development of an extensive system of graduate education of its physicians, and the practice of civic medicine by its medical societies.

F O

# NEWS NOTES

## LIVINGSTON COUNTY MEDICAL SOCIETY

An editorial comment

It is not our intention to print any news of a controversial or derogatory nature in this Journal. The records of the meeting of the Livingston County Medical Society on March 24, which we printed on page 630 of last week's issue, indicated that the society was alive to its civic duties. The session lasted nearly six hours, and two excellent scientific papers were presented. Two important civic matters were discussed. While the Society seriously considered a suggestion of District State Health Officer Wakeman that the Society assume the direction of the official children's health clinics, the suggestion was not adopted, but the Society voted to request the State Department of Health to assist in instructing the public health nurses of the county in infant feeding methods. This was a commendable action by the society, and will doubtless lead to still greater activities in child welfare.

The second civic matter that was discussed was that of establishing and locating a county laboratory, which would receive State aid. The report which we printed indicated that the County Medical Society was taking a proper interest in the laboratory, and while the reso-

lution which the society passed was of the nature of a protest against the choice of the location of the laboratory, yet it seemed to us to be entirely proper that the report should be printed as the record of the action of the Livingston County Society. However, we are in receipt of a communication from Dr. Walter S. Goodale, Chairman of the Board of the Jackson Health Resort, Inc., to whom the contract for the laboratory was given in which he quoted evidence to show that the managers of the Health Resort had acted in good faith in offering a laboratory and diagnostic service which was convenient to the physicians of Livingston County and which conformed to the standards of the State Department of Health.

The report which we printed indicated that the protest was directed solely against the action of the Board of Supervisors, and not against any group of physicians. If we had any intimation that conditions were otherwise, we would have edited the report.

We feel certain that the physicians of Livingston County will settle their own problems in entire good nature.

F O

## NEW YORK STATE ASSOCIATION OF PUBLIC HEALTH LABORATORIES

Ninth Annual Meeting, Hotel Syracuse, Syracuse, May 12, 1925

Dr. Wilhelm Kolle, Professor of Medicine, University of Frankfurt-am-Main, and Director of the State Institute of Experimental Therapeutics, has accepted the invitation of the New York State Association of Public Health Laboratories to speak at its annual meeting at the Hotel Syracuse on Tuesday morning, May 12th.

Prof. Kolle's investigations in the field of chemotherapy opened up by Paul Ehrlich, have extended our knowledge of the therapeutic action of salvarsan and the newer arseno-benzol derivatives now used in the treatment of syphilis. He has also developed precise methods of testing the value of these drugs in the treatment of early syphilis and the limitations of chemotherapy in the later chronic forms of the infection.

Prof. Kolle's earlier work when a student and assistant of Koch, his researches in South Africa and the Sudan, and his collaboration with Wassermann in the "Handbook of pathogenic Microorganisms" are among his many distinguished contributions to medical science. He has just delivered the Herter lectures and the Harvey Society lecture in New York.

Among the papers to be presented at the Annual Meeting are "Report of a Case of Botulism" by Alvin G. Foord, Buffalo, "Development of a County Laboratory Under State Aid" by J. A. Dickson, Amsterdam, "Tropical Sprue," E. A. Baumgartner, Clifton Springs, "Bacteriophage," Stanhope Bayne-Jones, Rochester.

Members of the Medical Society of the State of New York are cordially invited to attend the meeting

Scientific Program, 9 30 A M.

Relative prevalence of types of pneumococci in sputa submitted to the Syracuse laboratory [5 minutes]

Henry N Jones City Laboratory, Syracuse.

A case of botulism Clinical and laboratory investigations [10 minutes]

Alvin G Foord and Anna G Forsyth (by invitation), Buffalo City Hospital Laboratory

An atypical Weil-Felix reaction its diagnostic significance, and the effect of inactivating the patient's serum [10 minutes]

Ruth Gilbert and M Coleman (by invitation), State Laboratory, Albany

Variations in the alkaline tide in urine and parallel variations in gastric acidity [10 minutes]

Roger S Hubbard, Clifton Springs Sanitarium Laboratory

Development of the Montgomery County laboratory with the Julius Wassermann memorial under state aid [10 minutes]

J A Dickson, Montgomery County Laboratory, Amsterdam

Tropical Sprue. [10 minutes]

E. A. Baumgartner and Glenn D Smith (by invitation), Clifton Springs Sanitarium Laboratory

Bacteriophage. [20 minutes]

Stanhope Bayne-Jones (by invitation), University of Rochester Medical School, Rochester

Address

Wilhelm Kolle, Professor of Medicine, University of Frankfurt-am-Main and Director of the State Institute of Experimental Therapeutics

---

### SCHOOL MEDICAL INSPECTORS

An informal dinner and round-table conference of the School Medical Inspectors' Association will be held at the Onondaga Hotel, Syracuse, May 13, 1925. Dinner will be served at 6 p m. Price, \$1.50. The conference will be held at 7 30 p m. Brief addresses will be given by Haven Emerson, M D, John E. Burke, M D, and Warren W. Cox, Ph D. No formal speeches

will be given. School medical inspectors are urged to be present to contribute to the success of the gathering. Come and let all present profit by your personal experiences. Send in a postal card that we may expect you.

WM A HOWE,

State Medical Inspector of Schools

---

### STATE COMMITTEE ON TUBERCULOSIS AND PUBLIC HEALTH

The annual meeting of the New York State Committee on Tuberculosis and Public Health of the State Charities Aid Association, will be held May 8, Hotel Biltmore, New York City.

---

## GORGAS MEMORIAL

"On January 1, 1925," states a recent report by Dr. Franklin Martin, Chairman of the Board of Directors of the Gorgas Memorial Institute of Tropical and Preventive Medicine, "the Gorgas 'personal health' educational campaign was inaugurated on a modest scale. Since then 10 newspaper articles have been released to 1,000 newspapers and press services, 25 radio talks have been broadcasted by State Committee members, and 75 medical journals and county medical society bulletins have published news releases and articles. 1,600 newspapers, many of them large metropolitan dailies, are now regularly printing Gorgas material, and radio stations at New York, Chicago, Memphis, Fort Worth, St. Louis, Louisville and San Francisco are broadcasting health talks.

"Last September the Republic of Panama authorized the issuance of a \$750,000 bond issue to finance the construction of the research institute. A campaign is now under way in Panama and the Canal Zone to raise \$10,000 for the Endowment Fund. In addition, \$10,000 worth of laboratory equipment is available for use when a sufficient sum is obtained to finance a research team.

"1,500 doctors, representing every branch of medicine, surgery and public health, in cooperation with prominent laymen and women, are now serving as State Committee members. In line with our belief that the Gorgas Memorial could be established without resorting to the usual campaign methods, this organization was carefully formed without elaborate publicity or undue expense. The Gorgas movement is now in a fair way to become the strong influence we hoped it would be when we began organizing our State Governing Committees a year and a half ago."

Speaking for the American Dental Association, which has lately added its support to the Gorgas Memorial, Dr. D. M. Gallie, remarks:

"General Gorgas was a sanitarian, a medical man and a great organizer. But most of all he was a man with a keen sense of proportion and an innate love of justice. This is best exemplified in the fact that he lent his cooperation to the legislative committee of the American Dental

Association in the successful effort to secure the passage of the equal recognition bill, in October, 1917.

"The program of the Gorgas Memorial Institute in which the dentists of the United States will cooperate calls for a nation wide campaign of education and instruction in the wisdom of an ounce of prevention. Thus will people be taught to consider the body as something to be kept constantly in condition, rather than something that must be repaired when it breaks down. This is a program which dentists can endorse, since we constantly urge our patients to come in for periodic examination of their teeth. Not only can we approve of the work of the Gorgas Memorial along these lines, but we can also give it our financial support.

"A plan for the participation of dentists with physicians and surgeons in the personal health campaign has been approved by the Executive Committee. It endorsed the suggestion that state committees be appointed and subdivided into county and city committees and that each committee and subcommittee be assigned a quota for the support of the Gorgas Memorial."

Before this column of Gorgas news items goes to press Gorgas Memorial members and those listeners-in on the radio who by now have learned to watch for "Gorgas talks" will have enjoyed the address of Dr. Foster Kennedy scheduled for 11:20 A. M., Wednesday, April 22nd, over station WEAJ, New York City. Dr. Kennedy's subject is Mental Hygiene.

The Gorgas Memorial plans an impressive radio program for Child Health Day, Friday, May 1st. Speakers and subjects have not yet been announced but it is rumored that Governor Alfred E. Smith will broadcast first, and be followed by several leading scientific medical members of the New York State Governing Committee. Most of the Gorgas better health talks are given over station WEAJ, New York City. Great credit belongs to the New York Health Speakers Bureau, New York City, Dr. Iago Gallston, Director, for invaluable assistance to the Gorgas radio program.



# THE DAILY PRESS



What happens to violators of the Sanitary Code in Greater New York? The question is answered by the *New York Telegram* of April 11th in a half column article which we are reproducing as a matter of interest to the 900 or more doctors who are health officers in New York State

In the year 1924 the Health Department prosecuted 22,481 cases in the criminal courts and \$103,217 in fines were assessed in the cases, according to a report made today to Health Commissioner Monaghan by James D. O'Sullivan, counsel for the department. The report indicates that there was a great variety of prosecutions for violations of the sanitary code

A lunch concern was fined \$500 for keeping for sale three barrels of clams which were not properly tagged, so that in the event that a person contracted typhoid from eating the clams the source could not be traced

A dairy concern was fined \$500 for selling adulterated milk. This milk was 35 per cent low in solids, and because of previous convictions of the company the heavy fine was imposed

A physician, prosecuted by the department, was sentenced to the penitentiary after his conviction for filing a false certificate of death. He claimed a patient had died from nephritis of the lungs, whereas, it was shown the actual cause of the death was determined by the medical examiner as septic abortion

"If the Health Department," says the report, 'had to depend entirely on the voluntary co-operation of the public in protecting the city against disease, without being able to enforce its orders, it is self-evident its activities would be curtailed to a great extent'

"The results obtained through the courts by enforcement of the various provisions of the sanitary code act as a deterrent against similar violations. These factors emphasize the importance of the results obtained through court decisions"

We have frequently commented on the reasons which popular articles assign to account for the spread of influenza. Last week we quoted a prominent health official who ascribes the spread to shaking hands. The *Bronx Home News*, March 29, quotes Surgeon General Cumming in ascribing influenza to the common drinking cup. The *Gloversville Herald*, April 10, dwells on the protective value of the 'resistance' of the body, and says

"Health officials have never yet succeeded in stopping an epidemic of influenza. The avoid-

ance of "flu" or its consequences is a personal problem for each individual

"This is the time of year to be particularly on guard against 'flu' and pneumonia—as the two always go together—for in most vicinities their ravages usually reach the maximum toward the close of winter

"Cleanliness, good physical condition and plenty of sleep are our best safeguards. Something besides germs is usually required to make us sick. Much depends on our general condition—our 'resistance'."

It is no wonder that the people are confused in considering the means of preventing the spread of influenza. There is a common reason why shaking hands and the use of a common drinking cup may spread influenza and other respiratory diseases, and that reason is the fundamental one of spreading the infectious excretions of the nose and throat. If the infectiousness of these excretions were emphasized, any one can apply the principle of shaking hands, the common drinking cup, and all other auxiliary means of spreading the disease

The *Syracuse Journal*, April 9th, carries a column article on the proposed annexation of the Village of Onondaga Valley to the city of Syracuse, and gives the protection of health as the principal reason for the annexation. The article says

"Spokesmen favoring annexation stressed the health conditions at the Valley and charged that they would react to the detriment of the city unless action is taken by acquisition to remove menacing conditions

"Dr. Sears cited figures showing that from the illness of one boy only a few months ago, 78 of 80 residents of Chaffee Avenue were stricken by illness, due to pollution of water supply. He compared conditions at the Valley today as similar to those in Syracuse 40 years ago, pointing out that with the guarded water system the city has reduced all contagious diseases, particularly typhoid and tuberculosis. He urged a water supply, sewers and creek improvement as three essentials in the event the Valley is annexed"

Reports of meetings of Boards of Health are often statistical and concern inconsequential conditions. The *Little Falls Times*, April 7th, contains an account of a meeting of the Board of Health in which business of real importance was transacted. A new milk ordinance was adopted according to the following account

"Health Officer Santry submitted to the board what was termed the model milk ordinance,

urged by the state department of health This was adopted, with the exception that the city will accept grade B pasteurized and grade B raw milk which otherwise meets the requirements Health Officer Santry stated the producers themselves were anxious to comply with the regulation, as it would enable them to get pay for the cattle that were found to be tubercular and that had to be slaughtered"

The Board considered a nuisance created by sewage in a dry millrace and settled it by asking the mill owners to flush the race periodically A committee was appointed to conduct a cleanup week The milk inspector, the health officer, and the public health nurse all made detailed reports The reports indicated that the work of the nurse far excelled that of the other two officials in its probable effects on health

The two Watertown newspapers, the *Times*, and the *Standard*, have printed a number of articles of interest to physicians The issues of March 26th contain plans for health promotion contests during a proposed health week

The issues of March 30th contain accounts of health talks given in eight Sunday schools by local workers in public health They also announce health talks in the Y M C A and the Y W C A

The issues of March 31st contain accounts of an address on periodic health examinations given by Dr H C Montgomery before the Zonta Club, in which he explained what constituted a real health examination and its value to the one examined

The issues of April 1st contain accounts of several addresses on health given before several civic bodies The value of serums and vaccines were emphasized by various speakers, and the story of dog-sled races to supply antitoxin to Nome was dramatically told Judging by the publicity reports Watertown put on an extremely practical program for health week

Glens Falls is in the midst of a scarlet fever epidemic, according to the *Post* of that city The March 28th issue of that paper contains an interview with Dr Selleck, the Health Officer, in which he is quoted as saying

"Two children who were suffering from the disease had not been treated by physicians until the disease had almost run its course Consequently many other children were exposed Five cases developed a month ago, but the cases were reported, the children were promptly quarantined, and the outbreak was checked Then came the startling discovery that other children, who were suffering from the disease had not been treated by physicians until after they had been in contact with hundreds of other children One of these children had been in school three days

while suffering from scarlet fever, another had attended a party"

Dr Selleck goes on to describe the beginning signs of the disease, and to warn the people of the precautions to be taken We believe that the health officer has taken the best possible course for the control of the disease, for the intelligent cooperation of the people is absolutely necessary

We commented on another outbreak of scarlet fever on page 351 of the February 27th issue of this JOURNAL, and quoted from a local paper an account of the adoption of the preventive measure of accounting for every school child every day How this has resulted is told in the *Palchogue Villager*, April 2, as follows

"On February 16th the system of accounting for every child every day was started and proved a great success in the grade schools In contrast, nine cases of scarlet fever were discovered among the pupils of the High School during February and March

"It is easy to account for every child every day in the grade schools where each pupil sits in one room under the eye of one teacher who can easily detect the first signs of illness But in the High School the students pass from room to room and no teacher sees a student long enough to determine its physical condition

"If the ill children were in the grades, they would be detected and sent home But their detection is almost impossible in the High School

"Who is responsible for the continuance of scarlet fever? Obviously the parents of the student, and the students themselves

"How long will the people continue to allow children to go to school with colds and sore throats when these signs may mean scarlet fever?"

The *Amsterdam Evening Recorder*, April 8th, contains a half-page verbatim report of an address on the fresh air class in the Amsterdam public school given by Dr E Harrison Ormsby, School Physician The doctor explained that the class was for undernourished children and that as a result of their low physical condition, they were also backward mentally He reviewed the results attained both physically and mentally, and ascribed the failure of a very few to gain to the great distance they had to walk to school

Dr Ormsby gave the following conclusions

"This fresh air class is one of the most important phases of school health work

"About two to four per cent of the school population come within the eligible class

"Children admitted gain in nutrition and weight, and the temperature shows a marked tendency to become normal

"The children keep up to standard grade

"Good hygiene is introduced into the homes"

Dr Ormsby's lecture is a valuable contribution to the literature on open-air schools



# BOOK REVIEWS



**RACE HYGIENE AND HEREDITY** By HERMANN W. SIEMENS, M.D. Translated and Edited by Lewellys F. Barker M.D. 12mo of 178 pages, illustrated. New York, D. Appleton and Company, 1924. Cloth, \$2.00

This octavo of 178 pages is a little gem in itself and has been translated by Dr. Barker in his usual facile style, without loss in the exact meaning of the text, which is a difficult feat.

A clearer, more concise statement of Weismann's "Germ Plasm" theory and Gregor Mendel's Law could not be found. The brief discussion of these in their relation to heredity in general and the heredity of acquired traits is straight to the point and throws a flood of light on the *status præsens* of the human race, as well as future possibilities for the hygienic improvement of individuals of the race, assuming the possibility of a practical application of these laws. Such studies are profoundly related to future political history.

As physicians, we are in duty bound to acquaint ourselves with the modern concepts of such race problems. It is a difficult task, involving intimate knowledge of intricate details of the biologic processes in cells, and while there is no short cut to such knowledge, a little book like this goes far on the road and is, therefore, not only fascinating but highly useful as a beginning.

We heartily recommend the book, as lucid in style and comprehensive in matter and a necessary addition to one's library.

J. M. VAN COTT

**THE PNEUMOCOCCUS AND PNEUMOCOCCAL AFFECTIONS** By L. COTONI C. TRUCHE and Mlle. A. RAPHAEL—English Edition by D. S. PAGE, M.A., M. B. CANTAB D.P.H., and E. A. MORTON, M.R.C.S., Eng., L.R.C.P. Lond. Octavo of 218 pages, illustrated. London: John Bale, Sons & Danielsson. 1924.

This book is an intensive study of the pneumococcus dealing in particular with its immunological reactions and leading up to the practical subject of therapy. The literature is quoted extensively and much original research is reported. From theoretical considerations based on animal experimentation the authors have evolved a polyvalent serum, which is advocated in the treatment of all forms of pneumococcus lobar pneumonia. The antigens are chosen with great care and different animals are immunized against these chosen strains the sera of the animals being pooled to form the polyvalent serum. The antigens represent strains of Types I, II and III (American classification) and Type IV (Borrel and Kerand).

This serum is highly effective with animals, but the clinical section of the book, which describes the use of the serum in practice is rather unsatisfactory from our standpoint because no mention is made of the type of infecting organism. The authors are content to diagnose pneumococcus pneumonia from a smear and not lose time by more elaborate study. They admit such study is of interest but fail to inform the reader whether such studies were actually carried out and if so what the results were. We believe that with the methods of Avery and of Oliver we have means of determining the type of infection in a period short enough to make it quite feasible to make the diagnosis before proceeding to treatment. We are quite willing to be convinced that a polyvalent serum is equally useful in all types, but the present study fails to present a very important link in the chain of testimony.

T. H.

**CHEMICAL DYNAMICS OF LIFE PHAENOMENA** By Prof. OTTO MEYERHOF. Octavo of 110 pages. Philadelphia and London, J. B. Lippincott Company, 1924. Cloth, \$3.00 (Monographs on Experimental Biology).

As the title implies, this volume is devoted to a consideration of the chemical basis and operation of certain 'vital' processes, viz., (1) Physico-chemical mechanism of cell respiration, (2) Autoxidations in the cell, (3) Chemical relations between respiration and fermentation, (4) The transformation of energy in muscle and (5) The energetics of cell processes. The respective chapters represent lectures delivered by the author to research workers here and abroad.

While not intended as an exhaustive treatment of the subjects selected, the volume sets forth rather clearly much of the fundamental and experimental data on which are based the existing chemical theories of the processes discussed.

FRANK E. MALLON

**FRACTURES AND DISLOCATIONS, IMMEDIATE MANAGEMENT, AFTER-CARE, AND CONVALESCENT TREATMENT WITH SPECIAL REFERENCE TO THE CONSERVATION AND RESTORATION OF FUNCTION** By PHILIP D. WILSON, A.B., M.D., F.A.C.S., and WILLIAM A. COCHRANE, M.B., Ch.B., F.R.C.S. Edin. 978 Illustrations. J. B. Lippincott Company, Philadelphia. 1925. Price \$10.00.

In general this book expresses the views of the Staff of the Fracture Service of the Massachusetts General Hospital. This service is in charge of Dr. Daniel F. Jones. The methods both old and new, which have given the most satisfying results, are presented. The Fracture Service, organized in 1920, has functioned with gratifying success under the guidance of able teachers.

This unusual opportunity has permitted the authors to give their profitable experiences. During the preparation of this work Dr. Cochrane has returned to Edinburgh. This new association has caused no radical revision in the book, but has served indeed, to amalgamate the opinions upon the two sides of the Atlantic.

The book is written for the general practitioner and stresses the mechanical methods of treatment rather than open operative surgery.

R. H. F.

**WHEELER'S HANDBOOK OF MEDICINE** Seventh Edition, edited by WILLIAM K. JACK. 12mo of 629 pages. New York: William Wood and Company, 1924. Flexible binding. \$4.00.

The seventh edition of this book includes the advances in medicine since the previous edition. There are 600 pages of accurate description and treatment of diseased conditions of the entire body presented in the most concise language possible. This Handbook of Medicine is more thorough and inclusive than many similar books and would be useful to one desiring such a short cut in reviewing. Seven editions prove the value of the book to many.

H. M. M.

**THE INSULIN TREATMENT OF DIABETES MELLITUS** By P. J. CAMMIDGE, M.D., D.P.H. Second Edition. 12mo of 216 pages. New York, William Wood and Company. 1924. Cloth. \$2.50.

In this edition following the first one of January, 1924 the subject matter has been brought up to date. A very good description is given of the experimental investigation leading to the discovery of insulin.

Considerable attention is paid, as is usual with the author, to causes of glycosuria other than pancreatic. The belief is expressed that it is important to look for associated disturbances in the digestive tract and that

short periods of fasting at the beginning of treatment are of value in combating these as well as giving rest to the pancreas

Where a hyperglycemia is associated with renal disturbance particular care is necessary in the use of insulin as even small doses are sometimes poorly borne, in the author's experience.

In general, the methods of study of the patient and rules for the employment of insulin are the same as are recommended in this country. The book is well written, by an authority on Diabetes. W E McCOLLUM

**THE TREATMENT OF FRACTURES IN GENERAL PRACTICE.** By C MAx PAGE, DSO, MS, FRCS, and W ROWLEY BRISTOW, MB, BS, FRCS. Octavo of 239 pages, illustrated. (Oxford Medical Publications.) London, Henry Frowde and Hodder & Stoughton, 1923. Cloth, \$4.00

This short treatise of 239 pages makes no pretense to be any more than a guide to the general practitioner in managing his fracture cases. A clear-cut, simple description of the important therapeutic indications is given and a method of treatment outlined whereby a good result may be obtained, little discussion of different methods of handling a given fracture is entered into. Some valuable advice is contained as to the prognosis of end-results and periods of disability for the various fractures. The influence of Sir Robert Jones on the minds of the authors is plainly seen, again and particularly in connection with fractures of the lower extremity the orthopedic viewpoint is emphasized and the use of walking calipers and braces discussed in greater detail than the general surgeon is wont to find in more complete treatises on this subject. Advances gained from war experience are adequately covered within the scope of the volume. Without question the book supplies a definite need and could be introduced with great profit into every hospital library as a guide to the resident staff in the management of fractures.

JAMES L COBB

**PRINCIPLES OF GENERAL PHYSIOLOGY** By SIR WILLIAM MADDOCK BAYLISS, M.A., SSc., FR.S., etc. Late Professor of General Physiology in University College, London. Fourth Edition, 261 Illustrations. Longmans, Green and Co., New York, 1924

In the preface to the first edition we find the following "An elementary knowledge of physics, chemistry, and biology must be assumed, unless the book is to become altogether unwieldy." Let it be understood that this same elementary knowledge old and lately required if the fourth edition (the edition under review) is to be read, understood and enjoyed.

The whole field of general physiology is covered and the various theories and works of men, other than the author and his assistants, are freely quoted. In fact the book constantly refers to the work of others and the photographs of eminent scientists are often reproduced and the particular work of these men reviewed in a short resume.

At the end of each chapter is found an admirable summary of the chapter, just read, in which controvertible matter as well as established questions are reduced to the simplest explanation and interpretation.

This is a book long to remain an authority, in its particular field of science.

G W P

**A TEXT-BOOK OF ANATOMY AND PHYSIOLOGY FOR SCHOOLS OF NURSING, NORMAL SCHOOLS AND COLLEGES,** by JESSE FEIRING WILLIAMS, MD. 12mo volume of 523 pages with 369 illustrations. Philadelphia and London W B Saunders Co., 1923. Cloth, \$3.00

This book designed for nursing schools, normal schools and colleges supplies rather too much than too little for easy assimilation by students of these schools.

There is much scientific substance and accurate fact

crowded between these covers. The sketches of embryology and histology are short and good. The osteology is concrete and sane for a book of this type. We suggest omitting the nerve supply in the description of muscles and using the space for a description of their action. The nervous system, circulatory system, respiratory system, excretory system, reproductive system, endocrine system and organs of special sense are well cared for anatomically and physiologically. The endocrine description is timely and of value to those for whom this very excellent little volume is designed.

T L V

**INTERNATIONAL CLINICS** Vols III and IV. By Leading Members of the Medical Profession Throughout the World. Thirty-fourth Series, 1924. Philadelphia, J B Lippincott Co., 1924

**Vol III** This is an excellent number of an always interesting periodical. There are five articles on Public Health and Hygiene, the subjects treated being Dental Hygiene, Malaria, Communicable Disease, Control of Health Examinations. Regarding the latter subject, Dr James J Walsh has much to say in their favor but also believes that harm is sometimes done to the patient who is susceptible to unfavorable suggestion. He thinks that some people are started on the road to various functional derangements but this is less likely to happen when the examination is made by the family physician instead of a stranger.

"Evolution in the Treatment of Syphilis" is a comprehensive review of the subject. Smithies presents his views in "A Clinical Consideration of the Management of Peptic Ulcer." He stresses the importance of a consideration of the varied etiology of ulcer, infectious causes taking first place, in his opinion. He thinks that the removal of a focus of infection will prevent recurrences of ulcers. His method of management is outlined.

Some of the other titles are, "Habit Spasm," "Variation of the Chloride Content of the Blood," a very good article by de Wesselow, "Bronchial Asthma" and some allied conditions, and "Observations on Celiac Disease" by C G Kerley.

In the "Outlook in Insulin Treatment," Hipwell and Gilchrist of Toronto give the histories of some of the early cases of Diabetes treated with Insulin in 1922. In following these cases to date, the authors conclude that in three which have been persistently maintained sugar free, the fact is illustrated that there is in such cases a regeneration of the Insulin production function. In contrast, two cases demonstrate another fact—that with the persistent excretion of small amounts of sugar, they require increasing doses of Insulin and do not show improvement in their carbohydrate tolerance. Another patient, of her own accord, took 95 units of Insulin daily for about 18 months without apparent ill effect.

**Vol IV** Some of the subjects treated in this number are Blastomycosis, Pellagra, Vincent's Angina, Bacillary Dysentery, Malaria and Intestinal Obstruction. Banting contributes an article on Insulin which elucidates the principles involved in a brief but satisfactory manner.

In discussing "The Effect of Tonsillectomy on Existing Visceral Disease," Hand ranks the naso-pharyngeal mucosa as next in importance to the teeth as an avenue of infection, then the mastoid cells and the tracheo-bronchial lining. He also thinks that the intestinal mucosa, the appendix and even the gall bladder "may open the door to organic heart or kidney disease." If one accepts the mucosa of various regions as a focus of infection he will feel helpless at times in his efforts at eradication.

Topics of interest to the surgeon are "The Use of X-ray and Radium," "Internal Fixation of Fractures," "Ethylene" and a Review of "Fractures of the Lumbar Spine."

W E McCOLLUM



# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 16

NEW YORK, N. Y

MAY, 1925

## A CONTRIBUTION TO THE ETIOLOGY OF THE CYSTIC OVARY

By G L ROHDENBURG, M.D., and A. M. HELLMAN, B.A., M.D.,

(From the laboratory of the Lenox Hill Hospital)

NEW YORK CITY

ANYONE having access to considerable material encounters cases in which the cardinal symptoms are apparently of ovarian origin. Operative interference in such instances frequently shows the ovaries to be slightly enlarged and more or less studded with small cysts. The etiology of this condition is, as yet, not definitely established, and the present paper is an attempt to add to the knowledge of the subject.

The present conception of the physiology of the menstrual cycle is that puberty having been established and a matured Graafian follicle having ruptured, a corpus luteum, which is chemically active for from ten to fourteen days, develops at the site of the ruptured follicle.

The histologic changes that occur in and about the ovum in the course of its development and recession are as follows. At birth, there are pres-

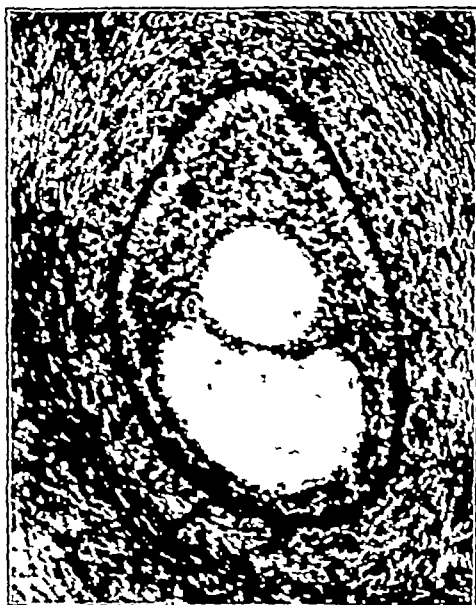


FIG. 2—Further stage of developing Graafian follicle, follicle cavity present.

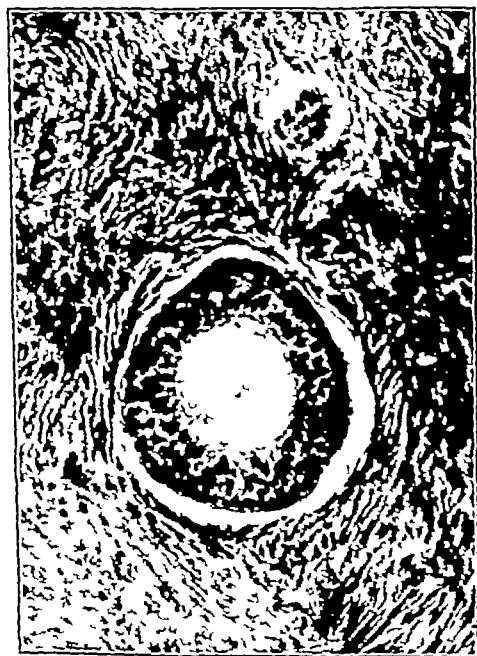


FIG. 1—Primordial follicle with adjacent follicle in a later state of development, from six-months-old child.

ent in the ovarian stroma thousands of primordial follicles (Fig 1) and, under normal conditions, at least 250 of these go through the cycle of maturation, corpus luteum formation and subsequent absorption. All of the remaining ova sooner or later undergo a process termed atresia. These are physiologic facts that have been stressed by all who have considered the physiology of ovulation. They are perhaps too often forgotten by the clinician.

In the normal process of development, the cells about the ovum proliferate and differentiate into two zones, an inner zona granulosa, and an outer double layer called the theca. The continued proliferation of these cells increases the size of the follicle and forces it to the surface of the ovary, during which process a zona pellucida forms between the ovum and the zona granulosa, and a follicle cavity develops (Fig 2).

Subsequently, the rupture of the follicle occurs,

short periods of fasting at the beginning of treatment are of value in combating these as well as giving rest to the pancreas

Where a hyperglycemia is associated with renal disturbance particular care is necessary in the use of insulin as even small doses are sometimes poorly borne, in the author's experience.

In general, the methods of study of the patient and rules for the employment of insulin are the same as are recommended in this country. The book is well written, by an authority on Diabetes. W E McCOLLUM

**THE TREATMENT OF FRACTURES IN GENERAL PRACTICE.** By C MAX PAGE, DSO, MS, FRCS, and W ROWLEY BRISTOW, MB, BS, FRCS. Octavo of 239 pages, illustrated (Oxford Medical Publications) London, Henry Frowde and Hodder & Stoughton, 1923. Cloth, \$4.00

This short treatise of 239 pages makes no pretense to be any more than a guide to the general practitioner in managing his fracture cases. A clear-cut, simple description of the important therapeutic indications is given and a method of treatment outlined whereby a good result may be obtained, little discussion of different methods of handling a given fracture is entered into. Some valuable advice is contained as to the prognosis of end-results and periods of disability for the various fractures. The influence of Sir Robert Jones on the minds of the authors is plainly seen, again and particularly in connection with fractures of the lower extremity the orthopedic viewpoint is emphasized and the use of walking calipers and braces discussed in greater detail than the general surgeon is wont to find in more complete treatises on this subject. Advances gained from war experience are adequately covered within the scope of the volume. Without question the book supplies a definite need and could be introduced with great profit into every hospital library as a guide to the resident staff in the management of fractures.

JAMES L COBB.

**PRINCIPLES OF GENERAL PHYSIOLOGY** By SIR WILLIAM MADDOCK BAYLISS, M.A., S.Sc., F.R.S., etc. Late Professor of General Physiology in University College, London. Fourth Edition, 261 Illustrations. Longmans, Green and Co., New York, 1924.

In the preface to the first edition we find the following "An elementary knowledge of physics, chemistry, and biology must be assumed, unless the book is to become altogether unwieldy." Let it be understood that this same elementary knowledge is still fully required in the fourth edition (the edition under review) is to be read, understood and enjoyed.

The whole field of general physiology is covered and the various theories and works of men, other than the author and his assistants, are freely quoted. In fact the book constantly refers to the work of others and the photographs of eminent scientists are often reproduced and the particular work of these men reviewed in a short resume.

At the end of each chapter is found an admirable summary of the chapter, just read, in which controversial matter as well as established questions are reduced to the simplest explanation and interpretation.

This is a book long to remain an authority, in its particular field of science.

G W P

**A TEXT-BOOK OF ANATOMY AND PHYSIOLOGY FOR SCHOOLS OF NURSING, NORMAL SCHOOLS AND COLLEGES,** by JESSE FEIRING WILLIAMS, M.D. 12mo volume of 523 pages with 369 illustrations. Philadelphia and London W B Saunders Co., 1923. Cloth, \$3.00

This book designed for nursing schools, normal schools and colleges supplies rather too much than too little for easy assimilation by students of these schools.

There is much scientific substance and accurate fact

crowded between these covers. The sketches of embryology and histology are short and good. The osteology is concrete and sane for a book of this type. We suggest omitting the nerve supply in the description of muscles and using the space for a description of their action. The nervous system, circulatory system, respiratory system, excretory system, reproductive system, endocrine system and organs of special sense are well cared for anatomically and physiologically. The endocrine description is timely and of value to those for whom this very excellent little volume is designed.

T L V

**INTERNATIONAL CLINICS** Vols III and IV. By Leading Members of the Medical Profession Throughout the World. Thirty-fourth Series, 1924. Philadelphia, J B Lippincott Co., 1924.

Vol III. This is an excellent number of an always interesting periodical. There are five articles on Public Health and Hygiene, the subjects treated being Dental Hygiene, Malaria, Communicable Disease Control of Health Examinations. Regarding the latter subject, Dr James J Walsh has much to say in their favor but also believes that harm is sometimes done to the patient who is susceptible to unfavorable suggestion. He thinks that some people are started on the road to various functional derangements but this is less likely to happen when the examination is made by the family physician instead of a stranger.

"Evolution in the Treatment of Syphilis" is a comprehensive review of the subject. Smithies presents his views in "A Clinical Consideration of the Management of Peptic Ulcer." He stresses the importance of a consideration of the varied etiology of ulcer, infectious causes taking first place, in his opinion. He thinks that the removal of a focus of infection will prevent recurrences of ulcers. His method of management is outlined.

Some of the other titles are, "Habit Spasm," "Variation of the Chloride Content of the Blood," a very good article by de Wesselow, "Bronchial Asthma" and some allied conditions, and "Observations on Celiac Disease" by C G Kerley.

In the "Outlook in Insulin Treatment," Hipwell and Gilchrist of Toronto give the histories of some of the early cases of Diabetes treated with Insulin in 1922. In following these cases to date, the authors conclude that in three which have been persistently maintained sugar free, the fact is illustrated that there is in such cases a regeneration of the Insulin production function. In contrast, two cases demonstrate another fact—that with the persistent excretion of small amounts of sugar, they require increasing doses of Insulin and do not show improvement in their carbohydrate tolerance. Another patient, of her own accord, took 95 units of Insulin daily for about 18 months without apparent ill effect.

Vol IV. Some of the subjects treated in this number are Blastomycosis, Pellagra, Vincent's Angina, Bacillary Dysentery, Malaria and Intestinal Obstruction. Banting contributes an article on Insulin which elucidates the principles involved in a brief but satisfactory manner.

In discussing "The Effect of Tonsillectomy on Existing Visceral Disease," Hand ranks the naso-pharyngeal mucosa as next in importance to the teeth as an avenue of infection, then the mastoid cells and the tracheo-bronchial lining. He also thinks that the intestinal mucosa, the appendix and even the gall bladder "may open the door to organic heart or kidney disease." If one accepts the mucosa of various regions as a focus of infection he will feel helpless at times in his efforts at eradication.

Topics of interest to the surgeon are "The Use of X-ray and Radium," "Internal Fixation of Fractures," "Ethylene" and a Review of "Fractures of the Lumbar Spine." W E McCOLLUM

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL. 25, No 16

NEW YORK, N Y

MAY, 1925

## A CONTRIBUTION TO THE ETIOLOGY OF THE CYSTIC OVARY

By G L ROHDENBURG, M D, and A M HELLMAN, B A., M D,

(From the laboratory of the Lenox Hill Hospital)

NEW YORK CITY

ANYONE having access to considerable material encounters cases in which the cardinal symptoms are apparently of ovarian origin. Operative interference in such instances frequently shows the ovaries to be slightly enlarged and more or less studded with small cysts. The etiology of this condition is, as yet, not definitely established, and the present paper is an attempt to add to the knowledge of the subject.

The present conception of the physiology of the menstrual cycle is that puberty having been established and a matured Graafian follicle having ruptured, a corpus luteum, which is chemically active for from ten to fourteen days, develops at the site of the ruptured follicle.

The histologic changes that occur in and about the ovum in the course of its development and recession are as follows. At birth, there are pres-

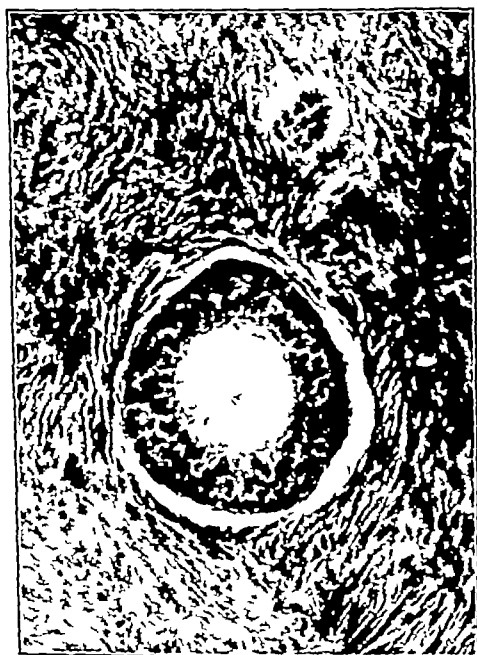


FIG. 1—Primordial follicle with adjacent follicle in a later state of development, from six-months-old child.

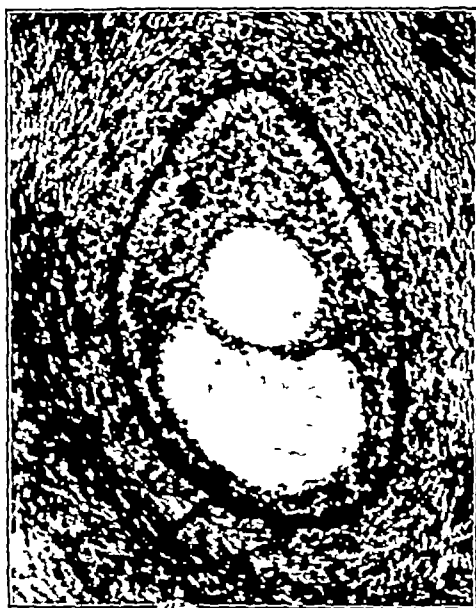


FIG. 2—Further stage developing Graafian follicle, follicle cavity present.

ent in the ovarian stroma thousands of primordial follicles (Fig 1) and, under normal conditions, at least 250 of these go through the cycle of maturation, corpus luteum formation and subsequent absorption. All of the remaining ova sooner or later undergo a process termed atresia. These are physiologic facts that have been stressed by all who have considered the physiology of ovulation. They are perhaps too often forgotten by the clinician.

In the normal process of development, the cells about the ovum proliferate and differentiate into two zones, an inner zona granulosa, and an outer double layer called the theca. The continued proliferation of these cells increases the size of the follicle and forces it to the surface of the ovary, during which process a zona pellucida forms between the ovum and the zona granulosa, and a follicle cavity develops (Fig 2).

Subsequently, the rupture of the follicle occurs,

and at the site of the former follicle a corpus luteum develops through a collapse and folding of the follicle wall with changes in the structure of the thecal envelope. The thecal coats mingle their elements with the granulosa, and the granulosa cells enlarge and become converted into luteal cells. Fibroblasts and capillaries penetrate the theca and granulosa layers and finally fill the old follicle spaces, creating a solid spherical epitheloid structure (Fig 3). Recession of the corpus luteum takes place by contraction of the core, which may or may not become cystic or be the site of a hematoma. The lutein cells degenerate, the connective tissue becomes increasingly hyaline, the blood vessels show hyaline changes, and the corpus luteum, now called corpus albicans, assumes a smooth homogenous appearance, with a wavy outline and varied shape (Fig 4).

Another phase of the normal physiologic cycle for the ovum follows follicle atresia, which may occur at any stage before the rupture of the follicle, owing to either hydropic degeneration of the ovum or hemorrhage into the thecal layers (Fig 5 a, b). In the small follicles liquefaction of the ovum occurs, and a replacement fibrosis completes the process. In the larger follicles, cystic degeneration is followed by the absorption of fluid and the development between



FIG 3—Fully developed corpus luteum.



FIG. 4—Well organized corpus albicans. Patent condition of blood vessels may be noted.

the degenerating granulosa and thecal layers of a flat band of hyaline connective tissue which gradually increases in size. This band contracts, and through it, from the outer thecal cells, a



FIG 5—a Follicle in state of hydropic degeneration.

wavy connective tissue penetrates and fills up the cavity (Fig 6 a, b, c).

In origin, cyst formation in the ovary is, therefore, of one of two types—the corpus luteum and the simple follicle. Each is normal but becomes pathologic when organization fails to occur. In consequence of these cyclic changes, there are in any ovary, even before puberty, follicles in all stages of development and atresia.

In normal physiology, the cyclic changes just



FIG 5—b Follicle with hemorrhage in granulosa and thecal coats



FIG 6—b Intermediate stage of same showing hyaline zone.

described are accompanied by changes in other organs, one of which is the uterus. In this, the cycle as now generally accepted is divided into three periods. The intermenstrual period begins as soon as menstruation ceases, and ends with the onset of the premenstrual change, from four to six days before the onset of the bleeding. The endometrium at this period shows the glandular elements in the resting stage, with the glands straight and rather widely separated (Fig 7)

The gland lumina is devoid of secretion, and the stroma is composed of densely packed lymphoid cells. Since the presence of a corpus luteum has been repeatedly shown to inhibit menstruation, this phase of uterine activity is probably associated with the duration of the activity of the corpus luteum.

The premenstrual period (Fig 8), which follows, is characterized by a condition in which the glands become tortuous and show papillary in-

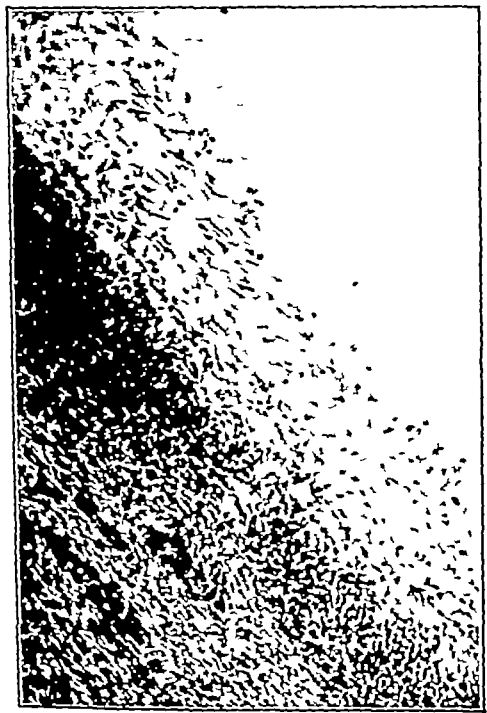


FIG. 6—a. Early stage of organizing atretic follicle.



FIG. 6—c. Terminal result of organization of healed cyst.

growths of the lining epithelium with distention of the gland lumina by the products of secretion. In the stroma, the closely packed cells become separated and the cell outlines become more visible. This phase is associated with recession of the corpus luteum and maturation of the follicle. In the third, or menstrual, period (Fig 9), the previous changes become still more marked and an edema of the stroma occurs with marked congestion of the capillaries and extravasation of red blood cells into the gland lumina and stroma. The glands discharge their secretions and the upper portions are desquamated, after which the endometrium returns rather rapidly to the condition present in the intermenstrual phase.

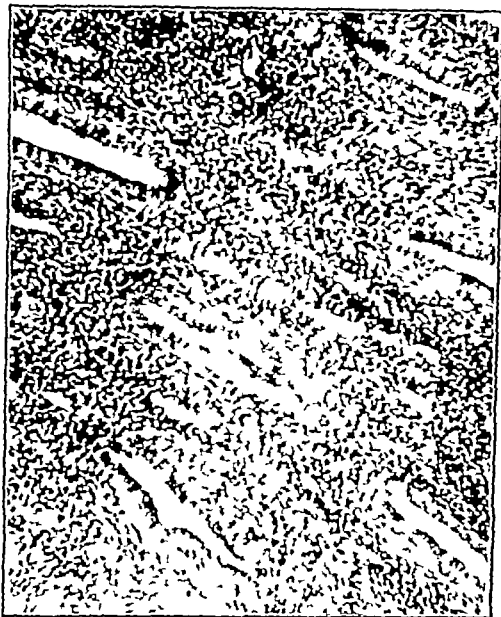


FIG 7—Resting stage of uterine mucosa.

Concomitant with the uterine and ovarian changes, there are symptomatic changes in the individual. A few days or hours before the onset of the flow, there is a sense of fulness in the lower abdomen, occasionally a backache, and in some instances marked tenderness of the breasts. In some females, thyroid overactivity occurs, with enlargement of the gland, while others have violent occipital headaches.

This rather sketchy review of the present conception of the normal physiology has been given so that the pathologic condition can be more properly understood.

About ten years ago, one of us was for a considerable time compelled to prepare sections of ovaries by the frozen section technic. These sections occasionally showed numerous corpora albicantes in which there were considerable amounts of luteal pigment still present. That such deposits had not previously been commented

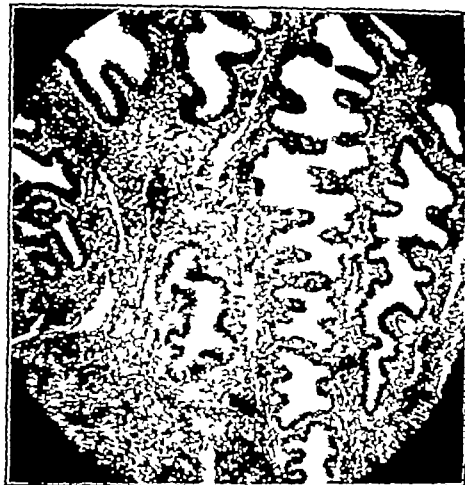


FIG. 8—Premenstrual phase of uterine mucosa.

upon is probably due to the fact that in the paraffin method of preparation, practically all of this lipid goes into solution, and even with the frozen section technic, the pigment gradually loses its color, and in many sections is completely bleached in from six to eight weeks.<sup>1</sup>

In 165 specimens in which both ovaries were available for study, and in which there was no concomitant suppurative inflammation of the fallopian tubes, the ovaries were sectioned at right angles to the long axis, the cuts being approximately 3 mm apart. The surfaces of these sec-



FIG 9—Menstrual mucosa.

tions were examined for the golden-yellow pigment deposit which characterizes the luteal body. In twenty cases (12 per cent) no such deposits were found, in eighty-three cases (50

<sup>1</sup> The photomicrographs accompanying the present article were all made from frozen sections.

per cent), from one to three such deposits were demonstrable, in thirty-two (20 per cent), there were four deposits, in twelve (7 per cent), there were five, in eight (5 per cent), there were six, and in ten (6 per cent) there were seven distinct and separate areas of pigment deposit

Viewed from the statistical standpoint the amount of corpus luteum pigment present in this group varies from none to a large excess. It is justifiable to consider this pigment as the precipitated luteal secretion, in some of the ovaries there was an excess. If the average diameter of a fully developed corpus luteum is taken as 3 cm., it is estimated that in those cases having four or more pigment deposits the amount present varied from 1.25 to 3.75 times that present in a single corpus luteum.

Histologic examinations were made of 124 sets of ovaries. It appeared from this study that premature hyalinization of the vascular supply of the corpus luteum at times occurs (Fig 10), and when it occurs the corpus luteum recedes very slowly and does not undergo prompt hyalinization. The detritus of the luteal cells is not completely and promptly removed. Histologic examination also showed many microscopic areas of pigment deposit not recognizable in the gross (Fig 11). In ovaries in which there were more than four foci of pigment deposit, there were a large number of follicles in the process

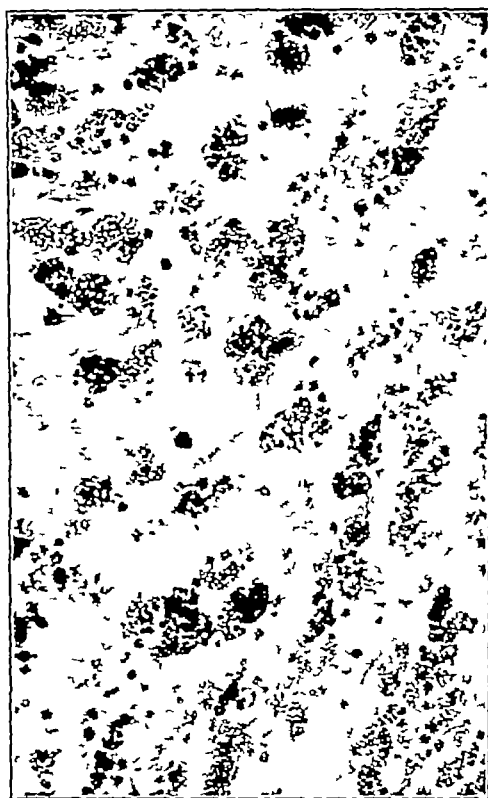


Fig. 11—Persisting luteal pigment in corpus luteum completely hyalinized



Fig. 10—Premature sclerosis of blood vessel supplying corpus luteum, with resultant poor organization of corpus luteum.

of atresia and in the stage of liquefaction, with little or no attempt at healing in the manner already described. The cysts resulting from the atresic phenomena were usually numerous and of fairly uniform size, with occasional cysts of larger diameter. In such ovaries, the tunica

albuginea was markedly thickened, and occasionally infiltrated with lime salts (Fig 12).

The picture was different in ovaries in which there were no persisting pigment deposits. In these organs, small cysts were occasionally encountered, but they were not all in the same phase of atresia at the same time. Some were undergoing liquefaction, others organization, some were microscopic, others were larger. In



Fig. 12—Thickened ovarian capsule with lime salt deposits

brief, they presented a picture of the normal process of atresia. Thus, from the histologic examinations, it appears that the presence of small follicle cysts, up to from 3 to 4 cm in diameter, is pathologic only when the cysts show no tendency to undergo organization.

As might be expected from a knowledge of the physiology of the ovarian function, the symptomatology of the "cystic ovary" is variable, one or another group of symptoms dominating. In an analysis of fifty-five cases in which the ovaries were subsequently examined microscopically, the average age at which the condition drove the patient to seek surgical relief was 32 years, with the extremes at 21 and 49 years. Of the fifty-five cases, thirty-four were in women who had never been pregnant.

The average age at which the menstrual function commenced was 13 years, and in 90 per cent the menstrual period until the onset of the present trouble had been of the twenty-eight day type. In 10 per cent, the menstrual period had always been irregular. The duration of the flow averaged five days, with extremes of one and fourteen days. In 81 per cent of the cases, the chief complaint was pain in the lower abdomen more often on the right side. Irregular or profuse bleeding occurred in 47 per cent, amenorrhea of variable duration in 5 per cent. A mass was palpable in 32 per cent. In 15 per cent, uterine fibroids were found at operation, the average age in this group (with fibroids complicating) being 41 years. The duration of symptoms before surgical relief was sought varied from six months to five years, making the average age at onset about 28 years.

The symptoms may be considered under two heads, those having directly to do with the ovary, and those due to endocrine disturbances of either the ovary or one of the related ductless glands. The most common symptom referable to the ovary is that of pain, which occurs more often on the right side. The pain is characterized by local tenderness which is worse either about a week before menstruation (swelling of the ovary due to maturation of the ovum) or about a week thereafter (period of maximum size of the corpus luteum). This pain may for a period be localized in the ovary, but usually radiates to the lumbar region or down the inner aspect of the thigh to the knee. There may or may not be a palpable mass, depending often on the period of menstrual cycle at which the examination is made, the mass being present only when the Graafian follicle or corpus luteum is of maximum size.

The endocrine symptomatology may include all or only part of the picture given in the succeeding paragraphs. Thyroid function may be overactive, giving rise to considerable or slight emotional instability. There are often profuse sweats. At this period, there is an increase both in the

basal metabolism and the blood sugar. These symptoms are not permanent, but are usually present for a portion of each menstrual cycle.

In chronic cases, there may be evidence of thyroid exhaustion suggestive of mild myxedema, with a complaint of periods during which the hands or fingers feel boggy and stiff, with muscular pains associated with indefinite areas of muscular thickening or infiltration, and an increase of weight. Although patients of the latter type often complain of feeling puffy or bloated, physical examination does not confirm their statements. Occasionally the breasts become tender and lumpy before or during menstruation. This may at times be very marked.

Other endocrine symptoms are referable to disturbances of pituitary function. There may be violent headaches, usually occipital, with or without visual disturbances such as slight double vision or blurring. With these there is some increase in blood pressure and an increase of carbohydrate tolerance. The pituitary symptoms are also usually of evanescent character, lasting for only a part of the menstrual cycle. The direct ovarian endocrine symptoms are irregularities of the menstrual flow, either amenorrhea, metrorrhagia or menorrhagia.

A short series of cases which have been observed from four to ten years will be described in detail, in order to bring out the various symptom groups.

#### REPORT OF CASES

*Case 1 Simple type without endocrine disturbances*—An unmarried woman, aged 26, began to menstruate at the age of 13, and up to the onset of the present complaint the menses had always been regular, at twenty-eight day intervals and lasting from four to five days. Three years ago, the periods became irregular, appearing at increasingly longer intervals, up to three months. About this time, a pain appeared in the left lower quadrant, localized at first, but subsequently radiating to the lumbar region and inner aspect of the thigh. The pain was much worse before menstruation and was much relieved when the flow started.

Physical examination revealed an enlarged and very tender left ovary, and an enlarged but not tender right ovary. Tampons of glycerin and a sulphoichthyolate preparation, with dry heat applied to the lower abdomen, were resorted to, and in addition, 5 grains of entire ovarian substance was given twice daily. Heat treatment was continued for four months, when menstruation again became regular. Local treatment (tampons) was discontinued after five months, as the ovary ceased to be painful. Administration of ovarian substance in 5-grain doses every other day was continued for ten months. There has been no



return of symptoms after a lapse of five years, though both ovaries are still larger than normal

*Case 2 Thyroid overactivity*—An unmarried woman, aged 39, began to menstruate at the age of 15 years. The menses appeared every thirty days and lasted three days. At the age of 29, the patient first noticed localized pain in the right lower quadrant. This pain only rarely radiated down the leg to the inner aspect of the knee and was always much worse about ten days before menstruation. One year later, the opposite side was involved in similar fashion. A diagnosis of chronic appendicitis was made, and judging from the hospital records, an almost normal appendix was removed. There was no relief of symptoms.

The pain during the third year of the condition was made worse by bowel movements, and the patient preferred to remain constipated five or six days to reduce the pain which at times became so severe as to cause syncope. She also had backache. At the end of the third year, she developed an irregular fever of one to two degrees, which occurred intermittently. A diagnosis of pulmonary tuberculosis was made, and she underwent treatment in a sanatorium for one year, which did not influence the temperature in the slightest. The pulse then became increasingly more rapid, reaching 120 without exertion.

A diagnosis of incompetent ileocecal valve with prolapsed large intestine was next made, and a supporting plastic operation performed. The symptoms were not relieved. After a diagnosis of hysteria, she abandoned medical treatment of any kind for four years, when she presented herself with a continuance of the pain. She had lost 45 pounds (20.4 kg), the pulse averaged 115, the basal metabolism was +30, the blood sugar was 180 mgms per hundred cubic centimeters, and both ovaries were enlarged and very tender. There were no anomalies of menstruation. A double oophorectomy was performed, and two ovaries about half again the normal size and studded with follicle cysts were removed.

Recovery was uneventful, and three years after operation the basal metabolism was plus 5 per cent, the blood sugar, 125 mg. All of the previous symptoms had disappeared, the patient had gained 55 pounds (25 kg), and had almost none of the usual symptoms of a surgical menopause. Glandular therapy was not employed.

*Case 3 Thyroid hypofunction*—A married woman, aged 35, who began to menstruate at the age of 14 years, with thirty-day periods, lasting from three to four days, dated the onset of her present complaint as ten years previously. She had had two children, pregnancies and labors being uneventful. Her first complaint was a localized pain over the right ovary, the diagnosis being "diseased ovary." She refused operation. This pain persisted, and about two years later

the other ovarian region became painful, the pains radiating down the left thigh. About this time, there were periods of amenorrhea of two or three months' duration. This amenorrhea lasted about two years.

After the amenorrhea, her periods had returned to the thirty-day type, but the flow lasted a full week and was very profuse. For about three years before coming under observation, she experienced localized swellings, which commenced ten days before each period and lasted until the flow was almost over. These swellings would be present, at one time, in the neighborhood of the eyes or about the mouth, while, at another time, one or both extremities would be swollen or the fingers of one or both hands would be involved.

Physical examination showed both ovaries to be very tender and somewhat enlarged, but was otherwise negative. The patient was placed on entire ovarian gland, 3 grains, and thyroid gland one half grain, taken three times daily for a period of six months, and finally on one such dose every day for ten days before each menstrual period. At the same time, local treatment with tampons of glycerin and a sulphoichthyolate preparation was instituted, and was continued for three months, combined with applications of dry heat to the lower abdomen, which was continued for four months.

For the past four years she has been free of swellings and of ovarian pain. The menstrual periods are now of five days' duration, and the flow is less profuse.

*Case 4 Pituitary and thyroid dysfunction*—A woman, married, aged 39, mother of three children, began to menstruate at the age of 16 years, the menses being of the twenty-eight day type and lasting four days. The present trouble developed with an acute onset six years before. She was then pregnant five months with her third child, when she apparently became edematous, her blood pressure rose to 200 (systolic) and violent headaches in the region of the occiput occurred, with double vision. The urine was free of albumin. Blood chemistry examinations were not made.

A diagnosis of impending eclampsia was made, and from the sixth to the eighth month the patient was in a hospital to be ready for an emergency. Labor was induced at the eighth month, and was without noteworthy deviation from the normal. After confinement, the condition of the patient remained unchanged, and she gained weight rapidly, at one time weighing 70 pounds (31.8 kg) more than normal. When the child was 1 year old, the patient came under observation complaining of headache, double vision, increased blood pressure, general boggy-ness of the tissues, emotional instability and muscular pains, chiefly in the shoulder girdle and

trapezius. A routine urine examination, chemical examination of the blood, Mosenthal test diet and the phenosulphonephthalein test failed to demonstrate the slightest evidence of any kidney involvement. The basal metabolism was minus 30 per cent, the sugar tolerance test failed to show sugar in the urine after the ingestion of 550 gm of glucose, the blood pressure was 210, systolic. The general appearance suggested a moderate myxedema.

Physical examination failed to reveal enlarged ovaries or any tenderness in that region. About ten days before each menstrual period, there was an acute exacerbation of all symptoms, which lasted until the flow had ceased. The patient was placed on thyroid, 1 grain, and entire ovary, 5 grains, three times a day. Within one month, the blood pressure had fallen to 150 systolic, the headaches had disappeared, and the patient had lost 45 pounds (20.4 kg). Most of the muscular pains were gone and double vision no longer occurred. The same glandular combination was continued for the succeeding month, and pituitary gland, 2 grains, was added.

After one week of pituitary gland therapy, there was a prompt return of all the previous symptoms, without the swelling, and a return to a blood pressure of 200. Discontinuation of the pituitary substance was followed by a cessation of the symptoms. During the following year, five different attempts were made to give pituitary substance, and each was followed by a return of headaches, double vision and high blood pressure. In spite of the great improvement, there were recurrences of the complaint with each menstrual epoch, and for this reason, radiotherapy was given to cause temporary cessation of menstruation. The course of radiotherapy resulted in an amenorrhea of nine months' duration, during which there were no complaints.

Menstruation had been re-established for three months when the patient became pregnant, and with pregnancy came a sharp recurrence of all symptoms, which developed before we were aware that the patient was pregnant, although she insisted, as soon as the symptoms recurred, that pregnancy existed. A therapeutic abortion was performed, and the symptoms promptly abated. Massive doses of radiotherapy were then given, and permanent sterilization was accomplished. Endocrine therapy is still kept up, in much smaller dosage, thyroid, 1 grain, and whole ovary, 1 grain, being given once a day.

At present, her total loss of weight is 65 pounds (about 30 kg), blood pressure, 135 systolic. Double vision and headaches are but slight and occur at rare intervals. Menopausal symptoms of flushing and profuse sweats are markedly in evidence. Emotional instability is at times marked, at times, completely absent.

On the basis of the histologic studies described

in the previous paragraphs, an attempt was made to produce the condition of "cystic ovary" with the following hypothesis as a working basis. This condition follows incomplete recession and organization of the corpus luteum whereby an excess of luteal secretion is deposited in the ovary. This excess of secretion causes follicles that are developing to undergo cystic degeneration and inhibits in these degenerated follicles the normal progress of regressive changes.

Twenty-four female guinea-pigs weighing 300 gm were divided into two groups of twelve animals each. The animals were kept isolated from males, and had a common diet and similar surroundings.

The groups injected with a saline extract of corpus luteum received a total of seventy-five injections, while the other group received a total of sixty injections. The animals were killed after the injections were completed and sections were made of the thyroid, suprarenals, uterus and ovaries.

In none of the animals of either group were there any demonstrable changes in the thyroid, suprarenals or uterine mucosa.

The ovaries of the group injected with the saline product showed numerous follicle cysts which varied in diameter from 0.02 to 1.3 cm. These cysts had the same histologic characteristics as those observed in the human material examined. In some, there were areas of hemorrhage about the follicles, in others, this was not in evidence, simple liquefaction having taken place. In none of these cysts was there any evidence of attempted healing. In Figure 13, one ovary of each of the twelve animals is shown.

In the ovaries of the group injected with the "lipoidal product" no cysts were found, although atresia of the follicles was in evidence. In contrast to the previous group, the follicles were in varying stages of atresia, and there was marked evidence of repair in all its stages. One ovary of each of six animals of this group is also pictured in Figure 14, for purposes of comparison. It is interesting to note the differences in size of the ovaries in the two groups, the magnification being the same throughout.

On a basis of experimental results, it would appear that the mechanism of this process is probably as follows. Several corpora lutea fail to recede completely owing to premature hyalinization of the blood vessels supplying the gland. In consequence, there remains a deposit of luteal secretion, which slowly becomes an excess. This excess prevents normal healing processes in the degenerated follicles. The principle which inhibits is apparently present in a saline extract of the corpus luteum. It is not present in the lipoid preparation. The normal recessive phenomena which should occur in atresic follicles are in-

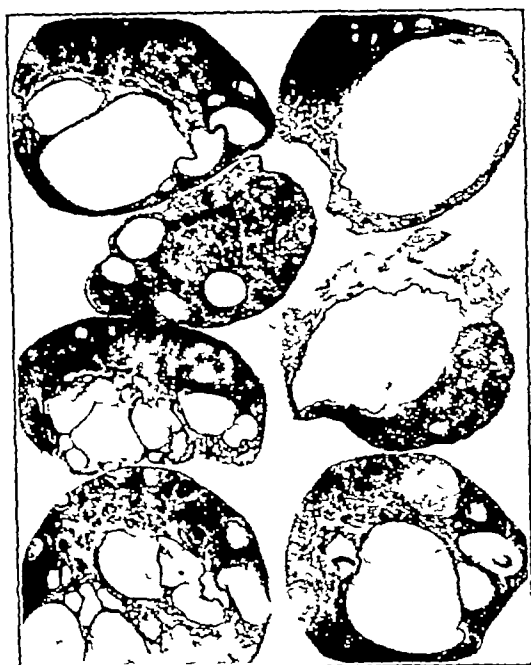


FIG 13—Low power view of guinea-pig ovaries after injections of saline extracts of corpus luteum

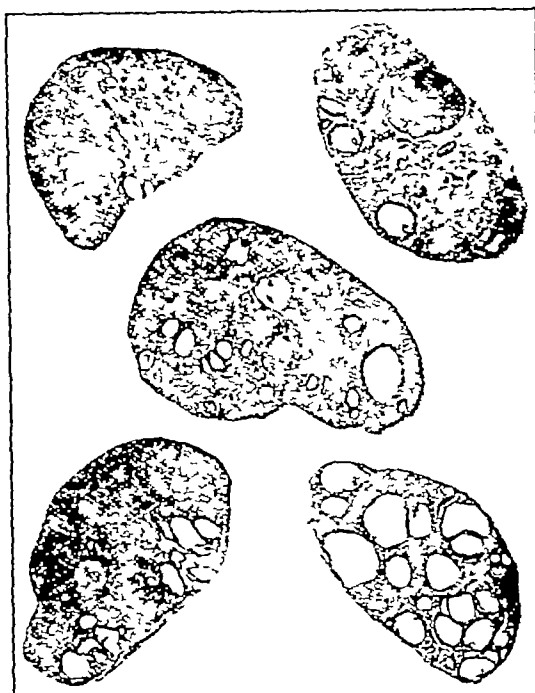


FIG. 13-a.

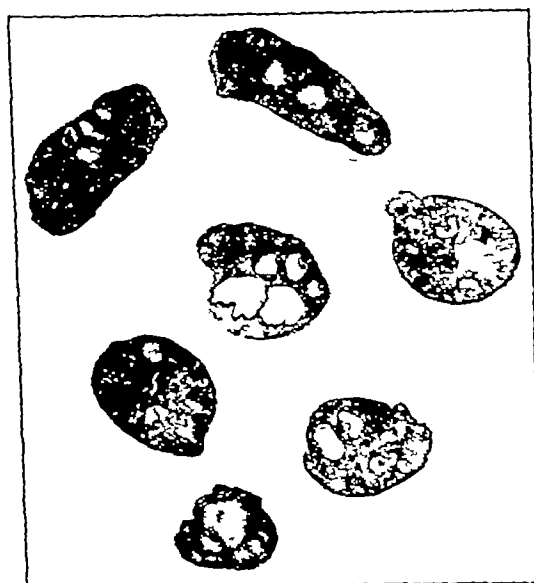


FIG. 14—Low power view of guinea-pig ovaries after injection of corpus luteum lipoid.

hibited, cysts of varying diameter develop, their size being dependent on the secretory activity of the epithelial lining

Excessive corpus luteum secretion is not responsible for remote or near endocrine phenomena. These endocrine phenomena, in the light of Loeb's communication, are probably due to the excessive amount of follicle fluid present in

the ovaries. It may be recalled that Loeb names two factors in the sexual cycle. The first factor is ovarian rather than associated with the corpus luteum. The walls of the maturing follicle secrete a substance that causes circulatory changes, growth processes, certain physical alterations and proliferation in the mammary glands, vagina and uterine walls, and, in a way, causes growth changes in the ovary itself, culminating in ovulation, which leads to corpus luteum formation.

The second factor in the sexual cycle is controlled by substances secreted by the corpus luteum. These secretions sensitize the uterus, make possible the formation of decidua or normal predecidual proliferation and facilitate the fixation and development of the fertilized ovum. They cause mammary growth and prevent proestrus, estrus, and ovulation, but not maturation of the follicles. There is an intermediate or a degenerative stage between the first and second factors.

The mechanism of the entire syndrome is possibly best explained as follows. The faulty recession of the corpora lutea being established, atresia of a number of follicles occurs and normal recession is interrupted. The follicles distend with secretion, and inflammatory changes having occurred in the capsule of the ovary, increased pressure is followed by pain. When for any reason the ovary becomes further distended, as with maturation of a follicle or development of

trapezius. A routine urine examination, chemical examination of the blood, Mosenthal test diet and the phenosulphonephthalein test failed to demonstrate the slightest evidence of any kidney involvement. The basal metabolism was minus 30 per cent, the sugar tolerance test failed to show sugar in the urine after the ingestion of 550 gm of glucose, the blood pressure was 210, systolic. The general appearance suggested a moderate myxedema.

Physical examination failed to reveal enlarged ovaries or any tenderness in that region. About ten days before each menstrual period, there was an acute exacerbation of all symptoms, which lasted until the flow had ceased. The patient was placed on thyroid, 1 grain, and entire ovary, 5 grains, three times a day. Within one month, the blood pressure had fallen to 150 systolic, the headaches had disappeared, and the patient had lost 45 pounds (20.4 kg). Most of the muscular pains were gone and double vision no longer occurred. The same glandular combination was continued for the succeeding month, and pituitary gland, 2 grains, was added.

After one week of pituitary gland therapy, there was a prompt return of all the previous symptoms, without the swelling, and a return to a blood pressure of 200. Discontinuation of the pituitary substance was followed by a cessation of the symptoms. During the following year, five different attempts were made to give pituitary substance, and each was followed by a return of headaches, double vision and high blood pressure. In spite of the great improvement, there were recurrences of the complaint with each menstrual epoch, and for this reason, radiotherapy was given to cause temporary cessation of menstruation. The course of radiotherapy resulted in an amenorrhea of nine months' duration, during which there were no complaints.

Menstruation had been re-established for three months when the patient became pregnant, and with pregnancy came a sharp recurrence of all symptoms, which developed before we were aware that the patient was pregnant, although she insisted, as soon as the symptoms recurred, that pregnancy existed. A therapeutic abortion was performed, and the symptoms promptly abated. Massive doses of radiotherapy were then given, and permanent sterilization was accomplished. Endocrine therapy is still kept up, in much smaller dosage, thyroid, 1 grain, and whole ovary, 1 grain, being given once a day.

At present, her total loss of weight is 65 pounds (about 30 kg), blood pressure, 135 systolic. Double vision and headaches are but slight and occur at rare intervals. Menopausal symptoms of flushing and profuse sweats are markedly in evidence. Emotional instability is at times marked, at times, completely absent.

On the basis of the histologic studies described

in the previous paragraphs, an attempt was made to produce the condition of "cystic ovary" with the following hypothesis as a working basis. This condition follows incomplete recession and organization of the corpus luteum whereby an excess of luteal secretion is deposited in the ovary. This excess of secretion causes follicles that are developing to undergo cystic degeneration and inhibits in these degenerated follicles the normal progress of regressive changes.

Twenty-four female guinea-pigs weighing 300 gm were divided into two groups of twelve animals each. The animals were kept isolated from males, and had a common diet and similar surroundings.

The groups injected with a saline extract of corpus luteum received a total of seventy-five injections, while the other group received a total of sixty injections. The animals were killed after the injections were completed and sections were made of the thyroid, suprarenals, uterus and ovaries.

In none of the animals of either group were there any demonstrable changes in the thyroid, suprarenals or uterine mucosa.

The ovaries of the group injected with the saline product showed numerous follicle cysts which varied in diameter from 0.02 to 1.3 cm. These cysts had the same histologic characteristics as those observed in the human material examined. In some, there were areas of hemorrhage about the follicles, in others, this was not in evidence, simple liquefaction having taken place. In none of these cysts was there any evidence of attempted healing. In Figure 13, one ovary of each of the twelve animals is shown.

In the ovaries of the group injected with the "lipoidal product" no cysts were found, although atresia of the follicles was in evidence. In contrast to the previous group, the follicles were in varying stages of atresia, and there was marked evidence of repair in all its stages. One ovary of each of six animals of this group is also pictured in Figure 14, for purposes of comparison. It is interesting to note the differences in size of the ovaries in the two groups, the magnification being the same throughout.

On a basis of experimental results, it would appear that the mechanism of this process is probably as follows. Several corpora lutea fail to recede completely owing to premature hyalinization of the blood vessels supplying the gland. In consequence, there remains a deposit of luteal secretion, which slowly becomes an excess. This excess prevents normal healing processes in the degenerated follicles. The principle which inhibits is apparently present in a saline extract of the corpus luteum. It is not present in the lipoid preparation. The normal recessive phenomena which should occur in atresic follicles are in-

severe epidemic once took place beginning in November

One would expect the extension of these epidemics to be general and regular, the contrary is true. An outbreak of poliomyelitis may spread to adjoining towns, or it may skip localities and appear in more distant communities. In 1910, a small epidemic occurred in Washington and shortly after in Philadelphia, but in Baltimore, which is between the two cities, there was a very slight increase in the number of cases. In 1907, when we had the severe epidemic in New York, a great many cases occurred in New England, whereas the country to the south and west of New York was comparatively free.

The most important aid in making the diagnosis of infantile paralysis is that obtained from an examination of the spinal fluid. In the instance which I related at the beginning of this paper, had the attending physician been careful enough to do a lumbar puncture, he would doubtless have reached the same conclusion as I did, and so have saved the patient from too early use of his leg, and the community from danger of contagion.

The spinal fluid in the beginning of poliomyelitis is clear, colorless and almost normal, there may be a slight increase in pressure. In a few days, however, there is a considerable change. The globulin reaction gradually increases and in the third week reaches its maximum. The most significant change, however, is in the number of cells. These rapidly increase, especially those of the mononuclear type. They may number hundreds, or even thousands. The normal count, as you know, does not exceed ten. The information given by an examination of the fluid, you will readily see, is considerable. I cannot, therefore, emphasize too strongly the importance and necessity of a lumbar puncture on all who develop an acute illness in the late summer or early fall. This is especially true if the illness appears to be one of slight importance, and occurs in a young person. These are the very types of cases which represent the mild non-paralytic or abortive form of infantile paralysis.

I think the most satisfactory classification made of this disease is that suggested by the department of health of this state. It is based wholly on the pathological anatomy. This classification has four types:

- 1 The non-paralytic or abortive type
- 2 The ataxic type
- 3 The cortical type
- 4 The ordinary spinal or sub-cortical type

The first the non-paralytic or abortive type, includes the very mild cases in which there is practically no paralysis or motor disturbances but in which there may be an involvement of the meninges.

In the second the ataxic type are included those cases in which the lesion involves the cere-

bellum, Clark's column, and the ganglia between the vertebrae.

The third, the cortical type, is that in which spastic paraplegia results. Thus third or cortical, and the second or ataxic types, are both rare.

The fourth, the ordinary spinal or sub-cortical, is the most common form. It is the one which is most frequent and the one which is self-evident. The lower motor neurone is affected and there results a flail extremity with subsequent atrophy and more or less paralysis.

After listening to this classification based on the pathological anatomy, you will realize that the disease is one which might be called multiple. The conception which you should form of infantile paralysis, is that of a general or systemic infection which has a predilection for attacking the nervous system. Therefore, both brain and cord are involved, and of course the symptoms must be both mental and physical. It is a disease, however, which may be so slight in its attack that the symptoms and danger signals may be mild enough in their manifestations to escape observation. This is especially true in the early stages, and in the mild, abortive types. This type is most baffling, and calls for the greatest care in diagnosis.

It should be borne in mind that there is one particular part of the nervous system especially prone to attack. The anterior horns bear the brunt of the illness. Now, just recall for a moment what would happen if the anterior horns of the spinal cord were affected, and you will readily grasp three or four leading symptoms of poliomyelitis. The anterior horns are the centers for controlling the motor functions. Therefore, there will be more or less paralysis. The anterior horns are the centers for the reflexes and form a part of the reflex arc. Therefore, there will be a loss of reflex. The anterior horns are the centers which nourish the muscles. Therefore, there will result atrophy of the muscles. Since the virus affects the posterior horns to so mild a degree as to be almost negligible, in this disease there will be no sensory disturbances. There will be no anesthesia, but on the other hand, inasmuch as the disease is a systemic infection, and therefore, must to a slight extent involve the entire nervous system, there will be an irritation of the posterior horns and the patient will complain of slight tingling and tenderness.

I said that there were other symptoms besides those of the spinal cord, and as one goes deeper into the subject, he realizes that the meninges, the coverings of the cord and the brain, and both the cerebrum and cerebellum may be affected. Therefore in some cases the physician will find rigidity of the neck, coma and Kernig's sign, if the cerebellum is affected, ataxia, if the cerebrum is affected, irritability, hyper-excitability, apprehensiveness, or stupor.

The meninges are almost always involved, a

another corpus luteum, the pain is increased. The simple excess of corpus luteum secretion would continue the resting stage of the menstrual cycle and produce amenorrhea, excess of follicular fluid would induce an undue continuance of the premenstrual phase with a resultant metorrhagia and menorrhagia.

In a similar manner, growth evidences in other organs, such as thyroid overactivity, and breast and pituitary changes are also attributable to excessive follicular fluid. The evidences of subgland function are explainable on the basis of fatigue following continued overstimulation from excessive follicular secretion.

Of the methods of treatment based upon such an hypothesis, the cases cited in other paragraphs are perhaps illustrative enough. Attempts

should be made to cause absorption of the follicle fluid by local treatment such as with sulphoichthyolate preparations and glycerin tampons, plus dry heat, combined with suitable endocrine therapy, such as thyroid medication for sub-thyroid symptoms, or suprarenal cortex for hyperthyroid symptoms. This proving futile, temporary or permanent cessation of ovulation should be attempted by radiotherapy, and this failing, a double oophorectomy should be performed.

It must be understood that just as the condition was a long period in arriving at its maximum, so treatment toward remedying the condition must be long continued, for it is well recognized in endocrinology that dysfunction of a gland is not quickly corrected.

## POLIOMYELITIS \*

By EDWARD LIVINGSTON HUNT, M.D.,

NEW YORK CITY

ON one of those cold and rainy days in early September, I met a friend who asked me how long it should take a patient to recover from an attack of intestinal neuritis. I replied that medically there was no such condition as intestinal neuritis, and inquired what were the patient's symptoms. He told me that just a week before his son, who was 19, had become suddenly ill with vomiting, diarrhea, and a temperature of 103, that the attack had been short, lasting three days, and that now a week later, the boy was able to be up and about, but complained of pain and tenderness in his right leg, and was quite lame. I suggested that the diagnosis was wrong, and that the patient had probably suffered a slight attack of infantile paralysis. I then asked if a lumbar puncture had been done. The reply was, "No, the attending physician did not think such a test necessary." Subsequent events proved that the case was one of infantile paralysis.

I tell you this for four reasons.

First, it describes very accurately the onset and early course of a typical case of infantile paralysis.

Second, it brings to your mind the fact that early in September a short acute illness in a boy of 19 should always suggest infantile paralysis, because the disease is most prevalent in the spring and fall.

Third, it emphasizes the importance of doing a lumbar puncture as part of a routine examination.

Fourth, it describes exactly the wrong treatment for the early stage of infantile paralysis.

The history and onset of this patient's illness had misled the doctor. This will remind you that in this disease the history is of minor importance. It is apt to be general, does not throw much light on the condition, and must not be given nearly so great weight as in other conditions. The story, which the patient afflicted with infantile paralysis, gives is typical of a systemic infection masquerading either as a gastrointestinal infection, or as a minor respiratory ailment. It may be so slight as to merit the name of ptomaine poisoning or grippe. It is the history of a few days indisposition, accompanied by a temperature of 102 or 103, and followed by an apparent complete recovery. So short is the attack and so marked the apparent initial recovery, that the whole illness encourages and misleads physician and patient, so that neither is on the alert for subsequent events. Even the slight tenderness which begins two or three days after is overlooked and given slight consideration.

Any acute illness, in a young person, occurring between June and November, ought to make the attending physician think of poliomyelitis, indeed it should impress itself on his mind so strongly that infantile paralysis ought to be considered until absolutely eliminated. Throughout the year occur sporadic cases, but the epidemics, with almost perfect unanimity, happen in the late summer and early fall. So unusual is it for an epidemic to appear at any other season, that the one or two which have occurred later in the year have been worthy of comment. In Norway, a very

\* Read at the annual meeting of the Fifth District Branch of the Medical Society of the State of New York at Oneida, October 2, 1924.

damage has been done, and also because we cannot forecast whether a severe attack is going to do much damage, or whether a mild one is going to do more. An attack, mild in its symptoms, may yet result in a slow but steady increase of paralysis lasting for several days.

The majority of these patients get well. I suppose it would be fair to take Lovett's figures, which are that 25 per cent completely recover. The prognosis is first as to life, and second as to the extent of paralysis. Unless the attack is exceptionally severe, which is evident at once, these patients live. The best that we can tell a patient is that there will be a recovery, that it will be more or less complete, and that it will begin when the tenderness subsides, but as to how far it will extend, time alone will show.

#### TREATMENT

The treatment should be divided into

- 1 The treatment of the acute stage,
- 2 The treatment of the convalescent stage, and
- 3 The treatment of the chronic stage.

I believe the most important treatment is that of the acute stage. The keynote of this treatment is rest and helping nature. It is far better to avoid drugs, and give the inflamed nerve cells an opportunity to get well. The extent of recovery depends upon two factors—the extent of the damage, and the care given in the acute stage.

Therefore, at once, as soon as the diagnosis has been made, the patient should be put to bed, fed nourishing food, and reassured with a cheerful environment. He should be made to take absolute and complete rest, in no way moving the paralyzed muscles. This treatment should continue for weeks until every evidence of the acute stage has subsided. The guide to this is the tenderness experienced by the patient when the affected muscles are touched. So long as this symptom is present, the patient is presumed to be in the acute stage of the disease, and, therefore, the only treatment indicated is one of rest. It is only when the tenderness subsides that one should consider at all the many aids which we have for treatment, such as massage, electricity and re-education.

Finally, when this tenderness has completely subsided, the patient passes into the second or convalescent stage. Positive harm can be done in this first stage by massage or by trying to stimulate the sick muscles. Before telling you what to do in the convalescent stage, I want to tell you a

few things not to do in the acute stage. I would not in that stage use any drugs. I would not apply any counter irritants to the spinal column, and I would not give any serum intravenously or intraspinally. Personally I do not believe you will do a great deal of damage by giving the serum, but I have yet to see very good results. Certainly there will be no very beneficial results, unless the serum is given in the very earliest possible days of the disease. Do not let a masseur or an electro-therapist have anything to do with the patient until all tenderness has subsided.

The treatment in the convalescent stage is one of stimulation and re-education of muscles.

When this convalescent stage has been reached one should try to ascertain just what muscles have been paralyzed and to what extent. Test all muscles, the test can be made in a hot bath, by means of both active and passive movements. Put the limb in such a position that weight and leverage cease to be factors.

Proceed then to use massage and to re-educate the muscles. Massage will improve nutrition, keep up muscular tone, and diminish atrophy. Do not give it to the point of fatigue else you will overture the muscle.

Re-education of the affected muscles will give most help. This treatment should consist of graduated muscle exercises given daily and arranged so as not to tire the muscles and also so as to bring into action the weak muscles as well as the strong. Too often the tendency is for the stronger muscle to derive all the benefit of the re-education exercises at the expense of the weaker.

Electricity is of some help, but is not nearly so important as muscle training.

Deformities must be corrected so that stretching of ligaments will be averted. If necessary keep the limb in its normal position.

The treatment of the chronic stage belongs to the orthopedist.

In conclusion then let me reiterate a few points.

- 1 Make the examination thorough, do a puncture.
- 2 Remember that tenderness is an important guide.
- 3 See that the patient has a long period of rest before beginning active treatment.
- 4 Muscle training is the greatest aid in treatment.
- 5 Muscle fatigue is the greatest danger.

stiff neck is a common and important symptom

The distribution of the paralysis should be mentioned. It is not peripheral but central, because of course it is not the nerve trunks which are involved, but the spinal cord segments, and for the same reason the paralysis is irregular in distribution, and incomplete as most muscles receive their innervation not from one particular segment alone, but from adjoining cord segments, that is, both from one segment and from the one partly above and the one partly below the affected one.

To sum up the symptoms, I want to ask you to think of four groups

- 1 An irregular, incomplete, and possibly unevenly distributed paralysis, or merely a loss of power affecting one or more extremities, especially the legs

- 2 An absence of anesthesia in the paralyzed limbs

- 3 A loss of reflexes in the paralyzed limbs

- 4 A definite change in the spinal fluid is shown by a great increase in the cells

In other words, in this disease you have three positive signs and one negative. The three positive are

- 1 Paralysis,

- 2 Destroyed reflexes, and

- 3 An inflammatory reaction in the spinal fluid

The negative sign is the complete absence of anesthesia. When these signs occur in an acute general systemic infection, especially prevalent in the late fall and in young people, the physician should think very seriously of poliomyelitis.

I do not wish to dismiss the subject of symptoms without saying a word about tenderness. For a great many years the significance of tenderness was disregarded, and I think even now is not made of sufficient importance. Tenderness means that when the paralyzed muscles are handled or very lightly squeezed, the patient suffers pain. This tenderness is of value in two respects: first as a symptom, and second, as a guide to treatment. There are very few conditions in which muscular tenderness occurs. Therefore its presence should greatly aid in the diagnosis. It may come early or late, but its presence is most significant.

The pathological changes which occur in this disease consist of congestion, which is accompanied by an exudate, hemorrhages, edema and anaemia, resulting from pressure upon certain vessels and finally a change in the nerve cells, which change is brought about by the toxic action of the virus. There are varying degrees, so that in some cases pathological changes are slight, in others moderate, and in the more severe cases, extensive. These changes occur throughout the nervous system. I mean by that, they are present in both the cord and in the brain. Those places in the cord which are most vascular are of course

the ones most likely to be affected, and therefore, it is in the cervical and lumbar regions that we most frequently find evidences of this disease, and particularly in the anterior part of the cord. Inasmuch as the disease is a general infection, other parts of the cord are also involved and small changes may be noted in the brain, pons, and medulla. Even in the posterior nerve roots changes will frequently be found. In the old cases, there is of course an atrophy of the cord, so that the ganglion cells degenerate, as do the fibres of the anterior horns and the nerve trunks. There is also an atrophy of the bones, so that the entire extremity—bone, nerve, and muscle is affected. The condition begins with a slight congestion, and if the attack is virulent, this is followed by an infiltration of small mononuclear cells. There is also infiltration of the cells along the nerve roots.

In addition to these changes in the nervous system, other organs are involved. The virus frequently affects the lymphoid tissues.

It is not possible to make any statement which is definite in regard to the virus of poliomyelitis. It is probably filtrable, gaining entrance through the mucus membrane of the naso-pharynx. The disease is probably contagious, certainly infectious, as washings from the naso-pharynx have communicated the infection to other patients.

#### DIFFERENTIAL DIAGNOSIS

There are many conditions from which we should differentiate infantile paralysis. I have seen cases of this disease diagnosed as rheumatism and meningitis. Other diseases which may confuse the picture are typhoid fever, cerebral hemorrhage, grippe, and mild respiratory or intestinal conditions.

In our large hospital services we have always found that the most difficult diagnosis to make was the differential one between anterior poliomyelitis and tubercular meningitis. In each there may be the fever, the rigidity, and the paralysis. In each there may be an involvement of cranial nerves, the Kernig sign and pain. In reaching a conclusion between these two conditions of tuberculous meningitis and poliomyelitis, the examination of the spinal fluid proves of most value and of great importance. In the meningeal condition, there is an increase of the sugar content, whereas, in poliomyelitis, this remains normal.

I now want to say a few words about the prognosis and treatment.

There is no disease in which the prognosis is more difficult than in poliomyelitis. The physician will be wise who after the first examination gives a guarded statement. This is largely due to the fact that we have very little data, very few and incomplete ways of judging as to what actual



is only necessary to be conservative in judging the number or the genuineness of such cases. The three additional influences which demand consideration in relation to the above generalization are heredity, modern living conditions, and the endocrine organs.

Heredity seems to be a real predisposing factor. As some families are full of diabetes, so others have nephritis, hypertension and apoplexy in generation after generation. The best explanation seems to be an inherited vulnerability of certain organs. Granting that practically everybody is sometimes subject to infections, there seems to be a special susceptibility to damage of the pancreas in diabetic families, and to damage of the cardio-renal-vascular system in other families. On the other hand, the great majority of cases of any of these diseases are probably not hereditary.

Present day civilization has been blamed for creating these medical problems which it faces. The chief evidence consists in the tremendous statistical increase of these diseases. Sedentary life, long hours, and psychic stress and strain are not known to cause either heart or kidney disease, though a popular idea makes them responsible for high blood pressure. On the other hand, others have pointed out that civilization in some respects has brought a quieter life. Primitive man, exposed to the constant terrors of wild beasts, human enemies, and his own superstitions, and likewise the medieval European, amid his numerous dangers of battle, murder, pestilence and sudden death, had in some respects more nerve-racking lives than ours. Laziness, obesity, and gluttony, including excessive protein diets, existed long ago. Alcoholism and other vices have on the whole diminished. Acute and chronic infections were much more prevalent formerly than now. If any metabolic diseases are more common among us than among primitive races, the difference may be due to something else than habits of life. Certainly the statistical increase among us as compared with our own ancestors for several generations or centuries seems to be explainable on the same two grounds for cardio-renal-vascular disease as for diabetes. First, we have better diagnoses and better statistics, so that the extent of the trouble is more accurately realized. Second, far more people live to middle and old age in other words, as the deaths in early life are prevented, more persons naturally become subject to the characteristic diseases of later life.

Endocrine disorders are a fad nowadays, and they are invoked by some writers to account for practically every obscure condition. Thus they are dragged into the question of hypertension, merely because the pathology is uncertain. But there is no evidence of adrenal excess as the basis of any typical case of hypertension. Thyroid excess

may presumably, like any intoxication, aggravate an existing tendency to hypertension, but its status is that of a complication, in typical hyperthyroidism there is no hypertension, and in typical hypertension there is no hyperthyroidism. The same is true of diabetes and hypertension; they may complicate and aggravate each other, but they are separate diseases, and observations of the frequency of hyperglycemia in hypertension cases and of hypertension in diabetic cases show merely the incidence of these complications. The sex glands have no scientific place in this subject. Castration in either sex does not raise blood pressure. Hypertension develops about the fifth decade of life as frequently in men as in women. A cure of hypertension by ovarian or any other kind of hormonal therapy has not been shown. The so-called hypertension of the menopause responds to diet treatment in the same way as other forms of hypertension. For these reasons the existence of any such separate entity as hypertension of the menopause must be denied.

#### PROPHYLAXIS

If we proceed on the hypothesis that all the cardio-renal-vascular disorders are the results of infectious or toxic damage of organs, we can face intelligently the second question, namely that of prevention. For this, two possibilities are open. The first and ideal one is to prevent infections. We are far from this goal, but yet acute infections are being either prevented or aborted by specific bacteriological methods with constantly increasing success. Thus, the recent discoveries in scarlet fever should aid in reducing the incidence of nephritis. Also, chronic and focal infections are being eradicated with increasing care and thoroughness. Therefore general hygiene, and the efficient application of medical and surgical knowledge as rapidly as it develops, offer real hopes for lowering the figure of the incidence of these diseases, which heretofore has risen so alarmingly.

The second possibility is to reduce the functional burden of organs that have been or may be damaged. Animal experiments in this Institute have proved that acute toxic injury of the kidneys is increased if they are at the same time subjected to a heavy load of nitrogen or salt excretion. An extreme application of this principle might consist in placing every scarlet fever patient on a diet low in salt and protein. Certainly in every form of severe acute infection tests should be made of the urine and if necessary, of the blood, and if the slightest renal damage is indicated the diet should be carefully restricted. Every acute nephritis, of whatever origin, should be followed by months of restricted diet, even if the renal trouble seems to have cleared up completely, and if the attack was severe, some degree of dietary restriction for the remainder of the

# HYPERTENSION AND THE TREATMENT OF NEPHRITIS\*

By FREDERICK M ALLEN, M D,

MORRISTOWN, N J

**T**HIS subject is obviously a large one. It covers a wide range of problems, largely unsolved, some of which must be mentioned very briefly and others omitted altogether. It should also be understood as standing second to no other subject in medicine in its importance for physicians and for the public.

The attack of medical science upon such a problem consists in learning the incidence, cause, prevention and most effective treatment. For clearness, we may best begin with some of the elements of present knowledge and methods.

## INCIDENCE

According to available statistics, cardio-renal-vascular disease stands first among the causes of death in adults. Cancer, tuberculosis and pneumonia rank below it. Within the past few years metabolic diseases in general have been winning their place as the leading division of medicine. Medical and popular attention has been drawn to the fact that there are a million cases of diabetes in this country. But the cases of high blood pressure alone possibly outnumber the diabetics, and when other types of renal-circulatory disease are included we may reasonably estimate the total number of sufferers somewhere between three and five millions. This has been the cause of death of the last two Presidents of the United States—Wilson and Harding—and also of Mrs. Harding. It is scarcely possible to pick up a copy of any large newspaper without seeing notices of deaths of more or less prominent persons from renal-vascular disease, and conspicuous among these are the sudden endings with apoplexy or heart failure resulting from high blood pressure. The problem is brought home to every individual, for in addition to the considerable chance of developing one of these disorders ourselves, there is almost a certainty that we cannot go through life without having some relative or close friend afflicted in this way.

## ETIOLOGY

The cause of cardio-renal-vascular disease is attributed essentially to infection. Infection in this sense means any acute or chronic disease in which bacteria or their toxins enter the blood. The proof is most complete for heart disease, in which it has been possible to demonstrate the bacteria in the heart valves. Embolic or suppurative nephritis, in which bacteria are demonstrable in the kidney, does not furnish adequate proof that other forms of nephritis are due to infection. But nobody doubts that tonsillitis, scarlet

fever and other acute fevers are frequently or occasionally attended by acute nephritis, or that such acute cases sometimes pass on into definite chronic nephritis. The connection of kidney disease with chronic focal infections in the teeth, sinuses or elsewhere is more difficult of precise proof but yet has been made so strongly probable by clinical observations that it is commonly accepted as established. The vascular diseases are the most recondite members of this group, and we are far from having either valid proof or general agreement concerning the etiology of arteriosclerosis or hypertension. But it will scarcely be disputed that hypertension is sometimes due to focal infection, as evidenced by the relief obtained by clearing up the focus. Also, elevation of blood pressure is not an uncommon accompaniment of the acute scarlatinal nephritis. Arteriosclerosis and hypertension may be caused by a chronic infection, such as syphilis. Furthermore, disorders of the heart, kidneys and blood vessels are so closely associated, and disease in one of these organs is so frequently complicated by disease in one or both of the others, that a common etiology is easily assumed. An assumption of this kind has actually become part of the generally accepted doctrine of nephritis. When hypertension occurs with acute scarlatinal nephritis, it is now generally interpreted as indicating toxic damage of the blood vessels, not of the kidneys alone. When edema occurs with either acute or chronic kidney disease, it is no longer explained as a simple retention of water or salt due to renal impermeability, but evidence has been found that altered permeability of the peripheral vessels is an important factor and apparently sometimes the sole factor. From all these considerations it is plausible to regard cardio-renal-vascular diseases as a common group, not only clinically but also etiologically, and to explain their cause and intimate connections as due to different infections and intoxications, which in different individuals produce various selective or generalized injuries of the heart valves or muscle, the kidneys, and the large or small blood vessels.

In this generalization, other poisons such as lead, mercury, alcohol and tobacco, and other influences such as exposure to cold, were ignored as being either debatable in status or of minor importance. No mention has been made of auto-intoxication, in the sense of absorption of harmful substances from the intestine. Here the point is merely one of proof. If it is proved that any substances, particularly products of putrefaction, are taken up from the bowel and cause any of these diseases, such cases are included under the head of infection or intoxication. It

\* Read before the Buffalo Academy of Medicine, March 11 1925

in research. Their practical status is open to question. In the first place, the average practitioner will not learn or perform them, and by making the subject appear unnecessarily formidable and complicated to him, they are detrimental to practical treatment. In the second place, why should the practitioner perform them? Granting that any or all of them turn out very badly, doubtless the prognosis is bad, but is there no simpler way of recognizing severe cases? In less severe cases, the practical reliability of the tests is not established. Furthermore, these tests pertain mostly to the function of nitrogen excretion. For salt and water excretion, the Ambard principle seems to lack practical value, and even the concentration and dilution test is not decisive. Any or all of these tests may show good functional capacity and yet the patient may die very soon of cerebral or pulmonary edema, apoplexy, heart failure, or secondary uremia. The argument is immediately made, these are circulatory accidents, while the tests measure only the function of the renal epithelium. The answer is, first, is it certain that a test can distinguish infallibly between epithelial and circulatory disturbances? and second, is the physician interested in a theoretical question of this kind, or in the practical questions of how to treat his patient and whether the patient is likely to live or die?

**Diet tests.** A simple classification was suggested above for its practical usefulness, and now an equally simple basis will be proposed for judging the severity, treatment and prognosis. If a case is to be treated at all, a diet is necessary, and this can serve as the most practical function test. Our cases in the Institute are studied by the usual methods for the usual theoretical purposes, but it seems reasonable to base a practical estimate of a renal-vascular disorder upon observations of what the renal-vascular system is able to do.

First, if a patient is able to eat a high protein diet without abnormal increase of non-protein nitrogen (or urea, whichever is preferred) in the blood, his nitrogen excretion is satisfactory and protein need not be restricted, unless as a theoretical precautionary measure. If moderate or severe protein restriction is necessary to reduce the blood nitrogen to normal, the nitrogen excretion is moderately or severely impaired. If limitation to twenty or thirty grams of protein, or a temporary protein-free diet, fails to bring the blood nitrogen near to normal, the nitrogen function is dangerously impaired, and, though discrepancies exist, the danger of uremia bears a crude relation to the height of the blood nitrogen.

Second, if a patient is able to eat unlimited salt without edema or hypertension, his salt function is adequate and prohibition of salt is unnecessary, unless as a theoretical precaution. If moderate or severe salt restriction is necessary to clear up edema or hypertension, the salt function is re-

garded as moderately or severely impaired. If the strictest salt exclusion fails to clear up edema or hypertension, the case is considered dangerous in proportion to the severity of the persisting symptoms. There are exceptions to all rules, but in general if any large dropsy, or blood pressure much above 200 mm, continues in spite of rigid exclusion of salt, not many months of life are to be expected.

I shall not attempt to mention the incidental or emergency therapeutic measures with which every physician is familiar, but some reference may be desirable to certain proposals which have attracted more or less recent attention. The theory of acidosis as the governing factor in either nephritis or edema, and the clinical use of Martin Fischer's alkaline injections, seem to have no sound support. Sansum makes the more rational suggestion that the diet should be so chosen as to furnish a nearly neutral urine, on the ground that a strongly acid reaction is injurious to the kidney. If acid retention has occurred, as indicated by high phosphate and low bicarbonate figures in the blood plasma, alkali may be administered not merely as sodium bicarbonate, but perhaps preferably by magnesia or calcium salts, which can be excreted through the bowel. Several suggestions have been made for the severe edema cases which are not cleared up by salt restriction. Where there is no important nitrogen retention, a few authors both in Europe and America have recommended high protein diets. I have not tried the plan in enough cases to contradict these claims, but can only say that in the few cases in which I have tried it the results were bad. Likewise with the recommendations of calcium chloride for edema, others have reported benefit, but my personal experience has been small and unsuccessful. Also I do not believe in the scientific soundness of the recent tendency to hold sodium responsible for all the trouble and represent chlorine as harmless. The well-known diuretics, especially of the caffeine-theobromin group, undoubtedly drive out some water which salt-free diet fails to remove, and still greater claims are made for some new drugs. The most prominent of these is novasurol, a mercurial which has been described as acting miraculously in many cases both of edema and of ascites, though in some other cases it has been found to produce disturbances such as bloody diarrhea. I have not tried it, for lack of suitable cases. In fact we have more important theoretical investigations which we are prevented from carrying out by lack of severe edema cases, and we should be thankful to anybody who would send us cases of marked edema, either nephritic or cardiac, on a charity or any other basis. Actually, edema cases which are resistant to strict salt-free diet are comparatively scarce. Those which resist lax salt restriction may still retain enough

patient's life is a measure of prudence. Such diets need not be particularly irksome, and by their use there is a chance that in some cases the danger of acute nephritis may be avoided, and that in other cases the onset of chronic kidney disease months or years after an acute nephritis may be prevented.

It is a doubtful question whether the eating habits of the general population need any change on account of these diseases. We have confirmed Newburgh's observation that excessive protein ingestion may produce signs of renal irritation in healthy persons, but it appears improbable that the meat or protein content of the average normal diet is a cause of kidney disease. There is ground for criticism that food is salted too heavily in many restaurants and also in many homes, but there is an apparent tendency to reduce the unnecessary use of salt, and it seems reasonable to believe that the moderate use of salt in general is not harmful and may be beneficial. On general principles, excesses in alcohol or tobacco must be considered harmful, though their direct connection with renal-vascular disease is uncertain.

#### TREATMENT

The third question, that of treatment, is necessarily the chief one to occupy the attention of physicians. Vital organs having been damaged, the essential treatment is to relieve them from functional overstrain. Here a division must be made, at least theoretically, between cardiac cases, which are treated on mechanical principles by muscular rest and stimulation by drugs, and renal-vascular cases, which are treated on chemical principles by diet.

In a brief summary of this kind, scarcely any mention can be made of anything except this all-important diet therapy. Sweating and purging may have a slight temporary usefulness in acute cases or in acute emergencies of chronic cases, but they are not equal in importance to one gram of salt or nitrogen in the daily diet. There is sometimes room for a skillful use of drugs, but the best principle is to refrain from putting into the body anything that the kidneys have difficulty in excreting, rather than to try to force a greater excretion. It must be understood that diet and excretion do not pertain to the kidneys alone. The elimination or retention of the substances in question involves the heart and the entire vascular system, and also all the tissues of the body. This fact is the basis of the general diet treatment of cardio-renal-vascular disease.

**Classification.** Obviously, it is necessary to break up this generalization into the different special diets suited to the different forms of disease. Many classifications of these disorders have been attempted, and we now follow the classification of Volhard as the latest and best. But

agreement between authorities is by no means reached yet, and for physicians at large clearness is more important than complicated or disputed pathological details. It is possible for practical purposes to ignore the morphologic pathology, which is the field of chief difficulty and disagreement. The chemical viewpoint is the simple one, the therapeutic viewpoint is the indispensable one, and these two happen to be identical. I believe the general practitioner will be aided by considering renal-vascular disease as divided on this basis into three type forms.

First, there is a form characterized essentially by nitrogen retention. Among morphologists, these cases are regarded as true nephritis, in the sense of an inflammatory etiology. Also the term glomerulonephritis has been applied by those who hold the glomerular changes as the decisive feature. But the anatomical subdivisions need not be mentioned here, because on the whole it is not feasible to differentiate them clinically. The important clinical fact is that this form tends to end in true uremia.

A second form is characterized preeminently by edema. Heavy albuminuria and anemia are also typically present, but not hypertension or nitrogen retention. Death may occur from the fluid accumulation or from circulatory or general weakness. The term nephrosis has become familiar for such cases.

The third form is characterized essentially by high blood pressure, and it tends toward death by apoplexy, heart failure, or pseudo-uremia. It is better that the term eclampsia should not be limited to puerperal cases but should be extended to all cases of false uremia, in which death often occurs with convulsions.

It must also be understood that all possible gradations and combinations occur between these three forms, and that the majority of cases are mixed rather than pure. Furthermore, secondary changes may become superimposed upon the primary ones, so that cases may appear to alter their clinical character. These facts furnish a defense against the criticism that this classification disregards fundamental pathological differences. Such differences, even if distinguishable by tests, do not affect treatment in the slightest and therefore have no particular value for the practitioner.

**Renal function tests.** This brings up the question of renal function tests and their usefulness. The excretion of test substances, notably the dye pnenolsulphonephthalein, the mathematical calculations of Ambard and his imitators, the retention of special substances such as creatinine or indican, trials of the concentrating and diluting power of the kidney, ordinarily performed by Volhard's plan in Europe or the Mosenthal modification in America, these and many other tests furnish theoretical information and have a place

plicated with diabetes are still among the most favorable prognostically, provided the diabetes is efficiently treated, and cases complicated with nephritis are still the worst in all respects and furnish the highest proportion of deaths. Otherwise, we lack prognostic indications, neither the height of the blood pressure nor anything else in the examination gives advance notice whether the condition can be controlled successfully or not.

The experience regarding complications remains as before. Apoplexy becomes rare when the blood pressure is reduced, and this rule holds even for patients who have previously had one or more strokes. On the other hand apoplexy keeps its usual frequency in cases where the pressure is not reduced. Myocarditis, heart failure and all cardiac complications are benefited as a rule, and sometimes very strikingly, by reduction of the pressure, but digitalis and the usual cardiac treatment may still be needed. The existence of nephritis with high blood nitrogen may sometimes call for a low protein diet prior to the withdrawal of salt, to avoid possible danger of uremia. But we have never seen a case in which salt exclusion was contra-indicated, and sometimes the renal function improves and albuminuria diminishes or disappears, presumably because of better circulation through the kidney. Retinitis is a grave, but by no means necessarily fatal sign. As a rule it can be permanently arrested when the blood pressure is controlled, and the prevention of blindness is in itself important enough to justify the whole treatment. Renal or cardiac "asthma" is generally relieved quickly and completely. The results with true angina pectoris are among the poorest, relief, if obtained, is apt to be transitory or partial, nevertheless the diet plan is probably better and safer than the spectacular surgical procedure of section of the sympathetic. Other vascular complications such as the so-called "crises," and also the flushings and other symptoms associated with the menopause, generally pass off gradually, if the pressure is controlled.

The results in severe cases furnish the most severe test of a treatment, but they cannot be the best results. The latter can be obtained only by treatment at the earliest and mildest stage possible. At such a stage, when the elevation of pressure is slight or brief, when symptoms are slight or absent, and when a little rest and vacation suffice to clear up everything, the condition should not be ignored, and neither should the prescription be rest, relaxation, or climate. A busy life does not cause hypertension, and rest does not reach the underlying cause or halt the progressiveness. The treatment should be by careful diet from the beginning, and by this means there is good hope of warding off the severe stage and most of the complications. The patient should be allowed to work, and invalidism should

not be fostered unless in the most severe type or stage of the disease.

#### OTHER USES OF SALT-FREE DIET

It may be remembered that in subdividing cardio-renal-vascular disease at the beginning, we split off the cardiac cases from the renal-vascular cases, on the ground that the former are treated mechanically and the latter chemically. A reunion is possible at this point, by calling attention to the benefit of diet in heart disease. It is unfortunate that books on the heart are so deficient on the subject of diet, and that most physicians who see a decompensated heart case think only of rest and digitalis. Whenever there is a tendency to edema, salt restriction is valuable for diminishing this tendency, easing the circulation, and reducing the need of driving the heart with drugs. Dry diet should not be ordered without excluding the salt which creates thirst.

It is doubtful if diabetes insipidus belongs anywhere in the cardio-renal-vascular group, but a salt-free low-protein diet is the best practical means for diminishing the thirst and polyuria.

Enuresis in children is occasionally a symptom of diabetes or kidney disease, but is generally a harmless condition which becomes very annoying when continued to too great an age. Abundant urine is generally one factor, and a cure is often possible by the use of salt-free diet and corresponding restriction of fluids until the habit is broken.

There are numerous other ways in which an understanding of the principles of metabolism and diet will be found useful in general medicine.

#### PRACTICAL APPLICATION OF TREATMENT

Summarizing broadly and briefly, the physician treating renal-vascular disease has to combat three things, namely nitrogen retention, edema, and hypertension, and for this purpose he has two weapons, namely low protein diet and low salt diet. These stipulations are perfectly simple to understand and to fulfill, but for successful treatment we must insist relentlessly on the equally simple fact that *they must be understood and must be fulfilled*.

Protein restriction is easy. Any physician who can prescribe a diet at all can easily make up three standard menus, one of them containing perhaps 30 grams of protein, another perhaps 60 grams, and another 80 to 100 grams. These may be used in testing the patient's power of disposing of nitrogen, and for the later treatment with low, moderate or high protein diet.

A salt-free diet will appear a childishly simple matter to the average physician, until he encounters the difficulty of making it accurate and appetizing. He should take notice of the fact that most specialists or others who have obtained no benefits from salt-free diets for hypertension have

functional capacity that they can respond to the above artificial forms of stimulation. But it is better to avoid all possible dietary strain upon a damaged function than to attempt to stimulate that function to overwork, and when the salt eliminating function is so feeble that edema persists in spite of rigid salt exclusion, I doubt if any of these artificial measures will give much benefit for any very long time.

**Results.** Turning to the results of diet treatment, we must recognize that they make up a brilliant chapter in modern medicine. Both the severity and the progressiveness of kidney disease have been reduced by dietary control. To a very large extent, uremia is prevented or greatly postponed by the protein restriction in general use. Thanks to salt restriction, as already mentioned, dropsy has become comparatively rare and seldom reaches the huge proportions which were previously common. Other kinds of therapeutic achievement—a surgical operation, or a new serum for an infectious disease—are more spectacular and impress the public accordingly, but the medical profession are agreed concerning the beneficent results of these diet methods.

There is no such unanimity concerning salt restriction in hypertension. We have revised the forgotten or ignored French work on this subject and have attempted to place it on a more accurate and efficient basis. Our observations, that salt restriction when accurately carried out gives strikingly beneficial results in the great majority of hypertension cases, have been confirmed by some writers but contradicted by others who have great experience and reputation. On this point, therefore, I am simply in the position of reaffirming my previous statements, and continuing to reaffirm them until they receive the acceptance which facts must ultimately win.

The benefits of salt restriction for hypertension are demonstrated partly by the immediate results. In many cases there is a transformation within the first few days or weeks, which is not explainable by rest, psychic influence, accident, or any other hypotheses. A stronger demonstration is afforded by the permanent results. Our previous publication<sup>1</sup> comprised an experience of four years and 180 cases, mostly severe. The pressure was reduced to normal in only a small minority (34 cases, or 19%). In 75 other cases (42%) the relief of pressure and symptoms was sufficient that the patients became subjectively well and remained so. In other words a total of sixty per cent of the cases gave striking success. In 16 other cases (9%) there was partial or transitory benefit. In 55 cases (30%) complete failure was acknowledged because there was no perceptible improvement beyond what might be attributed to rest and other routine measures.

The total mortality for the four years was 25 (13.8%).

We are now able to extend this experience to six years, and enlarge it with 148 cases in which the blood pressure was regularly above 190 and generally well above 200 mm. The percentages of success and failure have remained practically the same. We previously pointed out that these percentages are practically independent of time. If the pressure and symptoms are relieved, this relief is obtained rather quickly and generally continues indefinitely. In other words, the progressiveness of hypertension, which is the worst element in the prognosis, is arrested in the successful cases. On the other hand the unsuccessful cases are refractory from the beginning. There are exceptional cases, which begin successfully but end in death or relapse, or which on the other hand are refractory at first, but yield to months of continued rigid diet, but these are few. In line with these statements is the fact that our total mortality for the six years is 43, or 13.1% of the 328 cases.

These figures must be interpreted in the light of statements by other authors, that the majority of patients with severe hypertension are dead within five years (Janeway), and the majority of those with diastolic pressure above 120 mm are dead within two years. Our cases are unselected, we have been in the position of inviting physicians to send us their most hopeless cases, and in general they have done so. The tables in our previous paper showed that the diastolic as well as the systolic pressures have been high. In addition, all kinds of complications with the uremic form of nephritis, pre-existing apoplexy, heart disease, diabetes, and also old age are included in the series. One dealing with the patients does not receive the impression of thirty per cent of failures. Admitting the record of approximately 110 failures among 328 cases, based on the objective fact that there was no important reduction of blood pressure, the total of 43 deaths in six years would not make a very bad percentage if based on the failures alone, without regard to the rest of the series. Our actual belief is that the salt-free diet is beneficial in practically all cases, and that it has at least mitigated symptoms and prolonged life even in the majority of the cases classed as failures.

We divided the pure or essential hypertension cases into two classes, a majority with plasma chloride concentrations above 580 mg per 100 cc, and a minority with concentrations below 580 mg per 100 cc. Though the method for plasma chloride analyses is not as exact as desirable, high initial figures for chlorides in both plasma and urine may still be regarded as a favorable sign. This is rational, because if the body does not contain much chloride there is less chance of change by the exclusion of chloride. Cases com-

<sup>1</sup> Allan, Frederick M. and Sherrill James W. J. *Metabolic Research* 2, 1922, 429. *The Treatment of Arterial Hypertension*.

## THE FALLACIES OF A NEGATIVE PREOPERATIVE URINE REPORT

By HOMER L. NELMS, M.D.,

ALBANY, N. Y.

THE majority of surgeons require a preliminary routine urine examination on every patient before a general anesthetic is given. The object of this is to determine whether they are dealing with a nephritic or a diabetic condition, either of which, if present materially influences the prognosis in the case.

In many clinics this examination is made on the A. M. voiding. There are perhaps several reasons why early morning voidings are usually selected. In the first place, many patients requiring what are called selective or interval operations do not come into the hospital until the evening before operation, and in these cases the A. M. voidings represent the most convenient specimen that can be obtained. Secondly, the A. M. specimens are sent to the laboratory and examined within a few hours after voiding, and many surgeons place a great deal of emphasis on this early examination. In the third place, it is thought that the early morning voiding represents the functional activity of the kidney during the night and hence is a more representative specimen than a single daily voiding.

Having satisfied himself that the patient has an operative condition, the surgeon has the urine examined, and if it contains sugar albumen or casts he immediately begins to consider the advisability of more extended observation. Suppose, however, as is most often the case, the preoperative urine report is negative, what then? The surgeon proceeds with the operation without fear. It is for the purpose of emphasizing the fallacies of a negative preoperative urine report that this paper is written.

## A NEGATIVE URINE DOES NOT RULE OUT THE PRESENCE OF DIABETES

It has been estimated that we have in this country about two million diabetics, either potential or real. Assuming that the total population is 120 million we might say that one person in sixty has diabetes in some form. It is true that many cases are mild, and perhaps these figures have been overestimated, but this is a sufficiently high percentage to make diabetes a frequent complication in surgical conditions, and the careful surgeon must be on the lookout for it.

The advent of insulin has stimulated our interest in blood chemistry, so that it is safe to say we are making ten times as many blood sugar determinations today as we did three years ago. In comparing the relative sugar content of the blood with that of the urine it has been found possible to have a negative urine with a high blood sugar. That is, there exists what has been called a high renal permeability. In other words, there is a certain group of cases in which sugar

does not appear in the urine until the blood sugar has reached a high concentration. Dr. Henry John of Cleveland, in a series of 714 observations, found that 18 per cent of cases in his series had negative urines with blood sugar concentrations high enough to classify them as diabetics, some of them severe. The blood sugar level at which sugar appears in the urine varies with the individual and it is manifestly impossible to tell to what height the blood sugar may go before glycosuria develops. Were it advisable to follow cases over a period of years with frequent blood sugar and urine examinations, some interesting data on this point might be obtained.

It is common knowledge that in diabetics under treatment with diet and insulin, the glycosuria disappears long before the blood sugar has reached a normal concentration, the accompanying table illustrates this point very well.

TABLE SHOWING VARIOUS BLOOD SUGAR CONCENTRATIONS WITH NEGATIVE URINE

Case No.	Fasting Blood Sugar Mg Per 100 c. c.	No. of Subsequent Blood Sugar Determinations.
1	405	10
2	327	5
3	285	15
4	275	8
5	273	13
6	266	4
7	254	30
8	250	18
9	250	6
10	250	5
11	222	10
12	214	4
13	207	4
14	188	6
15	185	10

Table shows various levels at which sugar disappeared from the urine and did not reappear while these patients were under observation. The number of subsequent observations represent the number of blood sugar determinations that were made during the time these patients were being standardized with diet and insulin. At no time did sugar reappear in the urine.

These figures were taken during the transitional stage of diabetics while under treatment with diet and insulin. Many patients came in with higher blood sugars and had sugar in the urine. The figures quoted here represent the blood sugar level at which sugar disappeared from the urine and did not reappear in the subsequent daily observations that were made, even though the blood sugar concentration was on a steady decline under treatment with diet and insulin. There is perhaps some room for objection to this article because of this point, but my answer is this. Just as these patients had a rapid transitional stage from a high blood sugar to a lower or normal blood sugar level because the



failed because their diets were not accurately salt-free, and other specialists, have gone on record in writing that no patient can be induced to eat a salt-free diet for any length of time and that any results obtained are due to undernutrition. There is nothing impossible or abstruse about it, but anyone undertaking it must realize that the salt-free diet is more difficult than any ordinary diabetic or nephritic diet, and that it is not obtainable in most homes or in most hospitals without very special preparations and precautions. Also, patients who develop symptoms of salt privation on the very strict diet are few, but it is important that such symptoms be recognized immediately and treated by giving the necessary small allowance of salt.

Analyses of the blood and urine are indispensable, at first for the diagnosis and classification of the case, and later as a check upon the diet and progress. No one should attempt or claim to give a salt-free diet unless he controls it by at least an occasional chloride analysis of a twenty-four hour urine sample, for this is the only means of proving that the sodium chloride output is reduced to 0.5 gm per day. It is wrong to give haphazard general advice to avoid salt, with the idea that there is no harm in the trial and that stricter measures can be adopted later if the lax ones fail. Failure is the rule under such conditions, and a large proportion of patients then become skeptical or discouraged in regard to undergoing any more stringent application of the method. If a case of hypertension is complicated with nitrogen retention, diabetes, obesity or other disorder, there is nothing incompatible in the treatment of any or all of these combinations, but the diet requirements are somewhat more difficult for both the patient and the physician.

Several millions of patients cannot all be treated by a few specialists, and on the other hand most general practitioners are not very proficient in the management of diets. This practical problem is the same for both renal-vascular disease and diabetes, and a comparison with surgery may throw light on it. A surgeon can describe an appendix operation so that it appears even simpler than a diet treatment. Any of us could perform an appendectomy if necessary. Some physicians in isolated communities are compelled to cover

the entire field of medicine and surgery, and they do it well considering the conditions. Most of us who practice medicine do not perform major surgical operations, partly because we are too busy with other work, and partly because there would be a difference, even if it were as low as one or two per cent, between our operative mortality and that of an experienced surgeon. Also, major operations have been performed successfully in farmhouse kitchens, but a well equipped operating room is a better and safer place. Every diet specialist is affiliated with an institution with special equipment and a trained staff, and the very fact that he needs such an affiliation proves its importance for diagnosing, treating and teaching patients. A large proportion of physicians will be too busy to give the necessary attention to diet treatment, and will refuse to take on their consciences the responsibility for the poorer results which are yielded by half-way treatment in comparison with skilled treatment. On the other hand there is a great movement everywhere by some of the physicians, who are sufficiently interested, to train themselves to proficiency in the diet methods which are such an important new development in medicine, and a similarly extensive movement to establish metabolic clinics either independently or as departments in general hospitals, so as to provide the necessary place and equipment for accurate work. I am confident that the problem is being solved by the development of these numerous men and institutions at least partially specialized for metabolic treatment, and that general practitioners will either take pains to acquire the necessary knowledge and equipment or will refer their cases to others.

A closing exhortation is that physicians should realize the actual possibilities in the treatment of renal-vascular disease. Not long since, our profession was considerably scandalized by learning that Presidents of the United States do not necessarily receive the best possible medical care. A million or two of renal and vascular cases are still being treated by drugs and other antiquated methods, and a tremendous saving of disability, death and economic losses can be accomplished by extending to them the benefits of modern scientific management.



sionally be misled. We have all seen cases of so-called essential hypertension in which the systolic pressure ranged around 200 mm of mercury, but in which repeated kidney function tests failed to reveal any renal impairment. Conversely we occasionally see cases of advanced renal disease in which there is a low or normal blood pressure, especially where there is some cardiac involvement. One case referred to in this series had a negative urine and a blood pressure of 135/100, but the non-protein nitrogen content of his blood was 52 mg per 100 c c blood.

Coming back to the original question that if we cannot draw definite conclusions from the urine and the other renal tests have their limitations, how then should these cases be studied before operation if patients are to have the best that scientific medicine affords? I think the question is answered in careful blood chemistry determinations. Most modern hospitals have or have access to well equipped clinical laboratories, and of late years these blood chemistry procedures have been simplified. For practical purposes we need only to know the blood sugar concentration and either the non-protein or the urea nitrogen content of the blood. Three c c of blood is sufficient to make these determinations, providing the Folin Wu method is used. It is stated that six determinations can be made in about an hour and a half, so that the time element is not an especially important one. At the Albany Hospital a charge of one dollar is made for each individual determination, and this moderate fee does not put a prohibitive cost on blood chemistry as a routine procedure.

A fasting blood sugar concentration of 160 mg per 100 c c of blood, if not absolutely conclusive, is presumptive evidence that you are dealing with a diabetic, and if you get some of the higher levels that have been encountered, you will congratulate yourself that you knew of the condition before operation and can treat it accordingly. Likewise, when the non-protein nitrogen goes above 40 mg, or the urea nitrogen above 20 mg per 100 c c blood, you may rest assured that the patient has nitrogen retention and probably severe renal disease.

### CONCLUSIONS

1 Single negative A M specimens of urine are unreliable in ruling out the presence of nephritis or diabetes.

2 Twenty-four hour specimens are more reliable, but a negative twenty-four urine does not mean much.

3 Phenolsulphonephthalein tests are helpful if carefully done, but a high two-hour output will often give the surgeon a sense of false security, and a low output may cause anxiety where there need be no fear.

4 Blood pressure readings are of value but not conclusive.

5 The blood sugar concentration and either the non-protein or the urea nitrogen content of the fasting blood are the most conclusive single determinations that the surgeon can depend upon in ruling out the presence of nephritis or diabetes in preoperative cases.

## PRENATAL CARE

By JOHN O. POLAK, M.D.,

BROOKLYN, N. Y.

Abstract of the fourth clinical lecture in the course on Practical Pediatrics, given in the South Side Hospital, Bay Shore, April 1, 1925, under the auspices of the Suffolk County Medical Society.

The justification for the prenatal care of the pregnant woman is what it will do for both mother and child. We made a study of 3,000 cases of pregnancy and labor that were attended by senior students of the Long Island College Hospital Medical School. All of the toxemias and anomalies were sent into the Hospital. The first 1,000 had regular prenatal care by physicians at the clinic, and 19 babies were stillborn, and 6 died within two weeks after delivery.

The next 1,000 cases were seen regularly by visiting nurses who took their blood pressures and examined their urines and probably looked after them with greater detail than the average physician gives to his cases. In this group 47 babies were born dead.

The next 1,000 cases had no prenatal care, and in them 80 babies were born dead. The less prenatal care the mothers get, the higher the infant mortality among the babies.

In a demonstration of supervised midwives in Newark, there were 17 dead babies among 1,000 births.

Prenatal care will bring the death rate of newborn babies down to two and a half or three per cent.

What points are to be developed in prenatal care? The history is of great importance. Many have had one, two, or three babies born dead. Some were due to extra large babies, and some to contracted pelvis. One woman had had eleven consecutive breech deliveries of dead babies, and on this fact

deficiency of the pancreas was supplied in the form of insulin, so they had a gradual, perhaps very gradual transitional stage from normal carbohydrate metabolism to the severe diabetics that they were

At what point sugar appeared in the urine in this gradual upward blood sugar concentration is not known because these patients had passed their renal threshold when admitted and no diagnosis had been made until sugar appeared in the urine. When we as physicians and surgeons begin to make blood sugar determinations more frequently we will discover cases much earlier. This point is illustrated by the case of a rather obese railroad man who sought treatment for a scratch on his finger which for some reason did not heal up well. Two examinations of his urine were made at a three-day interval and both were negative. His blood was then examined and showed a blood sugar concentration of 280 mg per 100 cc of blood. This man had never used insulin, his diet had never been restricted, and he had obtained life insurance without difficulty, yet his subsequent stay in the hospital proved that his diabetes was very severe. These facts prove that it is possible to have a high blood sugar with a negative urine, and the surgeon who bases his conclusions on a single negative urine examination will occasionally be misled. However, the blood sugar concentration taken in the morning before breakfast is the most reliable single determination that can be made in establishing the presence or absence of diabetes.

#### POSSIBLE TO HAVE SEVERE NEPHRITIS WITHOUT ALBUMIN AND CASTS IN THE URINE

The idea of this paper was suggested to me by the case of a middle aged woman with carcinoma of the pylorus. The hospital admission specimen and the preoperative urine reports were negative. At operation it was found that this was a favorable case for pyloric resection, which was performed. This patient died within thirty-six hours following the operation, during which time she voided only about six ounces of urine, and this specimen was loaded with albumen and casts. Death was apparently due to a renal insufficiency. The point is this, that had the surgeon known that the patient had renal impairment, he would have been content with less radical measures at operation, and would not have increased his operative mortality by this case, but depending on the two negative urine reports he was misled. I have in mind another patient in whom the urine was persistently negative, but we were never able to get a total phenolsulphonaphthalein excretion above 25 per cent in two hours, and this on repeated examinations. There occurs to me now another patient whose urine was persistently negative, but his phthalein excretion was only 42 per cent in two hours, and the non protein nitrogen con-

tent of the blood was 55 mg per 100 cc of blood. Cases of this type are fairly common.

Another patient whose renal function was studied more thoroughly had two negative A.M. specimens of urine and one negative twenty-four hour specimen. Two phthalein tests were done, one of which was 23 per cent in two hours, and the other one 25 per cent in two hours. The non protein nitrogen content of the blood was 52 mg per 100 cc. The Mosenthal concentration test was also done and showed a specific gravity varying from 1012 to 1017. The two hour amounts ranged from 70 cc to 115 cc. The total day amount was 550 cc, and the total night amount 65 cc. This patient had three routine urine examinations which were negative, yet he had a definite renal impairment which was dangerous as far as an anesthetic was concerned, inasmuch as he was a surgical case.

These findings make one very skeptical about a single negative preoperative urine report and brings up the question of the advisability of more reliable preoperative renal and diabetic studies, especially where the circumstances of the case permit it and the patient is in the age group in which these complications are most often encountered.

#### LIMITATIONS OF THE VARIOUS RENAL TESTS

We are now facing the question that if definite conclusions can not be drawn from a single urine examination, how then shall we study these cases before operation?

Phenolsulphonaphthalein determinations alone are not always reliable and are only of value when carefully controlled and considered with other findings. Occasionally in a stout person a short needle is used and in such a case the dye does not reach the muscle, or when a larger needle is used, some of the dye runs out when the needle is withdrawn. The ampules contain more than one cc, consequently the patient often gets an overdose of the dye. Again we have all seen laboratory technicians who have some difficulty in matching colors. All of these things probably help to account for the conflicting reports we occasionally get from phthalein estimations. I recall one case which showed an excretion of 24 per cent in two hours and the next day the test was repeated by someone else and there was a sixty per cent excretion in two hours. It is hard to believe that the function of the kidney fluctuated to this extent in so short a time. Assuming that the above objections have been overcome we must admit that the phthalein test represents only the excretory capacity of the kidney for the moment and gives no true idea of retained products in the blood.

Blood pressure readings will be helpful in the nephritics, but if we base our conclusions on blood pressure and urine alone, we will occa-

measurement is that in which the doctor uses his thumb and middle finger to span the distance from the patient's wrist to her elbow. If he can span the distance, the arm is short and the pelvis is likely to be small.

Another point is the length of the middle finger. Normally it is much longer than the others. If it is nearly the same length as the others, and the ends of the fingers form a straight line instead of a pointed angle, an abnormal shape of the pelvis may be suspected.

The lumbo-sacral rhomboid or diamond, is easily observed, especially when the woman stands. The lateral points of the diamond are indicated by dimples which cover the posterior superior spines of the ilium. The upper angle is a dimple just below the third lumbar spine. The lower angle is the upper end of the furrow between the nates.

A line connecting the lateral points will cross over the sacro-lumbar joint, and a point just above the center of this line corresponds to the posterior landmark of the external conjugate.

Normally the angles of the diamond are equal. If the pelvis is flattened, the lateral measurement of the diamond is increased and the vertical is diminished. The result is not only a decrease in the antero-posterior diameter of the inlet of the pelvis, but also an increased prominence of the promontory which disturbs the inclination of the pelvic bone and still further lessens the pelvic inlet.

While examining the diamond, place a ruler along the spine touching the sacrum and the upper lumbar vertebrae. The forward curve of the back will leave a space between the ruler and the body. If the space is over 3 cm, lordosis and excessive tilting of the pelvis are present.

The poise of the body when the patient stands or walks has a suggestive diagnostic value. If a woman has a protruberant abdomen, she must bend the upper part of her body backward in order to balance the abdomen. The lordosis of the spinal column raises the pelvis posteriorly and lowers it anteriorly, and thus tilts it forward, and when the pelvis is tilted forward, the expulsive forces of labor are directed backward rather than downward.

When the pelvis is tilted, and labor pains begin, place the woman on her side with her thighs flexed strongly on her abdomen. This reduces the tilting and increases the size of the pelvis at least one centimeter, or enough to permit a head to engage. The position may determine whether a woman shall be delivered normally or instrumentally.

It is desirable that pregnant women wear corsets. They support the protruberant ab-

domen, and hold the baby in proper alignment for ready entry into the pelvis.

The fundus of the uterus rises three and one-half centimeters for each lunar month of pregnancy. Its average height at term is 35 cm, which, divided by 3.5, gives 10 lunar months, or the duration of the pregnancy.

The linea nigra, or black median line, reaches the height of the fundus. When the fundus falls at term, the black line is left higher than the fundus. This is a point of some value in determining the probable date of labor.

The distance between the anterior superior spines of the ilia is normally about two centimeters less than the distance between the crests of the ilia. This relation of size will be preserved if the pelvis is of normal shape, no matter what its size. But compressing the pelvis from before backward flares out the ilia and makes the inter-spinous distance equal to or greater than the inter-crestal.

The external measurement from the lumbo-sacral joint to the symphysis pubis is important. A measurement of 16.5 cm or less always indicates a flattened pelvis.

The position of the fetal heart may give important information regarding the progress of labor. It shows the descent of the body and its rotation, for as the presenting part descends, the heart comes nearer to the median line and descends toward the pubis. The important time to follow the fetal heart is while the baby's head is on the pelvic floor. During that period observation of the fetal heart will show the condition of the child. If the cord is short, or is compressed, or is twisted, the fetal heart, which normally beats 120-140 times per minute, will drop to 80 or less, but in the interval between pains it will gradually come back to its normal rate. If there is an obstruction in the pelvis, the fetal heart will become slower and slower. Also if the cord is tightened while the child is driven downward, a souffle will be heard with each beat. If the fetal heart is weakening, its beats will not go back to 120 between pains. A progressive slowing of the fetal heart is a sign of danger to the child.

A stethoscope may be worn attached to the forehead by head clips. This will enable the doctor to examine the fetal heart almost continuously while his hands are free.

If the uterine souffle is heard just over the symphysis before labor, a presumptive diagnosis of placenta previa may be made.

The physician can follow the progress of normal labor without making a vaginal examination. The position of the fetal heart indicates the descent and the rotation. A rectal examination shows the condition of the cervix and the position of the fetal head.

alone the doctor made a diagnosis of uterine fibroid, which caused the fetus to adjust itself as a breech position

The toxemias are often causes of the loss of babies at birth or soon afterward. There is a tendency for abortion to occur at an earlier and earlier stage. This is the opposite to the history of abortion in syphilis, in which the miscarriages occur at later and later stages until a living child is born.

Congenital syphilis is not so common in the pregnant as was generally supposed. From three and a half to six per cent is about the usual incidence in our hospital clinics.

Do not consider the uterus of a pregnant woman apart from the rest of the body. Every pregnant woman has the right to demand a full physical examination by her doctor. Her teeth, tonsils, heart, lungs, and thyroid are of special importance. The better care of teeth and tonsils in early life has lessened the incidence of heart disease as a factor in obstetrics.

Dr. Polak says he has not seen a case of eclampsia in a woman who has an enlarged thyroid. An enlargement of the thyroid is normal in pregnancy. In Spain it is the custom of mothers to measure the girth of the necks of their daughters after marriage to see if they are pregnant.

The kidney function is important in pregnancy, for the mother's kidneys have to bear the extra strain of excretion for the fetus. A woman who has had pyelitis or scarlet fever is likely to have a lessened kidney reserve.

There are four conditions to be especially considered in toxemias:

- 1 Blood pressure
- 2 The kidney function, especially the presence of albumin
- 3 The body weight
- 4 The thyroid gland

A reduced blood pressure is normal in pregnancy. The normal systolic pressure is from 95 to 110. If it goes to 125 and increases to 130 or 140, look out for trouble and examine the urine.

If the blood pressure is 110 or less, the urine is likely to be normal. Increased blood pressure antedates albuminuria by days and weeks.

A gain in weight of 20 pounds during pregnancy is normal. A gain of more than that is suggestive of edema and the retention of fluids in the body. Most of the gain develops during the second half of pregnancy.

What are some of the significant signs of trouble in pregnancy?

Headache is a late sign of toxemia. A frontal headache is characteristic. If prenatal care is given, the headaches will be prevented.

Changes in the retina are also late signs of toxemia. They will not develop unless there is a nephritic toxemia or a glomerular nephritis. Albumin, low specific gravity, and other

evident kidney signs will precede the eye signs.

Vaginal bleedings are significant. If they occur early in pregnancy, they suggest threatened abortion, or ectopic gestation or hydatiform moles. In the later months they suggest placenta previa, accidental hemorrhage, or premature labor.

Heart disease is no longer considered with the fear of former days. Think of the condition of the heart muscle rather than of the valvular lesion. A woman with damaged valves can go through labor safely if she is spared the efforts of straining. Suppose a heart case is in labor. She will go through the first stage without trouble if she is spared a nervous excitement from causes outside her body, by the employment of morphine and scopolamine.

In the second stage when the desire to strain is present, give an anesthetic, preferably ether.

In the third stage, when the uterus is contracted and an extra amount of blood is forced back into the circulation, permit some bleeding to take place from the venous side of her circulation in order to relieve the engorgement of the pulmonary circulation.

Use the functional test of the heart in order to determine the condition of the heart muscle. A standard test is to have the woman walk upstairs and down again, and note the pulse before, immediately after, and again three minutes after the effort. A return of the pulse rate to normal in three minutes indicates a good heart muscle.

How shall the breasts be prepared for nursing? The woman should wear a proper brassiere to support the breasts.

Previous to labor, wash the nipples daily with soap and water, and apply lanolin ointment. After labor, wash the nipples after each nursing and apply the following mixture: Boroglyceride, one part, and saturated solution of boric acid, seven parts.

Pelvic measurements have a great value in suggesting preparation for possible difficult delivery. If the pelvis is abnormally small, a baby's head can come through it if the head also is small. There were two slim little women who each had a small pelvis. One had two babies by normal deliveries, but the babies weighed only six pounds. The other woman had two babies by Caesarian section, but each baby weighed over eight pounds. The difference was in the babies rather than in the mothers.

There are two external signs which suggest the size of the pelvic outlet, 1, the length of the forearm, and 2, the shape of the lumbosacral rhomboid.

A short forearm goes with the general body build in which the pelvis is small. A rough

sponsibilities Every physician fails in his duty to his profession if he fails to assume his share of these burdens

Legislative bodies, such as the county and state societies, and the American Medical Association, are doing organization work through delegated representatives from the county to the state and state to the nation, and while necessarily more conservative in thought, and slower in action than radicals and visionaries desire, are steadily progressing toward solid ground upon which the profession may securely stand in defense of our citizens from the attack of charlatany, and for their protection from the destruction of disease

The Medical Society of the State of New York, the largest medical group in the world, excepting of course the American Medical Association, located in the most populous community, and in the most fertile field for study, cultivation and development, is ever striving to give an increasing membership valuable return for their individual investment

The Journal, with a full time Executive Editor, is developing in its various departments, the individual interests of the membership On the scientific side, it prints the papers read before the State Society, the District Branches, County Societies, and other valuable contributions In the Legal Department it publishes most valuable and informative material based upon the discussion of actual cases selected from the great experience of our legal counsel

In the Legislative Department it elaborately prints matters of legislative interest, classified and indexed, and accompanied by lucid explanatory notes by our indefatigable Chairman of the Committee on Legislation, and by our executive officer In surveys of conditions affecting our members in counties and cities throughout the State, which are exhibiting conditions not previously appreciated, and spreading inspirationally valuable information The surveys have attracted wide attention and will be continued to cover not merely every county, but other general matters relating to public health whether conducted by scientific or lay organizations, with the hope that physicians may, through better understanding, become more interested and may be inspired to assume the leadership which should be theirs in all matters affecting the health of our citizens

The present Committee on Publication is studying, in detail, plans for the general improvement of the Journal, and will pass on to its successor many valuable suggestions Beginning in November, a distinguished Medical Editor will assume responsibility for a Department of Medicine and Surgery containing

brief abstracts of up-to-date scientific information written in a crisp, concise, easily read form

The executive officer, a full-time officer, created by the last House of Delegates, began his work last fall and has proven his value to the society in his legislative work at Albany in a convincing manner He has made as many contacts with individuals and with county societies as his time has permitted He will endeavor to discover the desires of the county societies and of their members He will try to interest non-member physicians and enlist them, and while at this moment our membership is numerically greater than it has ever been, we have a reasonable expectation that it will be considerably increased this year

Our Directory is of inestimable value to those who use it, but may be improved by the addition of new material

Defense in malpractice suits and the privilege of the special group rate for indemnity insurance are worth far more than the State dues The sober realization that the practice of medicine is a hazardous occupation, makes it beyond comprehension how any doctor can have a comfortable moment without both the assurance of defense and of financial protection

The activities of the Committee on Legislation have shown the way to the other committees of the State Society The money spent by this committee has been valuable to the profession at large, to the citizens of our State, and especially to members of the Society The conferences of the Legislative Chairmen have sent back interest and enthusiasm to every county society, have awakened warm inter-county relationships, and have been of greater value than any other activity

The committees on Public Health and Education and on Economics may be able, providing sufficient financial balances appear, to do similar work, holding annual conferences of committee chairmen and making these chairmanships important offices which will be held by men chosen because of their peculiar fitness

We often wonder whether many of our members appreciate the one officer of the county society who is usually the one who does more work and more thinking for the county society than all of the other officers combined We feel that the secretary is that man, and that annual meetings of secretaries, with seriously planned programs, should be held at the expense of the State Society, so that these officers, many of whom have satisfactorily held their places for many years, and who possess the greatest possible knowledge



The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer.

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

*Editor-in-Chief*—NATHAN B VAN ETTEN, M.D,  
New York  
*Associate Editor*—ORRIN SAGE WIGHTMAN, M.D.,  
New York  
*Executive Editor*—FRANK OVERTON, MD  
Patchogue

### COMMITTEE ON PUBLICATION

E. ELIOT HARRIS, M.D., <i>Chairman</i>	New York
ORRIN SAGE WIGHTMAN, M.D.	New York
EDWARD LIVINGSTON HUNT, M.D.	New York

**MEDICAL SOCIETY OF THE STATE OF NEW YORK**

## OFFICERS

<b>President</b> —OWEN E. JONES, M.D.	Rochester
<b>First Vice President</b> —GEORGE A. LEITNER, M.D.	Piermont
<b>Second Vice President</b> —LUZERN COVILL, M.D.	Ithaca
<b>Speaker</b> —E. ELIOT HARRIS, M.D.	New York
<b>Vice Speaker</b> —GEORGE M. FISHER, M.D.	Utica
<b>Secretary</b> —EDWARD LIVINGSTON HUNT, M.D.	New York
<b>Assistant Secretary</b> —WILBUR WARD, M.D.	New York
<b>Treasurer</b> —CHARLES GORDON REYD, M.D.	New York

### CHAIRMAN, STANDING COMMITTEES

Arrangements—FREDERICK H. FLAHERTY, M.D.	Syracuse
Public Health and Medical Education —JOSHUA M. VAN COTT, M.D., Brooklyn	
Scientific Work—ANDREW MACFARLANE, M.D.	Albany
Medical Economics—HENRY LYLE WINTER, M.D.	Cornwall
Lepidation—JAMES N. VANDER VEER, M.D.	Albany

**COUNCIL**

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex President and the Councilors of the District Branches.

First District—EDWARD C. RUSHMORE, M.D.	Tuxedo Park
Second District—FRANK H. LASHER, M.D.	Brooklyn
Third District—ARTHUR J. BEDDLE, M.D.	Albany
Fourth District—CHARLES C. TREMBLEY, M.D.	Saranac Lake
Fifth District—NELSON O. BROOKS, M.D.	Oneida
Sixth District—GEORGE H. FOX, M.D.	Binghamton
Seventh District—WILLIAM I. DEAN, M.D.	Rochester
Eighth District—HARRY R. TRICK, M.D.	Buffalo

**COUNSEL**

COUNSEL  
GEORGE W WHITESIDE, Esq, 27 William St New York  
Telephone, Broad 1744

ATTORNEY

ROBERT OLIVER, Esq 27 William St New York

EXECUTIVE OFFICER

JOSEPH S. LAWRENCE, M.D. 51 Chapel Street, Albany

## SECTION OFFICERS

*Medicine*  
Chairman—ROBERT L. LEVY, M.D. New York  
Secretary—L. WHITTINGTON GORHAM, M.D. Albany

### Surgery

Chairman—MARSHALL CLINTON, M.D. Buffalo  
Secretary—EDWARD S. VAN DYKE, M.D. Syracuse

## s and Gy

Chairman—HAROLD C. BAILEY, M.D.  
Secretary—NATHAN P. SEARS, M.D.

*Pediatrics*

Chairman—JOSEPH C. PALMER, M.D. Syracuse  
Vice Chairman—ROGER H. DENNETT, M.D. New York  
Secretary—ARTHUR W. BENSON, M.D. Troy

### Eye, Ear, Nose and Throat

Chairman—ARTHUR G BENNETT, M.D. Buffalo  
Secretary—EUGENE E HINMAN M.D. Albany

## Public Health Hygiene and Sanitation

Chairman—PAUL B. BROOKS, M.D. Albany  
Secretary—ARTHUR D. JACQUES, M.D. Lynbrook

## Neurology and Psychiatry

Chairman—EUGENE N BOUDREAU, M.D  
Secretary—CLARENCE O CHENEY, M.D

For a list of the officers of the county medical societies, see April 24th JOURNAL, advertising page v

## STATE SOCIETY ACTIVITIES

Thirty-five years of active medical service are cumulatively convincing to the writer of the value of social contacts with the members of our profession, and the value of mass relationships

By education rather than by any other se-  
What are some of the signs are placed in a  
trouble in - is more definite  
members of any  
of the interician looks upon  
es w point, and is in  
e all reserved place  
he is the seven  
language, elop ps the twelve  
perha omc

hundredth man in his community, he is regarded as qualifying his privileged place if he engages in extra professional activities. Tradition has honored him as respectable and poor, but looked askance at him, as having capitalized suffering, if he attains anything more than a modest financial success.

Sympathetic association with his fellows is as necessary to him as the breath of life. Self-preservation as a profession has compelled organizations, which, pyramided upon small local groups, up to and through state and national representation, have developed strong nation-wide groups which carry national re-

sponsibilities Every physician fails in his duty to his profession if he fails to assume his share of these burdens

Legislative bodies, such as the county and state societies, and the American Medical Association, are doing organization work through delegated representatives from the county to the state and state to the nation, and while necessarily more conservative in thought, and slower in action than radicals and visionaries desire, are steadily progressing toward solid ground upon which the profession may securely stand in defense of our citizens from the attack of charlatanry, and for their protection from the destruction of disease

The Medical Society of the State of New York, the largest medical group in the world, excepting of course the American Medical Association, located in the most populous community, and in the most fertile field for study, cultivation and development, is ever striving to give an increasing membership valuable return for their individual investment

The Journal, with a full time Executive Editor, is developing in its various departments, the individual interests of the membership On the scientific side, it prints the papers read before the State Society, the District Branches, County Societies, and other valuable contributions In the Legal Department it publishes most valuable and informative material based upon the discussion of actual cases selected from the great experience of our legal counsel

In the Legislative Department it elaborately prints matters of legislative interest, classified, and indexed, and accompanied by lucid explanatory notes by our indefatigable Chairman of the Committee on Legislation, and by our executive officer In surveys of conditions affecting our members in counties and cities throughout the State, which are exhibiting conditions not previously appreciated, and spreading inspirationally valuable information The surveys have attracted wide attention and will be continued to cover not merely every county, but other general matters relating to public health whether conducted by scientific or lay organizations, with the hope that physicians may, through better understanding, become more interested and may be inspired to assume the leadership which should be theirs in all matters affecting the health of our citizens

The present Committee on Publication is studying, in detail, plans for the general improvement of the Journal, and will pass on to its successor many valuable suggestions Beginning in November, a distinguished Medical Editor will assume responsibility for a Department of Medicine and Surgery containing

brief abstracts of up-to-date scientific information written in a crisp, concise, easily read form

The executive officer, a full-time officer, created by the last House of Delegates, began his work last fall and has proven his value to the society in his legislative work at Albany in a convincing manner He has made as many contacts with individuals and with county societies as his time has permitted He will endeavor to discover the desires of the county societies and of their members He will try to interest non-member physicians and enlist them, and while at this moment our membership is numerically greater than it has ever been, we have a reasonable expectation that it will be considerably increased this year

Our Directory is of inestimable value to those who use it, but may be improved by the addition of new material

Defense in malpractice suits and the privilege of the special group rate for indemnity insurance are worth far more than the State dues The sober realization that the practice of medicine is a hazardous occupation, makes it beyond comprehension how any doctor can have a comfortable moment without both the assurance of defense and of financial protection

The activities of the Committee on Legislation have shown the way to the other committees of the State Society The money spent by this committee has been valuable to the profession at large, to the citizens of our State, and especially to members of the Society The conferences of the Legislative Chairmen have sent back interest and enthusiasm to every county society, have wakened warm inter-county relationships, and have been of greater value than any other activity

The committees on Public Health and Education and on Economics may be able, providing sufficient financial balances appear, to do similar work, holding annual conferences of committee chairmen and making these chairmanships important offices which will be held by men chosen because of their peculiar fitness

We often wonder whether many of our members appreciate the one officer of the county society who is usually the one who does more work and more thinking for the county society than all of the other officers combined We feel that the secretary is that man, and that annual meetings of secretaries, with seriously planned programs, should be held at the expense of the State Society, so that these officers, many of whom have satisfactorily held their places for many years, and who possess the greatest possible knowledge

of local matters, should have opportunities to develop a close sympathy and to help to cement the county societies into harmonious understandings

While our information does not justify us in attempting discussion of a new budget, and will not until such a time as the collection of

the annual dues shall give us accurate knowledge of our finances, there is, however, every assurance that the members of the State Society are strongly behind, and willing to pay for real activities which have a reasonable degree of promise of success

N B V E

## THE YEAR'S PROGRESS

As the official year of the Medical Society of the State of New York draws to a close, and the officers and policies for the next year are about to be determined, it will be well to estimate the progress of the Society during the present year. We believe that the progress has been greater than in any previous year, and has kept pace with the evolution in other lines of scientific endeavor

The Society has had a wholesome growth with no retrogression in any line. The progress has been well balanced, with the strengthening of weak parts and the assumption of new activities. The Society is on the threshold of new opportunities, and is developing a mass consciousness and a pride of achievement. The name of Medical Society of the State of New York arouses respect and a feeling of pride in its membership and achievements. The people generally know that there is a State Medical Society and that it is doing things. Let us consider its achievements.

If the Society could answer the salutation "How are you?" Its reply would be "Fine!" There is an excellent morale throughout the ranks of the medical profession and a spirit of cooperation among the physicians. Medical Society meetings pass off with enthusiasm, their business is transacted with dispatch, new lines of endeavor are undertaken, and physicians generally plan their work in order to attend the meetings and find in them comradeship and an inspiration to give better medical service. The morale of the medical profession is convincingly shown by the deep interest taken by the leaders of the State and County Societies in the welfare of the organizations. They are willing and anxious to work for the Societies and for the welfare of the communities. The activities of the members have found its highest expression in the Committee on Legislation of the State Society, and the legislative committee of the County Societies. Literally hundreds of physicians now respond to calls for service where only dozens were active a few years ago. Cooperation has replaced individualism and collective action has replaced the zealous activities of the few.

Marked progress has been made morally. The practice of medicine was never on a higher plane and the influence of physicians in the community was never greater. Doctors

were a unit in demanding the repudiation of the legislative claims of quacks and cultists with no manner of compromise with them. The high ideals of the medical profession have been translated into action during the last year. The new spirit of progress is shown in a social way. Physicians call one another by their first names, and Society meetings are begun and ended with a luncheon or banquet. No one can fight a fellow practitioner whom he has met in a friendly way. The public is the gainer by this spirit of brotherhood.

One of the best yard sticks for measuring medical progress is the willingness of the members of the State Society to vote to double the annual dues in order that the activities of the Society might be developed to a greater extent and efficiency. The price does not deter physicians from getting what they want, and they want a better Medical Journal, more comprehensive legal protection, and a more available service of advice and assistance in conducting the affairs of the County Societies. All this costs money, and the increased demands which County Societies are making for expert help shows that the increase in dues is in accord with the spirit of increased service. The cordial reception given to the two full-time employees, the executive editor and the executive officer, demonstrates the approval of the increased dues.

The past year has witnessed new steps in the evolution of the practice of civic medicine. The medical profession has come to realize that it has a duty to direct the larger phases of disease prevention and the promotion of vigor among the people of a community. There are questions of educating the public, of building and managing hospitals, and of graduate medical education within the reach of all physicians. These are problems which can be settled only by medical organizations, and solving them constitutes the practice of civic medicine. One may confirm the recent progress in that line by perusing the pages of the Journal and noting the extension of the work into new fields and its adoption by an increasing number of county societies.

The progress of the past year is a prophecy of still greater results in the year to come. We are almost envious of the incoming president as new fields of opportunity open before him.



## OPPORTUNITIES

The fundamental duty of the Editor is to get information about the activities of the officers and committees of the State Society and of the new developments that have taken place in the District Branches and the county societies. This information is necessary in order that we may coordinate and correlate it for dissemination through the Journal.

An editor is also a teacher in that he is expected to formulate practical opinions and judgments. We have frequently been asked to give editorial comments on various phases of the activities of the officers and committees, because a question properly stated is already half solved. The editor is expected to express diagnoses and prognoses, and to write prescriptions for the benefit of the great mass of the members and for laymen as well.

We have always tried to acquaint ourselves with the formal actions taken by the House of Delegates, the Council, the Executive Committee, the standing committees, and the special committees, and to express ourselves strictly in accordance with the wishes of those in authority.

An examination of the editorial pages and the news columns of the Journal will show that we have confined ourselves to topics on which action has been taken by some official body in the State Society. Some of the records of these actions are hidden in obscure corners of the minutes or of official reports which have been approved.

We have kept our ears open to expressions of opinions from the members of county societies, and have tried to urge the assumption of practical activities by the county societies along lines which have been officially approved by the proper department of the State Society.

We desire to call attention to certain approved subjects which offer immediate opportunities for action and progress.

1 *District Branches*—It was the intention of the organizers of the Medical Society of the State of New York that the officers of the District Branches should function actively as advisors and leaders of the county societies. Great opportunities lie in the adoption of a definite plan of action to the end that the District Branches shall function throughout the year in close contact with the county societies.

2 *Periodic Health Examinations*—There are great opportunities in educating physicians to make periodic health examinations. The Kings County Medical Society has developed a practical plan of beginning the work by examining physicians themselves. New York County has formu-

lated statements regarding what an examining physician is to look for. There is an opportunity to extend these two lines of work to the county societies as a part of the educational scheme of the State Society.

3 *Graduate Education*—The greatest need of the medical profession is the education of physicians in the modern fundamentals of the art and science of the practice of medicine. There are great opportunities in the plan that the State Society shall assist the county medical societies to put on programs consisting of teaching clinics. The county societies have difficulty in securing first-class clinical teachers, but the teachers will gladly go when they are sent by the State Medical Society.

We have seen teaching clinics put on by county societies often enough to be assured of their success, and we have received a sufficient number of requests for such programs to convince us that the time is ripe for the State Society to undertake that activity. This is a great field of opportunity for the District Branches.

4 *Medical Publicity for Laymen*—The education of the people generally in regard to medicine has been frequently discussed in several departments of the State Society, and many different plans have been proposed, all of which come back to the fundamental basis of the composition of the articles. The range of subjects is enormous, and the difficulties of writing the articles are so very great that no physician has yet risen whose syndicated articles are eagerly sought by physicians generally.

We have conducted a Daily Press Department, and have subscribed to a clipping bureau for the special purpose of discovering a practical publicity idea which can be adopted by the State Medical Society. We believe that the best opportunity for publicity lies in the county societies and even smaller groups, as each seizes a local opportunity to write on a medical subject of which the people of the community are talking. It may be a scarlet fever outbreak, or a sewage disposal project. Wherever there is an audience and a topic for discussion, there let the local medical writer get busy. The opportunity lies in developing local talent for writing. Our Daily Press Department has often carried comments on especially good pieces of local medical writing.

We might continue our list of opportunities, but we will stop in order to give a practical illustration of a fundamental principle in all writing and speaking—not to present too many topics at one time, or at too great length.

## CLINICAL PROGRAMS FOR COUNTY MEDICAL SOCIETIES

We have frequently been invited to make suggestions regarding the programs of the County Medical Societies, and we have responded with the suggestion to make them clinical in character. The plan is that the local members shall bring a few cases, and the teacher or consultant shall talk about these particular cases and the medical principles that are involved in their diagnosis and treatment. Teaching clinics have been officially proposed by the Scientific Committee, and approved by the House of Delegates, and a committee has been appointed to study the problem. (See minutes of the House of Delegates as printed in the Journal in May, 1924, page 695.) A comprehensive plan of graduate education was developed and put in operation by the Medical Society of the County of Kings over two years ago, and in March of this year it was extended into Suffolk County, and

a series of weekly pediatric clinics was arranged and conducted along the exact lines approved by the House of Delegates, even that they should be aided by the State Department of Health. We made editorial comment on the plan on page 573 of our April 3rd issue, and on pages 658 and 659 of the April 17th issue. We described the Suffolk County Clinics on page 587 of the April 3rd issue, and we printed an abstract of the first lecture on page 653 of our April 17th issue. We are printing an abstract of the fourth lecture on page 735 of this issue.

The Suffolk County Pediatric course is an extension of clinical programs which had previously been carried out by the county society. We believe that any county medical society which puts on one or two clinical programs will wish to establish a graduate course in clinical teaching. F O

---

## A GENERAL SESSION

The reports of the officers and committees that will be given to the House of Delegates will touch upon many subjects which are worthy of a far more extended discussion than can be given to them during the meeting of the House of Delegates. Some of the reports concern the administration of the State Society, and are of little interest to the general run of members. Some reports are on questions of policy and the adoption of new lines of work which are of interest principally to the leaders and chairmen of committees. Other reports are on subjects in which every member of the Society is interested.

Some of the reports will be discussed at length, and others equally important will be passed by without comment. The greater part of the discussion will be over questions of the administrative policy of the State Society. There will be little discussion on any topic relating to social and scientific problems.

Many problems which are of deep interest to every member of the State Society will not be discussed simply because a place has not been made for them. There is need for an afternoon of general discussion when all the members may come together and discuss some of the newer problems which are barely touched upon in the reports of the officers and committees. We might suggest the following seven topics which would be of great interest to every member.

- 1 Periodic Health Examinations
- 2 Clinical Programs for County Society Meetings
- 3 The Practice of Civic Medicine by County Societies
- 4 Insurance Against Malpractice Suits
- 5 Medical Education of the People
- 6 The Nursing Problem
- 7 The Journal

We would make the presentation of these topics practical, and have the officers and chairmen tell what is actually being done in the State, and make definite suggestions for their adoption and extension.

There are now seven scientific sections, but not one of them covers this field of general topics, unless possibly the section on public health could do so. However, the object of the general meeting would be defeated if the topics were discussed in a section while six other sections were going on at the same time.

If we are a trifle enthusiastic in making this suggestion for a half day general meeting devoted to such general topics as we have named, the valid reason for our enthusiasm is that we are continually discussing them in the JOURNAL. We know that all doctors are thinking on these topics, and we would like to give abundant opportunity for their public discussion. F O



# LEGAL



By GEORGE W. WHITESIDE, Esq.  
Counsel, Medical Society of the State of New York

## CLAIMED X-RAY BURN WITH RESULTANT ULCER AND AMPUTATION OF LEG

In this matter the complaint charged that the plaintiff had been referred to an X-ray specialist for the treatment of psoriasis. He claimed that on a certain day, in the application of the X-ray, the doctor was negligent and careless in that he exposed the plaintiff's body to an excessive amount of X-ray, for an excessive length of time, and placed the bulb or tube too close to the plaintiff's body, neglected to take proper care and the usual safeguards of filters and cones, and that by reason of this claimed negligence the skin and tissues of the plaintiff's leg were severely burned, injured and destroyed, and that he suffered an X-ray burn on his right leg which required extensive medical and surgical treatment and subsequent amputation of the leg.

The plaintiff, a man of about seventy-two years of age, had been afflicted with psoriasis for about fifty years, the disease affecting his elbows, his back and right leg. From time to time for many years he had received medical treatment for his ailment and was under the care of an able dermatologist who, after extensive treatment, suggested X-ray applications as a means of alleviating the affliction.

In the early spring he called upon the defendant for X-ray treatment. He was attended by a physician associated with the defendant who, during a period of four months, gave seven applications of X-ray to the right leg, the left elbow, and the lumbar region. These treatments were completed toward the latter part of June. The plaintiff did not return to the defendant's office until the end of the following October, at which time the defendant treated the right leg and right elbow with X-ray. Another treatment was given to the right leg and right elbow about three weeks later. The factors of dosage used in the October and November treatments were

Time	Distance	Gap	M-a	Filter
Oct 5th	11	9	45	1
Nov 4th	8	7	5	1

The October dosage is about sixty-five per cent of an erythema dose and the November dosage about sixty-four per cent. At both of these times the psoriasis upon the elbow being generally diffused, no lead sheet was used upon the elbow. The psoriasis upon the right leg being in a concentrated spot, in the application of the ray to the leg a lead protector was placed on the leg over the area adjoining the psoriasis and not to be radiated.

On the day following the last application the plaintiff returned to the office of the defendant and stated that during the night the spot on the leg became irritated and red. The defendant gave the plaintiff a wet dressing containing zinc oxide, carbolic acid, glycerine and lime water in the proper proportions and advised him that within a few days the redness would disappear. Nothing further was heard from the plaintiff until the institution of this action, except that about fourteen months after the last treatment the plaintiff wrote the defendant claiming that at the last treatment the defendant had burned him in the application of the X-ray.

When this action came on for trial the plaintiff testified that at the last X-ray application given by the defendant the glow from the tube was stronger than on the previous applications, so that it was necessary for him to shade his eyes with his hand and that when the ray was applied to the leg he felt a sensation of air currents, which he claimed he had not felt when the ray was applied to his elbow at that treatment or on any of the previous treatments. He further testified that he had received no medical care or attention for his leg until the following August, a period of about eight months after the X-ray application by which he claimed he was burned, that in the following August, while in the mountains on his vacation and during the night, his leg suddenly became very painful and the skin broke open and that the under-flesh was black, that he received medical attention from his physician at the hotel and then returned to his home, and that from that time until a year from the following November, he was under constant medical care for his leg, that the ulcer which had formed on his leg continued to grow larger, that at one time a curettage was performed and that gangrene developed and that it subsequently became necessary to amputate his leg. He also testified that the application of X-ray to his leg was at a point about five inches below the knee. A photograph of his leg introduced in evidence, which was taken on the day preceding the amputation of the leg, disclosed the ulcer in the lower third. Under cross-examination of the plaintiff (which facts became known to the defendant only a few days prior to the trial), it was developed that in January, March, April and May following the treatment in November by the defendant, the plaintiff had received X-ray treatment from

another physician. He admitted that the dates, factors of dosage, amounts paid, and parts of the body radiated by the other physician were correct, except that he denied that the other physician treated the right leg, but claimed that the other physician treated the left leg. On behalf of the defendant it was proved that the amputation of the plaintiff's leg was due to the disease of endarteritis obliterans or thrombo angutis obliterans and that the ulcer was the result of this disease and not caused by any overdose of X-ray given by the defendant. It was also proved that the redness of which the plaintiff complained was the static or electrical reaction and that it would disappear within a few days with no untoward results. The plaintiff called as an expert in his behalf a physician who had been practicing for over forty years and who, on his direct examination, testified that he was familiar with X-ray reactions or so-called X-ray burns and with the disease of endarteritis obliterans and ulcers resulting from such disease. On cross-examination, however, it was shown that this particular physician could not with any definiteness state when or where he had treated an X-ray burn or the disease of endarteritis obliterans—whether he had done so within the last five years or within the last ten years. It was also brought out on cross-examination that

he had never seen the plaintiff until about a month prior to the trial and that he was being paid for testifying as an expert. On behalf of the defendant it was proved by various physicians, as witnesses, that the factors of dosage used by him were proper and would not cause an X-ray reaction or burn, that the redness complained of by the plaintiff was the static or electrical reaction which is quite frequently seen in X-ray applications, particularly where a lead covering is used to protect the parts adjacent to that to be radiated. It was proved by a surgeon who examined the plaintiff a few days prior to the amputation that the ulcer was not one due to an X-ray burn, but due to the disease of endarteritis obliterans, which fact was also proved by the surgeon who performed the amputation. By a physician who had made an extensive study of the disease of thrombo angutis obliterans it was proved that this is a progressive disease and that an ulcer may be caused at any time by the slightest trauma, or may result without any trauma, and there is no known cure for the disease except amputation.

Upon all of this evidence the case was submitted by the trial court to the jury, which did not take long in their deliberation, and returned a verdict in favor of the defendant, dismissing the complaint.

### NEEDLE BREAKING IN HYPODERMOCLYSIS

In this action the defendant, a surgeon who had operated upon the plaintiff, was charged with the negligent breaking of a needle and the failure to notify the plaintiff of the fact and permitting the broken needle to remain within the plaintiff's body for a period of time.

The defendant operated upon the plaintiff for the removal of a fibroid tumor, which operation was carefully and skilfully done in accordance with the most approved technic. Upon the completion of the operation, the patient was returned to her bed and instructions given by the operating surgeon to the house physician to administer to the plaintiff a hypodermoclysis of a saline solution about two hours after the completion of the operation. The hypodermoclysis was prepared by one of the hospital nurses and the needles inserted by the house physician underneath the patient's breasts. Upon the completion of the administration, in withdrawing the needles the shaft of one became dislodged from the hilt and remained within the patient's body.

The defendant was not present at the time of the administration of the hypodermoclysis and upon the breaking of the needle was notified by the house surgeon of this fact. He thereupon visited the patient and probed for the needle, but

was unable to locate and remove same. The patient at this time was not informed of the breaking of the needle. At a subsequent time, when visiting the patient, the surgeon made a small incision over the site where the needle had entered the body and endeavored to extract the same, but again was unsuccessful in procuring the broken needle. The surgeon had to stop his attempts because of the protests and highly nervous condition of the patient. The patient remained in the hospital only the normal period of time after the operation and visited the defendant at his office for post-operative treatment. At one visit the patient complained of a pricking sensation at the top of the breast. At this time the surgeon made a small incision at that point and with forceps extracted the broken needle, which he unthinkingly laid upon his desk and which the plaintiff took possession of. The presence of the needle did not cause the plaintiff any particular injury or inconvenience.

After the case had remained upon the calendar for several years and the plaintiff's attempts to procure a settlement were unsuccessful, the action was finally abandoned and the complaint dismissed, terminating the action in favor of the surgeon.



# State Department of Health



## DISTRICT STATE HEALTH OFFICER BITTEN BY RABID DOG

Doctor Richard Slee, District State Health Officer for Nassau, Suffolk and Westchester Counties was bitten on the hand recently by his pet dog which was ill at the time but not with symptoms pathognomonic of rabies. A few days later the dog was killed and pathological examination of the brain showed that it was suffering with rabies. Dr. Slee is now taking Pasteur treatment.

In Westchester County a 4-year-old child died of rabies on April 15th, having been bitten on March 26th by a dog proven to have had rabies at the time. The State Department of Farms and Markets has had reports of several cases of dog rabies in Southern Westchester County, and has established a quarantine for dogs in that area.

In view of this unquestionable prevalence of dog rabies it will not be amiss to call attention

to certain procedures which should be carried out in all instances of dog bite.

1 All cases of dog bites should be reported to the health officer (this is *required* by the Sanitary Code if there is suspicion that the dog is rabid). The health officer will take charge of the dog, confining him for such time as is necessary to determine if the dog has rabies, or if the dog is killed he will have the necessary laboratory examinations made to determine whether the dog was rabid.

2 All dog bites should be thoroughly cauterized at once with *fume nitric acid*. This is the only cauterizing agent of value in the prevention of rabies, but is not effective unless used within 24 hours after the bite.

3 If the dog was rabid, commence Pasteur treatment at once.

## THESE DEATHS FROM DIPHTHERIA MIGHT HAVE BEEN PREVENTED!

During the week ending April 18, the Division of Communicable Diseases received supplementary reports on the deaths from diphtheria of nine children.

With one possible exception, the circumstances involved were such that a greater degree of care might have prevented death. In at least seven cases the patients were not seen by a physician until later than the first day of the disease. In the two remaining cases the reports indicate that a physician saw the patients on the first day. In one of these, however, the doctor apparently did not recognize the disease, as no antitoxin was given until the child was taken to a hospital four days later. In the other case which came to the attention of a physician on the first day of the disease, the child died a few hours later, autopsy showing respiratory obstruction at the bifurcation of the trachea, so that the intubation performed five hours previously had been of no avail. Unfortunately antitoxin was not given, as the diagnosis was not made until a positive culture was obtained after death.

One child "was getting along well, when he

got up to go to the toilet, he toppled over and died in a short time." This death occurred on the twelfth day of the disease, no antitoxin having been given until the fifth day. This is a common history and not only illustrates the need of early administration of antitoxin, but also indicates that greater care should be taken to keep patients in bed during convalescence.

*None of these nine children received antitoxin earlier than the fourth day of the disease.* In seven cases the parents were evidently remiss in failing to summon a physician at once. In only one case, however, was antitoxin given on the day of the first visit of a physician, although nearly all were seen so late that the patients might well have been given the benefit of any doubt as to the diagnosis. In two cases at least the physician apparently waited for the result of a culture before giving antitoxin, although the culture was not taken until late in the disease.

*If diphtheria is suspected, antitoxin should be given immediately.* The proper use of the culture is to determine the period of isolation and to confirm, not to make a diagnosis.

## VENEREAL DISEASE CLINIC ACTIVITIES INCREASE

The number of indigent patients treated at the forty-five venereal disease clinics in the State last year was the largest since the clinics were established five years ago. Four thousand seven hundred and forty-three new cases of venereal diseases were admitted for treatment, 2,789 cases

continued treatment from the year before and 3,594 patients who had discontinued treatment were persuaded to return for continuance of treatment. This total of 11,125 indigent cases of venereal diseases were given 120,383 treatments.

## DIPHThERIA NOT RECOGNIZED—CHILD DIES

A report has been submitted to the Department on the death from diphtheria last January of a child six years of age. According to this report, the child was taken ill on January 2, but was not seen by a physician until January 6. It is stated that the roads at this time were almost impassable. The physician made a diagnosis of tonsilitis and gave no antitoxin. Apparently he took no culture. When he was called a week later, the child

was dying. At this time he gave 12,000 units of antitoxin intramuscularly, which was, of course, too late to be of any value.

This is one of the many cases which have come to the attention of the Department where, evidently, it would have been better for the physician to take the risk of erring on the side of safety by giving antitoxin. If this had been done here, the child's life might have been saved.

## FAILURE TO DIAGNOSE DIPHThERIA

Early in November a practitioner was called to attend a child of about five years of age. He made a general examination of the child, also taking the temperature and pulse and prescribed the necessary medication for the condition. He was not called again until the latter part of November, at which time he examined the child with a stethoscope, also examining the throat and taking both the temperature and the pulse, and after examination made a diagnosis of croup. Upon his examination of the throat he saw no evidence of membrane. The necessary medication was prescribed and instructions were given as to the child's diet. The doctor also advised the mother to use a croup kettle, to

keep the child's bowels open with milk or magnesia, that the child was to remain in bed, and that he would call on the following morning.

On the following morning, the child not having responded to the treatment of the previous day, the doctor advised the removal of the child to the hospital, as there was impairment of breathing, and it would probably be necessary to intubate the child. The child was removed to the Willard Parker Hospital, where it was intubated. Two days thereafter the intubation tube was removed, upon which day the child died the cause of death being given by the hospital as diphtheria and bronchial pneumonia.

## DIPHThERIA DEATHS STIMULATE PREVENTIVE WORK

According to a recent report of District State Health Officer Sears, five cases of diphtheria have been reported in the city of Cortland during the present year. Three of the patients died. Dr. Sears hopes that in view of this experience the work of immunization against diphtheria will now be pushed vigorously in this city.

In the same report, Dr. Sears makes mention of the results of the diphtheria immunization campaign in the village of Solvay. Formerly diphtheria was prevalent almost continuously there, but following an intensive toxin-antitoxin campaign there has not been a case reported in that village since last October.

## PHYSICIAN DOES NOT BELIEVE IN ANTITOXIN—PATIENT DIES

That rare species of the "genus homo," the physician who does not believe in antitoxin is not yet extinct, is indicated in a report on a death from diphtheria received recently by the Division of Communicable Diseases. The patient, a girl of seven, was visited by the physician in question apparently on the second day of the disease. The physician stated that the child died of post-diphtheritic cardiac involvement, over a month later. No antitoxin was given, as he does not believe in it. According to the medical

directory published by the American Medical Association, this man graduated from the New York Homeopathic Medical College and Flower Hospital in 1907. As homeopathic medical colleges now teach the value of antitoxin in diphtheria, it is difficult to understand his failure to keep abreast of the times in such matters of life and death, especially when we consider that he received his medical diploma in comparatively recent years.

## PHYSICIANS OF UTICA ORGANIZE NEW SOCIETY

The physicians of the city of Utica announce the formation of the Utica Academy of Medicine, founded for the sole purpose of the advancement

of medical science. This organization has no connection with any hospital staff, nor does it propose to supplement any other existing organization.

# NEWS NOTES

## MEDICAL SURVEY NUMBER 11—MEDICINE IN ROCKLAND AND ORANGE COUNTIES, NEW YORK

**EDITOR'S NOTE** The information on which this Survey is based was supplied by Dr Ralph O Clock, President of the Medical Society of the County of Rockland, by Dr J D Mars, President, and Dr H J Shelley, Secretary, of the Medical Society of the County of Orange, and by Dr Frank W Laidlaw, District State Health Officer

### ROCKLAND COUNTY

Rockland County is located on the west side of the Hudson River, next to New Jersey. It has an area of 183 square miles, and a population of 45,548, according to the Federal census of 1920. A large proportion of the people are commuters from New York, and are grouped in four principal centers of population, each of which is served by a line of railroad. The station in the county nearest New York City is 24 miles distant, and the farthest is 35 miles. Travel is easy between the various sections of the county. While conditions in the county are rural, yet the influence of New York City is felt in medicine as well as in living conditions.

**Physicians**—The number of physicians practising in Rockland County is 52, grouped in 15 centers, according to the directory of the Medical Society of the State of New York. This gives one physician to every 865 of population. But since several New York City physicians are registered in their summer homes in the county, there is one physician to about every 1,100 people.

The Medical Society of the County of Rockland has 40 members, or 77 per cent of the physicians listed in the directory. The percentage would be practically 100 if only those in active practice were counted and summer residents from New York City were not listed.

The Medical Society holds five meetings annually, and the average attendance is over 75 per cent of the membership. Rockland County probably excels all others of New York State in the proportion of its physicians who are members, and in the proportion of members who attend the meetings. The utmost good feeling prevails among the physicians, and the standards of the practice of medicine are high.

The programs of the meetings are always practical. One meeting is held in Letchworth Village, and cases of mental defects are usually presented. Endocrine Disturbances was the subject of a recent meeting, and illustrative cases

were presented by Dr Walter Timme of New York. The programs have consisted of teaching clinics whenever possible.

A social supper is often served at the close of the meeting, and the annual meeting consists almost wholly of a dinner.

The dues in the County Medical Society were formerly two dollars, and were not sufficient to carry on the varied activities of the Society. At the last meeting they were raised to five dollars by the enthusiastic vote of the Society. One speaker said to the President, "We don't care how high the dues are, so long as you keep on giving us our money's worth."

There is a group medical society, called the Ramapo Clinical Club, which is composed of about fifteen physicians practising in Suffern and vicinity. It meets monthly in the evening at the homes of its members, and has a scientific program and a social supper.

The public health work of Rockland County is in charge of nine health officers who serve districts composed of ten villages and five towns. Each health officer serves an average population of 5,000 persons. Nearly all of the health officers have made a special preparation for their work by taking a health officers' course conducted by the State Department of Health.

A special feature of the public health work of Rockland County is the high standard of its milk inspection in Nyack and some other municipalities in which bacterial counts are made regularly and the results published.

**Hospitals**—Rockland County has two general hospitals. The Nyack Hospital is rated with a capacity of 26 beds, but it is usually overcrowded. The funds have been provided which will triple its capacity. The hospital has an excellent laboratory, and its staff does first-class surgical and medical work.

The Good Samaritan Hospital in Suffern has 30 beds.

The County supports a Tuberculosis Hospital of fifty beds.

The number of hospital beds available in Rockland County is about 22 in every 1,000 of population, but the number will be nearly doubled when the present building plan is completed.

There are seven public health nurses in Rockland County. Nyack has a nurse supported by the Board of Health of the village. The County has a tuberculosis nurse, a paper mill in Pierman has an industrial nurse, and there are school

nurses in Spring Valley, Hillburn, Suffern and West Nyack

The after-care of poliomyelitis and other orthopedic work among crippled children is supervised by a nurse who also works in the neighboring counties of Orange, Sullivan, Ulster and Greene

The tuberculosis work of Rockland County is very well done. It is centered in the Sanatorium, and is headed by Dr. W. J. Ryan, Superintendent of the Sanatorium, who conducts diagnostic clinics. The field nurse has listed seven cases for each annual death.

There is a county tuberculosis committee which derives its funds from the sale of Christmas Seals. It employed an executive secretary for six months last year to do educational and nutritional work.

The physicians of Rockland County have the advantage of a small area, with easy automobile communication, and easy access to the metropolitan center. They are of a high class, and the efficiency of the Medical Society reflects the favorable conditions under which the physicians live and work.

#### ORANGE COUNTY

While Orange County adjoins Rockland, the two counties are medically distinct owing to the peculiarities of transportation. The principal commuting railroad lines end in Rockland County, and the Ramapo and Bear Mountains shut off easy automobile traffic between the two counties, except to the northwest, where the main state road extends to Middletown, Port Jervis, and the center of the State.

Orange County has an area of 834 square miles and a population of 119,844, according to the 1920 Federal Census. It had only a small increase in population during the decade from 1910 to 1920, and the increase was confined to its three cities, while the rural sections and most of the villages decreased in value. Yet the people of Orange County are prosperous, and the industries of farming, dairying and horsebreeding are still actively carried on.

Orange County has three cities, as follows:

Newburgh	Population, 30,000
Middletown	Population, 18,000
Port Jervis	Population, 10,000
	<hr/> 58,000

These cities are the medical centers for the surrounding territory.

Orange County has 163 physicians grouped in 25 centers according to the Directory of the Medical Society of the State of New York. This gives one physician to every 670 population. But if the nine physicians on the Staff of the State Hospital and the physicians who are only summer residents are deducted, there would

be left about 145 physicians who are in actual practice, or one to every 900 of population.

There is a larger proportion of physicians in the cities than in the rest of the County, owing to the location of the specialists in the cities. The distribution of the physicians is shown in the following table:

Locality	Number of Doctors	Population	Ratio to Population
Newburgh	38	30,000	1 to 800
Middletown	34	18,000	1 to 530
Port Jervis	17	11,000	1 to 600
Total Cities	89	58,000	1 to 650
Rest of County	56	61,000	1 to 1,100

Orange County has an active County Medical Society with a membership of 106, or 73 per cent of the active practitioners of the County. The Society holds four meetings annually, and its programs are purely scientific. The leaders are planning to enlarge the activities of the Society and to institute a series of teaching clinics.

There is a local medical society, the Newburgh Bay Medical Society, which has 75 members drawn from Newburgh and the surrounding counties of Ulster and Dutchess. It holds six meetings annually. The program of each consists of a social supper followed by a scientific discussion.

Middletown has a Physicians' Club which is a factor in unifying the local profession.

The hospitals of Orange County are as follows:

Name	Location	Number of Beds
Thrall	Middletown	40
Middletown Sanatorium	Middletown	40
Warwick	Warwick	20
St. Luke's	Newburgh	100
Tuxedo	Tuxedo	25
Deerpport Sanatorium	Port Jervis	30
St. Francis	Port Jervis	55
Goshen	Goshen	25
Odell Memorial	Newburgh	48
		<hr/> 383

The total number of hospital beds available in Orange County is 383, or 3.2 beds in every 1,000 of population.

The larger hospitals are well managed and conform to the standards of the American College of Surgeons.

The three physicians who organized the Warwick Hospital made an earnest attempt to develop group medicine, but the experiment was abandoned owing to the difficulty of securing a sufficient number of specialty cases in a village of 2,500 people.

The official public health work of Orange County is done by a health officer in each city and by a health officer in each of the 12 villages and 20 towns, but there are only 21 health officers, for some serve more than one unit. Each



health officer outside the cities serves an average of 3,000 population

A special feature of the public health work is the extent to which toxin-antitoxin has been given to school children for protection against diphtheria. This procedure has been extensively followed in Newburgh, Middletown, Port Jervis, Goshen, Chester, Florida, and Otisville, and has been done at the spontaneous request of the local school authorities, backed by the local health officers and physicians.

Orange County has 13 public health nurses, as follows

County T B nurse	1
Newburgh	4
Port Jervis	2

Middletown	2
Chester	1
Goshen	1
Monroe	1
Walden	1

Of these, four are school nurses and four are under the Board of Health.

Tuberculosis work is well done in Orange County. The Odell Memorial Hospital in Newburgh is the County Tuberculosis Hospital, and the County maintains a field nurse. Diagnostic Clinics are held in various parts of the County under the auspices of the State Department of Health, assisted by local health officers and physicians. F O

### BRONX COUNTY MEDICAL SOCIETY

A regular meeting of the Bronx County Medical Society, held at Hollywood Gardens, 896 Prospect avenue, on April 15, 1925, was called to order at 9 p m, the First Vice-President, Dr Edward R. Cuniffe, in the Chair.

Drs Isidore Berger, Moses Lewis Furman, William H. Godsick, Isaac Goldstein, S. Carlyle Trattler, were elected to membership.

Reports of committees being called for, Dr Lukin reported for the Committee on Medical Economics. At the conclusion of the reading of the report, Dr Lukin moved that the secretary be instructed to write Dr S. S. Goldwater a letter of commendation, and expressing the hearty support of our Society with regard to his paper on "The Extension of Hospital Privileges to All Practitioners of Medicine," published in the March 28th issue of the Journal of the American Medical Association. This motion was carried.

Dr Friedman, for the Committee on Public Health, reported on the subject of periodic health examinations, and announced that the next meeting of the Society will be in the form of a mass meeting, at which this subject will be fully discussed.

Under New Business, Dr Gitlow moved that the Comitia Minora's recommendation be concurred in, that there be an annual assessment of one dollar per member for the purpose of defraying the expenses for literature, etc., in connection with the committee's work on behalf of periodic health examinations.

Dr Magid, on behalf of several members of the Society, proposed several amendments to the By-Laws.

It was ordered that the proposed amendments be printed in the next issue of The Bulletin.

Dr Rostenberg moved that a letter be sent to Dr Alexander Goldman, expressing the sympathy of the Society on the death of his son. This motion was carried.

Dr Keller appealed to the members on behalf of The Bulletin, with particular reference to the necessity of securing advertisements.

The scientific program, arranged by The Bronx Pediatric Society, then proceeded as follows:

Pathogenesis of Tuberculosis in Childhood (with lantern slide demonstration)

Prof. Bela Schick

Discussion by Drs Fisher, J. B. Cohen and Lukin. The discussion was closed by Dr Schick.

Dr Rost moved that the Society extend a vote of gratitude and thanks to Dr Schick. This motion was carried, and Dr Cuniffe expressed the thanks of the Society to Dr Schick.

The Chairman, Dr Cuniffe, announced that at the next meeting the question of periodic health examinations will be considered and urged the members to be present.

The meeting adjourned at 11 p m.

Respectfully submitted,

I. J. LANDSMAN, M.D.,  
Secretary

nurses in Spring Valley, Hillburn, Suffern and West Nyack

The after-care of poliomyelitis and other orthopedic work among crippled children is supervised by a nurse who also works in the neighboring counties of Orange, Sullivan, Ulster and Greene

The tuberculosis work of Rockland County is very well done. It is centered in the Sanatorium, and is headed by Dr W J Ryan, Superintendent of the Sanatorium, who conducts diagnostic clinics. The field nurse has listed seven cases for each annual death.

There is a county tuberculosis committee which derives its funds from the sale of Christmas Seals. It employed an executive secretary for six months last year to do educational and nutritional work.

The physicians of Rockland County have the advantage of a small area, with easy automobile communication, and easy access to the metropolitan center. They are of a high class, and the efficiency of the Medical Society reflects the favorable conditions under which the physicians live and work.

#### ORANGE COUNTY

While Orange County adjoins Rockland, the two counties are medically distinct owing to the peculiarities of transportation. The principal commuting railroad lines end in Rockland County, and the Ramapo and Bear Mountains shut off easy automobile traffic between the two counties, except to the northwest, where the main state road extends to Middletown, Port Jervis, and the center of the State.

Orange County has an area of 834 square miles and a population of 119,844, according to the 1920 Federal Census. It had only a small increase in population during the decade from 1910 to 1920, and the increase was confined to its three cities, while the rural sections and most of the villages decreased in value. Yet the people of Orange County are prosperous, and the industries of farming, dairying and horsebreeding are still actively carried on.

Orange County has three cities, as follows:

Newburgh	Population, 30,000
Middletown	Population, 18,000
Port Jervis	Population, 10,000
	<hr/> 58,000

These cities are the medical centers for the surrounding territory.

Orange County has 163 physicians grouped in 25 centers, according to the Directory of the Medical Society of the State of New York. This gives one physician to every 670 population. But if the nine physicians on the Staff of the State Hospital and the physicians who are only summer residents are deducted, there would

be left about 145 physicians who are in actual practice, or one to every 900 of population.

There is a larger proportion of physicians in the cities than in the rest of the County, owing to the location of the specialists in the cities. The distribution of the physicians is shown in the following table:

Locality	Number of Doctors	Population	Ratio to Population
Newburgh	38	30,000	1 to 800
Middletown	34	18,000	1 to 530
Port Jervis	17	11,000	1 to 600
Total Cities	89	58,000	1 to 650
Rest of County	56	61,000	1 to 1,100

Orange County has an active County Medical Society with a membership of 106, or 73 per cent of the active practitioners of the County. The Society holds four meetings annually, and its programs are purely scientific. The leaders are planning to enlarge the activities of the Society and to institute a series of teaching clinics.

There is a local medical society, the Newburgh Bay Medical Society, which has 75 members drawn from Newburgh and the surrounding counties of Ulster and Dutchess. It holds six meetings annually. The program of each consists of a social supper followed by a scientific discussion.

Middletown has a Physicians' Club which is a factor in unifying the local profession.

The hospitals of Orange County are as follows:

Name	Location	Number of Beds
Thrall	Middletown	40
Middletown Sanatorium	Middletown	40
Warwick	Warwick	20
St Luke's	Newburgh	100
Tuxedo	Tuxedo	25
Deerpont Sanatorium	Port Jervis	30
St Francis	Port Jervis	55
Goshen	Goshen	25
Odell Memorial	Newburgh	48

---

383

The total number of hospital beds available in Orange County is 383, or 3.2 beds in every 1,000 of population.

The larger hospitals are well managed and conform to the standards of the American College of Surgeons.

The three physicians who organized the Warwick Hospital made an earnest attempt to develop group medicine, but the experiment was abandoned owing to the difficulty of securing a sufficient number of specialty cases in a village of 2,500 people.

The official public health work of Orange County is done by a health officer in each city and by a health officer in each of the 12 villages and 20 towns, but there are only 21 health officers, for some serve more than one unit. Each

Response President's Address—Julia Kimball Qua, M D

"Alkaline Reserve and Acidosis"—Isabel M Meader, M D, Watertown

"Clinical Utility of the Newer Laboratory Tests"—Rose R. Donk, M D, Buffalo

"Non-operative Treatment in Gynecology"—Anna Harvey Voorhis, M D, Yonkers

"Radiotherapy in Menorrhagia"—Leila Knox, M D (by invitation), New York City

"Relation of Physical Findings to Scholarship and Intelligence Quotient in State College Freshman"—Marion Collins, M D, Albany

"Effect of Treatment on Neonatal Morbidity and Mortality"—Mary Jane Foley, M D, Rochester

"Rickets—Comparison of Medical Treatment

With That of Ultra Violet Ray"—Ruth J Cras-  
son, M D (by invitation), New York City  
Election of Officers  
Luncheon

#### AFTERNOON SESSION, 2 00 P M

Lantern Slide Demonstration of the Normal Variations of the Study of Visceral Ptosis—Agnes C Vietor, M D (by invitation) New York City

"The Management of Pregnancy and Technique of Normal Labor"—Adelaide Dutcher, M D, Syracuse

"Treatment of Speech Defects—Stammering, Stuttering, Cleft Palate, Voice Phonation, etc"—Miss Helen Pierce (by invitation), Buffalo

Banquet, 6 30

The Committee of Arrangements have reserved a room at the Hotel Syracuse for the use of the members

---

### WOMEN'S MEDICAL ASSOCIATION OF NEW YORK CITY

Preceding the annual meeting, the Women's Medical Association of New York City will have an informal dinner at the Women's City Club, 22 Park Avenue, Wednesday, May 20, 1925, at 6 30 P M Tickets \$2 00 Applications for reserva-

tions enclosing check should be made to Ethel D Brown, M D, 26 Gramercy Park, New York City, before May 18 All medical women, graduates and undergraduates are invited

---

### REUNION AND DINNER OF THE MEDICAL OFFICERS OF THE WORLD WAR

An attractive feature of the Annual Meeting of the American Medical Association at Atlantic City will be the reunion of the medical men who served their country in the Army and Navy during the World War, to renew the memories, friendships and associations of those eventful days The Chief Surgeon of the A E F will be there, and the President of the Association of Military Surgeons, Surgeon General Hugh E Cumming, and other officers of the Association under whose auspices the meeting will be held An effort will be made to group together those

who served in the same organizations and so it is requested that reservations be made as early as possible, and that comrades state in writing for them the base hospital or other medical unit to which they belonged Write for tickets to Colonel Burt R Shurly, Med-Res, U S A, 62 West Adams Avenue, Detroit, Mich

Time and Place May 27th at 7 P M at the Ritz-Carlton Hotel, Atlantic City

Members of the Association of Military Surgeons are requested to wear the badge of the Association

## ROCKLAND COUNTY MEDICAL SOCIETY

The first stated meeting of the year of the Medical Society of the County of Rockland was held on the afternoon of Thursday, April 23rd, in the new Recreation Room of the County Tuberculosis Sanatorium, Summit Park. Twenty-one members and six guests were present.

Dr R O Clock, the President of the Society, announced the death of Dr W F Kaufmann of Haverstraw, from erysipelas following a mastoid operation. Resolutions of appreciation were passed by the Society.

The subject of the meeting was Tuberculosis. Rockland County has always done its anti-tuberculosis work well. The County Medical Society has promoted the construction and maintenance of the Sanatorium, and a physician, Dr George A Leitner, of Piermont, is President of its Board of Managers. Clinics are held regularly, and field work is done by a nurse employed by the County. There are seven cases listed and visited for every annual death. With such a record as this, the physicians were prepared to take a deep interest in a program devoted to Tuberculosis.

The principal speaker was Dr James Alexander Miller, Director of the Tuberculosis Department of Bellevue Hospital. His subject was "The Early Diagnosis and Sanatorium Care of Tuberculosis," and was both informative and inspirational—an ideal combination for an address before a meeting of physicians.

Dr Miller appealed to the physicians to keep tuberculosis in mind always in dealing with patients who show only mild symptoms of chronic fatigue and indigestion. He described a typical routine of events in which these patients have recurrent attacks of a mild disorder, such as indigestion. A doctor gives them some medicine, and they are "cured" for a time, and then the symptoms return because they are due to the toxemia of a mild tuberculosis. These cases usually get well permanently when they are treated for tuberculosis, but many develop advanced tuberculosis because tuberculosis is often the last instead of the first thing that doctors think about when they examine the cases.

Dr Miller urged the doctors to use the Sanatorium for the treatment of cases in the earliest possible stage. He closed his lecture with an interesting series of lantern slides showing the value of X-ray photographs in the diagnosis of mild pulmonary tuberculosis which gives few or no physical signs.

The very great value of Dr Miller's address was the simplicity of his language and the clearness of his thought. A physician listening to him feels that tuberculosis cases are no rare mysterious conditions that rich organizations like to monopolize, but that his own intimate patients have the disease, and that it is his duty to recognize and treat it.

The substance of Dr Miller's address was printed on page 188 of the February 6th, 1925, issue of this Journal as a part of the symposium on Periodic Health Examinations conducted by the Medical Society of the County of New York.

Dr Robert L Plunkett, Director of the Division of Tuberculosis of the State Department of Health, described the diagnostic clinics of the State Department of Health, and emphasized the fact that they were held in co-operation with the local physicians.

Dr Orrin S Wightman, Associate Editor of THE NEW YORK STATE JOURNAL OF MEDICINE, spoke on the doctor's responsibility to take a deep interest in tuberculosis and other chronic conditions, and not to permit lay organizations to usurp the field which physicians can control far better than anyone else.

Dr W J Ryan, Superintendent of the Sanatorium, described the newer phases of the work in the institution.

At the close of the meeting a supper was served which enabled the physicians to get together and discuss their personal problems. The President took the opportunity to urge the physicians to show their good fellowship by attending a dinner on May 7th, to be given to Dr W R Sitler of Suffern, on the fiftieth anniversary of his graduation in medicine.

F O

## WOMEN'S MEDICAL SOCIETY OF NEW YORK STATE

The One Hundred and Nineteenth Annual Medical Meeting has so many attractive and interesting events that we can assure our Syracuse friends of one of the largest conventions the State Medical Society has ever had.

Besides the splendid program provided by the State Medical Society and the attractive entertainment for the wives and friends of the physicians, the Women's Medical Society of New

York State, Nineteenth Annual Meeting is to be held in the Hotel Syracuse, Monday, May the Eleventh.

Invocation—Eliza M Mosher, M D

Address of Welcome—Elizabeth L Shrumpton, M D, Chairman, Committee of Arrangements

Greeting—Owen E Jones, M D, President, Medical Society of the State of New York

Response President's Address—Julia Kimball  
Qua, M D

"Alkaline Reserve and Acidosis"—Isabel M  
Meader, M D, Watertown

"Chemical Utility of the Newer Laboratory  
Tests"—Rose R. Donk, M D, Buffalo

"Non-operative Treatment in Gynecology"—  
Anna Harvey Voorhus, M D, Yonkers

"Radiotherapy in Menorrhagia"—Leila Knox,  
M D (by invitation), New York City

"Relation of Physical Findings to Scholarship  
and Intelligence Quotient in State College Fresh-  
man"—Marion Collins, M D, Albany

"Effect of Treatment on Neonatal Morbidity  
and Mortality"—Mary Jane Folev, M D,  
Rochester

"Rickets—Comparison of Medical Treatment

With That of Ultra Violet Ray"—Ruth J Cras-  
son, M D (by invitation), New York City  
Election of Officers  
Luncheon

#### AFTERNOON SESSION, 2 00 P M

Lantern Slide Demonstration of the Normal  
Variations of the Study of Visceral Ptosis—  
Agnes C Viotor, M D (by invitation) New  
York City

"The Management of Pregnancy and Tech-  
nique of Normal Labor"—Adelaide Dutcher,  
M D, Syracuse

"Treatment of Speech Defects—Stammering,  
Stuttering, Cleft Palate, Voice Phonation, etc."  
—Miss Helen Pierce (by invitation), Buffalo  
Banquet, 6 30

The Committee of Arrangements have re-  
served a room at the Hotel Syracuse for the use  
of the members

---

### WOMEN'S MEDICAL ASSOCIATION OF NEW YORK CITY

Preceding the annual meeting, the Women's  
Medical Association of New York City will have  
an informal dinner at the Women's City Club, 22  
Park Avenue, Wednesday, May 20, 1925, at 6 30  
P M Tickets \$2 00 Applications for reserva-

tions enclosing check should be made to Ethel D  
Brown, M D, 26 Gramercy Park, New York  
City, before May 18 All medical women, gradu-  
ates and undergraduates are invited

---

### REUNION AND DINNER OF THE MEDICAL OFFICERS OF THE WORLD WAR

An attractive feature of the Annual Meeting  
of the American Medical Association at Atlantic  
City will be the reunion of the medical men who  
served their country in the Army and Navy dur-  
ing the World War, to renew the memories,  
friendships and associations of those eventful  
days The Chief Surgeon of the A E F will  
be there, and the President of the Association of  
Military Surgeons, Surgeon General Hugh E  
Cumming, and other officers of the Association  
under whose auspices the meeting will be held  
An effort will be made to group together those

who served in the same organizations and so it is  
requested that reservations be made as early as  
possible, and that comrades state in writing for  
them the base hospital or other medical unit to  
which they belonged Write for tickets to  
Colonel Burt R Shurly, Med -Res, U S A, 62  
West Adams Avenue, Detroit, Mich

Time and Place May 27th at 7 P M at the  
Ritz-Carlton Hotel, Atlantic City

Members of the Association of Military Sur-  
geons are requested to wear the badge of the  
Association



# THE DAILY PRESS



Our pile of daily press clippings this week is larger than ever, but they are exceedingly commonplace, both in content and in form. They are statistical rather than informative, and many bear all the earmarks of having been dragged by eager reporters from unwilling doctors and boards of health. The week seems to have been an off one for news of a medical nature, or of a kind that bears even remotely on medicine.

The clipping readers seem to have standards of their own. Senator Copeland was a former health officer, and so everything he says relates to health, according to the clipping bureau readers.

May Day as Child Health Day comes in for whole columns of clippings, every one of which emphasizes the fact that Herbert Hoover is the President of the National Child Health Association. The May Day articles have a great sameness and bear all the marks of having been written in one office and syndicated throughout the land.

We wonder why the local health officials don't write up Child Health Day from a local point of view, and give it a personal appeal to the people of their community. We recall that our old school reading book had a picture of an eager mother throwing her happy baby into the Ganges River where a blinking crocodile waited expectantly for his meal, but that did not inspire us with any desire for baby saving—it all seemed so commonplace and far-away as a dull movie. What is needed in medical publicity is an appeal which reaches each particular community.

The lay organizations promoting Child Welfare, anti-tuberculosis work, and other health measures are not spending 10 per cent of their energies in reaching physicians. If they would devote 90 per cent of their energies and funds to influencing physicians, and would endow medical organizations so that physicians could do effective preventive work, would not the use of preventive medicine make a tremendous advance? We know of county medical societies which are already undertaking advanced public health work, but lack the funds to carry it on effectively. It would seem that an endowment of these societies by a lay organization would produce far better results than attempts to establish an organization that is independent of the practicing physicians of a community.

So far as publicity goes, we seldom see a clipping stating that a county medical society is leading in public health work, and yet we know that

several are doing so—as for example the Jefferson County Society whose activities we have frequently recorded. What physicians do is all in their commonplace daily work, and they do not publish the details of their civic practice of medicine any more than they do their private practice.

The practice of civic medicine necessarily requires publicity, for it is largely done by organized medical societies, and publicity is necessary to carry the news to the great mass of members of the society, and to hold their interest so that they will pay their dues to support the work. Publicity is also necessary in order to get the people to vote money for public health, to build hospitals, to finance health departments, and to support other measures which constitute the practice of civic medicine.

We have made a rather extensive acquaintance among reporters, and have found them anxious to give reasons and explanations of health matters which they report. They wish to make every news item so interesting that people will talk about it, and ask for more news on the subject. Doctors will always find reporters receptive to explanations which they give. If doctors would comment on the medical news of the day, the health items in the daily papers would be far more interesting than we have found them to be during the last week or two.

The Mineola Times, April 3rd, contains two items of health news which have a great local appeal. One is an account of a meeting of the Parent Teachers' Association of the Village in which particular items of advice were given, such, for example, as the following:

"Mrs. Beatty spoke on the dangers lurking in the use of a common drinking cup and cautioned the children against swimming in Simonson's Pond west of Marcellus Road as the water is polluted by drainage from the village streets."

The meeting also took a definite stand in regard to serving milk in the school.

"The question was brought up of the advisability of serving milk to the younger children during school hours. Records of other schools in Nassau County indicate it has been beneficial. A motion was passed to bring this matter before the school board for their approval. Young children grow restive and inattentive during the morning hours and other schools have found a glass of milk refreshes and fortifies the children. This is no reflection on home care and feeding,

but is a condition of childhood when a little nourishment given often is better than large meals at longer intervals"

We commend the newspaper because reporting definite items of health advice which are given in civic medicine are like a personal prescription given to a patient in private practice

---

The second item in the Mineola paper is a column and a half article on the proposed Preventorium for Tuberculous Children to be added to the County Sanatorium. Dr A J Davis, Superintendent of the institution, gave an interview in which he described the need of preventive work among children. The interview closes

"Much if not all tuberculosis begins in childhood. We do not at present know whether the adolescent disease is a lighting up of an old process or a new super-imposed infection. But in either case, childhood is the most important period in the history of the disease, because it is the true incipient stage—the very beginning of nearly all tuberculosis

"It is very important to recognize and to watch children who are infected, for if we are to stamp out the disease we must attack it here—in its real, incipient stage. Such children do very well under watchful care, but without it, they may do very badly. If we accept the common view that a positive tuberculin reaction means nothing except in infancy, we lose our greatest opportunity in combating the disease in its inmost stronghold—when we have our best chance of wiping it out"

---

How many cases does it take to make an epidemic? The death of a four-year-old child from rabies in New Rochelle has led the health authorities of the adjoining city of Mount Vernon to require that the preventive inoculations against rabies shall be given to all dogs in the city. There seems to be a disposition of the health authorities and the newspapers to minimize the existence of rabies in New Rochelle, although the same papers say the disease is prevalent in other parts of Westchester County, in Rockland County, and in Connecticut. They admit it is all around the city, but the *New Rochelle Star*, April 16th, says

"A local quarantine would not be effective. In his opinion the community would benefit from a quarantine only if dogs were ordered muzzled throughout Westchester and Rockland counties, in both of which there has been an unusual number of cases this spring. If such a move is contemplated, it is entirely up to the state department. The state authorities receive immediate reports of all cases and are in a position to

handle the situation. If they order a quarantine, all dogs not muzzled will be corralled and shot by state health officers. In this city the rabies has not reached epidemic proportions by any means, with only one case reported"

One human case of rabies in a city and many known cases of rabies in dogs in the surrounding territory! What more is necessary to constitute an epidemic of rabies?

The Mount Vernon *Argus*, April 23, says

"All dogs in Mount Vernon must be immunized to prevent rabies or else they will be shot. Dr William H Purdy, health commissioner, arrived at this decision today after discussing the question of a quarantine with Dr William S Corlis, veterinary surgeon and inspector of the local health department

"The process of immunization, as explained by Dr Corlis, is the injection of a vaccine into the dogs to prevent them from contracting the disease. Each dog must be vaccinated by a representative of the health department and a tag showing that the animal has been so treated will then be attached to the regular license. No date for such an order becoming effective has been fixed"

The city authorities of Mount Vernon are to be highly commended for their active efforts to control rabies

---

Cases of poisoning by cream puffs continue to appear frequently in the metropolitan papers. We do not know whether the cases are actually developing often, or the reporters have got it into their heads that every obscure gastro-intestinal outbreak is caused by cream puffs. It is strange that cream puffs are always the guilty food. However, the following report from the *New York Mirror*, March 24th, has all the appearance of reliability

"Simultaneous with the removal of four more persons to the Reception Hospital yesterday suffering from food poisoning. Health Commissioner Monaghan announced that the source of the food had been located. A total of 12 persons have been stricken within the last few days. Seven are in the hospital

"It was found by Health Department authorities that all those suffering from the poisoning had purchased cream puffs from a bakery in East 96th Street. They believe that the poisoning was due to bacteria as the shop was reported to be unsanitary

"Samples of the pastry and the ingredients used were taken for chemical and microscopic analysis

"The cream puffs were eaten at a party"



# BOOK REVIEWS



**HOW IS YOUR HEART?** Intimate Talks on the Prevention of Heart Disease and on the Care of an Already Damaged Heart By S CALVIN SMITH, M.S., M.D. 12mo of 208 pages New York, Boni and Liveright, 1924 Cloth, \$1.75

This is a small book written with the object of educating the layman as to the causes, prevention and general management of heart disease. The author's style of writing is entertaining and lucid with a dash of humor. Unlike some books of its general type, it is not a bore for the physician to read this one, indeed he may do so with profit, as the views expressed are those held in the best repute today.

The influence of faulty habits in causing heart disease is discussed, especially the one of overeating. This is well explained, also the influence of lack of exercise, harmful habits of thought and previous illnesses. A chapter is devoted to the influence of infected teeth and another one to the tonsils.

The author's views regarding tobacco and alcohol are sane and conservative. He believes that the former in moderation does not make a good heart bad but may make a bad heart worse. His paragraphs on "defending the companion of our solitary hours" are satisfactory and have the ring of truth.

The book is free from fads, dietary and other, and may be safely recommended to the intelligent layman. The perusal of books of this type should cut down the number of believers in foolish cults.

W E McCOLLOM

**THE HAPPY BABY** Editorial Advisor, Dr L. EMMETT HOLT Contributors Dr L Emmett Holt, Dr Harvey J Burkhart, Dr Ralph Lobenstine, Dr Henry L K. Shaw 12mo of 120 pages New York, Dodd Mead and Company, 1924 Cloth, \$1.00

The articles composing this book were published in one of the lay magazines for women, "The Delineator," and are by different authors, namely Dr Holt, Dr Harvey J Burkhart, Dr Ralph Lobenstine and Dr Henry L K Shaw.

Dr Holt has written chapters on "General Care of the Baby," "Maternal Nursing," "Artificial Feeding," and "Diet Problems of Childhood." Dr Shaw contributes a chapter on "Early Childhood" while Dr Lobenstine takes up "The Care of the Expectant Mother and the New Baby," and Dr Burkhart writes on "The Child's Teeth."

The lay press has done a great deal to spread the gospel of health and nutrition especially with regard to children, its publications reach a vastly greater percentage of the people of any country than any medical or scientific writings. Furthermore the real hope of overcoming malnutrition and dental cares and other results of improper hygiene and feeding lies in educating the mother of young children. For many reasons, then, such articles as the ones here considered must be productive of an enormous amount of good.

WM HENRY DONNELLY

**PRACTICE OF PEDIATRICS** By CHARLES GILMORE KERLEY M.D., and GAYLORD WILLIS GRAVES, M.D. Third Edition, revised and reset Octavo of 922 pages with 150 illustrations Philadelphia and London, W B Saunders Company, 1924 Cloth, \$9.00

This new edition of this well known work has been brought up-to-date in most subjects and contains many valuable hints on treatment. The book is well printed in large enough type so as to make easy reading, on good paper and is well bound. It can be highly recommended as a standard text book on this subject. P L P

**MODERN ASPECTS OF SYPHILIS** By M J HORGAN, B.A., M.B., B.Ch., B.A.O., NUI 12mo of 136 pages. London, Henry Frowde and Hodder & Stoughton, 1923 Cloth, \$1.75 (Oxford Medical Publications.)

This book of 136 pages is engagingly written in a brisk style, and considering its size is surprisingly full of valuable information. It is a successful "effort to reproduce the standpoints of the Vienna School." There is an adequate index and reference list. Compared to the standard practice of American authorities the doses of arsenicals advised are small and the duration of treatment, particularly in early cases, too short. Bismuth and tryparsamide are not mentioned. Despite these reservations the work will repay the time of the reader.

GRAY PHILLIPS.

**FUNDAMENTAL PRINCIPLES IN TREATMENT** By HARRY CAMPBELL, M.D., B.S., F.R.C.P., Lond., Senior Physician West End Hospital for Nervous Diseases Wilham Wood & Co, New York, 1924 Price, \$4.00

The writer has given us a scholarly treatise upon the many factors which enter into the care of patients. He considers not only the sick individual, but his surroundings and social condition. The physician himself comes in for an amount of instruction concerning himself and his manner of treating individuals. This carefully prepared book would benefit anyone who studies it, as the fundamental principles of treatment are frequently omitted or slighted in the medicinal treatment of patients.

H. M. M

**THE EFFECTS OF INANITION AND MALNUTRITION UPON GROWTH AND STRUCTURE.** By C M Jackson, M.S., M.D., LL.D., Professor and Director of the Department of Anatomy, University of Minnesota. 117 Illustrations P Blakiston's Son & Co, Philadelphia, 1925 Price, \$8.00

Human famine has become so frequent of occurrence since the beginning of the World War that a study of the effects of inanition and malnutrition is a matter of great practical importance. This volume may be taken as an authoritative monograph on this subject. It offers a comprehensive consideration of the results of malnutrition. The bibliography is extensive and the completeness with which the current literature has been covered is commendable.

HENRY M FEINBLATT

**MANUAL FOR DIABETICS** By GLADYS L. BOYD, M.D., and MARION D STALSMITH Introduction by F G BANTING, M.D., 12 mo Cloth, 101 pages Price, \$1.50 net. Funk & Wagnalls Company, Publishers 1924

This is a useful small book to place in the hands of the patient to relieve the physician of some of the burden of instruction. The chapters of which there are eight, deal with insulin, food in diabetes, weights and measures, complications of diabetes, examination of the urine, tables of food values, diabetic recipes and menu planning.

The book is very well arranged and compares favorably with the others of its type. It may well be recommended to diabetic patients.

W E McC



# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

Vol. 25, No. 17

NEW YORK, N. Y.

JUNE, 1925

## PRESIDENT'S ADDRESS \*

By OWEN E. JONES, M.D.,

ROCHESTER, N. Y.

SOMETIME in the world's early history, where man, clothed with intelligence, became afflicted with some of the ills to which he became heir, art, if not the science, of medicine soon found a field for its activities, as history records that about 4500 years B. C., in the ancient city of Memphis one Imhotep, who was the physician to the King, became widely known for his skill, and people came from afar to obtain his counsel and care, his influence moulded the medical teaching and practice of that time, thus with the advance of time at various periods in the world's history there stood out to illuminate the path of medical practice and teaching such men as Aesculapius, Galen, Herodotus and Hippocrates, whose teachings and practices became the standard of medical ethics which today largely govern our relationship between the physician and patient.

And thus down through the various epochs of time the physician has played his part in the world's history by ever devoting his time and energies in caring for the ills of mankind, thoughtful ever of the best interest of those whom he served.

Owing, however, to the brilliant mind of Hippocrates, medicine early became a science of its own among the Greeks, and for centuries Greeks exercised almost a monopoly on medical knowledge throughout the civilized world. The Greek physicians were honored as among the most highly educated people of their times and our knowledge of early medicine is almost entirely due to their observations and writings. Prior to the time of Celsus, who lived about the time of Christ, the practice of medicine among the Romans was considered the least desirable of all professions. The employment of a physician was postponed when possible and only resorted to, if at all in the last extremity. The Roman had great faith, however, in the power of

his gods, of which he had a great selection. For every common disease there was a god or tetish. Celsus was not a physician, but one of the most learned men of his time and wrote extensively on many subjects of learning. His writings on medicine, fortunately for us, were not lost through the middle ages and were among the first medical works to be printed after the invention of printing.

Without undue strain upon our imagination it is not difficult for us to group the people about us into two classes representing to the physician and his profession the attitudes of the ancient Greeks and Romans. There are those who, like the Greeks, consider the practice of medicine a science and an art and avail themselves of its advantages, while the other group, like the ancient Romans, take great pride in their physical fitness and boast that they are immune from disease and when stricken rely upon their constitution to overcome their affliction, calling a physician only when death stares them in the face. Except during the lethargy of the middle ages, the physicians have ever striven to increase the group of those who would scientifically care for their bodies, but with indifferent results. Today, owing to our general advance in education, the average individual has an infinitely greater knowledge of his own body and its function and is less inclined to be impressed by superstition and fetish than he was at any time in the past. Also many powerful influences are stimulating the prevention of disease and the preservation of health by scientific measures.

The physicians, through their medical organizations, have an unequaled opportunity now of freeing the practice of medicine from its medieval shackles and advancing it to the position in society where the physician will rightly receive recognition as the representative of the most important of all professions. There are a number of ways in which this Society can aid its members in realizing their ideal—the practice of preven-

\* Delivered at the Annual Meeting of the Medical Society of the State of New York at Syracuse May 14, 1925.

tive medicine The first step which has received considerable attention in a number of groups including several County Societies, is that of developing among the laity the practice of having physical examinations made upon themselves at regular periods A committee should be appointed to study the methods employed and the results obtained by those in this Society and in other organizations who have endeavored to develop the practice of periodic examination The Society should develop facilities for aiding the physician in equipping himself for intelligently making and recording such examination This is such a new feature in medicine that no effort has been made by medical schools to teach the subject as such and hence the concept of the work is exceedingly vague in the minds of most physicians and even considerable variance will be found among those who have clear ideas as to what the term embraces

During the past year we have endeavored to bring the importance of this subject to the physicians throughout the State We have referred to it invariably on our visits to County Societies and have been pleased to observe the eagerness with which the physicians have taken up this subject

There are a number of encouraging signs that we have noted in the Society during the past year, to which we desire to call your attention There is an abundance of evidence of an increase of interest among the physicians in their County Societies This is an exceedingly healthful condition and we have done what we could to encourage it Several Societies have notified us of resolutions passed to increase the number of meetings held annually Several have undertaken through their committees on public health and public education, the publication in local papers of articles of medical interest for the instruction of the people At least half a dozen counties have adopted a scheme or have appointed committees who are preparing a method for the periodic physical examination of apparently well people

The Committee on Legislation during this year advanced markedly its consolidation of the County Societies in an effort to secure favorable legislation and prevent the passage of bills inimical to the practice of medicine The legislature itself by its action upon bills introduced, reflected a recognition of this unity in the medical profession

The Scientific Committee has undertaken an innovation in its program for the annual meeting by the development of a clinic and demonstration on a particular subject for the third day of the meeting

The special Committee on Post-Graduate Medical Instruction has made a thorough study of

schemes and methods employed in other states for the extension of medical education from the hospitals and medical schools to the practicing physician This report should not only be accepted and recorded, but should form the basis of some definite activity during the next year There was never such a demand from the physicians actively engaged in the practice of medicine for the establishment of facilities that will keep them in touch with centers of learning and with large hospitals and laboratories, as there is today

The special Committee on Nursing has also made a very careful study of a subject that demands immediate attention from this Society The problem of providing adequately trained nurses for all of the positions which they are called upon to fill today, is an important one and attempts at its solution have been undertaken by a number of different groups, but should not be solved without the co-operation of the physicians, because fundamentally, nurses have been trained to be assistants to the physicians and whether eventually they are employed as bedside nurses or public health nurses, as general nurses or specialized nurses, they, nevertheless, must take direction from the physician and, therefore, the Society should use its influence to have the report of this special committee developed

In the past the chairmen of our standing committees have found it exceedingly difficult to accomplish the programs they laid out This is largely due to two factors, first, that the members of the committees are always practicing physicians who have little time that they can actually spare for the work, and, second, that the tenure of office of the members of the committee is entirely too short to accomplish marked constructive work, but now that we have employed an executive officer, one of whose functions it will be to serve *ex-officio* on such committees and to continue from one year to another the execution of programs outlined, we can expect greater results of our standing committees whose programs have called for co-operation with the County Societies

The Committee on Legislation, with its three years of experience, has conclusively proven the advisability of having a standing committee ally itself intimately with a similar committee in each of the County Societies, and I would recommend that this plan be considered by the standing committees of Public Health and Medical Economics

Our County Society must be its own judge as to its membership and the qualifications of those admitted to membership but I would urge that more attention be given to the keeping up and increasing membership There are practicing within this State 16,000 physicians, only 10,500 of whom are members

of County Societies. Among these 5,500 non-members there must be many men who would be valuable additions to their respective County Society. The problems of the County Society are receiving considerable attention in medical circles today. In my opinion the secret of success for any County Society lies in the interest which the members take in its functions. A Society should not limit itself and its interest to its meetings, but should take an active interest in all activities within its jurisdiction that have relation to the practice of medicine and health education. Physicians receive a license from the State to practice and this license, it seems to me, not only confers the privilege of practicing his profession, but also a duty to assist the State with his knowledge in its protection of its citizens.

The State Society can and should aid the County Societies in developing the social and civic side of their program as keenly as it does their scientific program.

In addition to increasing their membership the County Societies should be stimulated to increase the number of their meetings. Thirty per cent have but two meetings a year and another 40 per cent do not meet more than four times a year, thus fewer than 30 per cent of the Societies meet six times a year or oftener. One Society has monthly meetings, four others have ten meetings annually. I realize that in many instances, where the County Society has so few meetings, it is largely due to the fact that the physicians are members of other medical organizations which meet more frequently. A scheme should be devised, however, by which the County Society as such would meet more frequently. It could be done by holding its meeting in conjunction with some of the other groups, allowing the other group the privilege of presenting the scientific program, and the County Society take some time for the transaction of its business.

Just as the County Society should familiarize itself with and function at least in an advisory capacity on all medical activities undertaken within its County, so the State Society should manifest an interest and assert its prerogative in consulting with all lay organizations, whether voluntary or governmental, whenever they engage in State-wide activities which relate to the practice of medicine or the

conservation of public health. Our absence from such conferences in the past has been noted, and we have been charged with indifference or even unwillingness to cooperate with those endeavoring to promote public health measures. There may be a question in the minds of some as to the advisability of our Society thus taking an active interest in things other than the immediate practice of medicine, but the right of the individual to protect himself against disease cannot be denied him and who is better qualified to advise with him in the measures he may wish to take than the practicing physician, and to whose interest will such measures react more directly than to the physician's?

Is it not as unfair to expect any group of citizens, no matter how highly educated or what regard they may have for the physicians and their profession, to be able to act wisely on questions requiring medical decision as it would be to expect physicians to give legal decisions? Our unwillingness to express ourselves clearly and forcibly where the practice of medicine is involved, has led to much confusion among the laity.

It is also quite reasonable to expect that the human being who now realizes the necessity of calling a physician when he feels his end approaching, will eventually, under the present scheme of education, be equally eager to call a physician when the earliest symptoms of disease or sickness appear, or even seek his advice and care in preventing sickness, a condition which we are hopeful will result from our present activity in stimulating periodic examinations.

In all of our activities it is well for us to bear in mind that we compose the largest Medical Society in the world, and that also within our State are located 688 hospitals, 11 medical schools and 2 post graduate schools, the world's largest research institute and more than 100 diagnostic laboratories, the most advanced State Department of Health and the largest number of most highly endowed philanthropic organizations. With these facilities for advancement we should constitute the most effective medical unit the world has ever known. I think we realize our position and believe that we have started a program which will give our Society a unique place in future medical progress.

## THE DOCTOR OF THE FUTURE \*

By GEORGE E VINCENT, Ph D,

President Rockefeller Foundation

LET me at the outset disavow any idea of forecasting definitely or dogmatically the future of the medical profession. One can hope only to enumerate conditions and tendencies of the present and to raise rather than to settle questions as to the probable effects of these things in the coming years.

The outlook, of course, varies with different countries. Racial, economic, social and political conditions affect medical service in a variety of ways. There can be no uniformity of development. Kinds of doctors and services appropriate to widely diversified environments will appear in different parts of the world. This address will deal with the outlook for such countries as the United States and Canada.

The rapid increase of scientific medical knowledge, experience, and technical resources is causing obvious changes. Medical education costs a great deal more in time and money. The modern doctor is dependent as never before on laboratory, hospital, and complicated and costly means of diagnosis and treatment. The specialist has become a necessity. No one person can control the whole range of knowledge and technique.

The present situation with regard to American population groups and the kinds of medical service they are receiving may be roughly described as follows. The mass of the population (perhaps 75 to 80 per cent) are treated by general practitioners who have limited technical appliances, little or no specialization of skill, and slight relation to medical services organized in hospitals, dispensaries, and clinics. The rich and well-to-do (perhaps 5 per cent) receive attention from specialists who depend primarily upon their own individual equipment, who have little connection with institutional medicine, but provide a high degree of specialized skill. The poor (perhaps 15 to 20 per cent) are under the charge of organized practice, that is, doctors who have access to institutional equipment, offer a high degree of specialization, and are fairly well connected with hospital, dispensary, and health center services.

There are forces at work which will gradually modify this state of things. Thus, preventive medicine in reducing the amount of sickness is limiting curative practice, in many areas typhoid fever, which used to be prevalent, is rare, malaria is yielding to comprehensive measures of control, and other communicable diseases which used to afford a good deal of practice are being steadily reduced in amount.

Again, the high cost of sickness is causing changes. There is a growing demand that this cost be distributed over large population groups.

The principle of insurance against sickness is being applied in different ways. In some countries the state system of compulsory insurance has been adopted. Elsewhere, hospital associations and sick benefit societies are, for a small weekly or monthly fee, guaranteeing free care in case of illness. Industrial groups are providing medical hospital care in return for small sums deducted from the wages of employees and supplemented by contributions from the companies. Such developments, which are multiplying rapidly, have a bearing upon the future of the medical profession.

Changed conditions affect the geographical distribution of physicians. The unwillingness of doctors to settle in the country and a tendency towards concentration in the towns and cities is unmistakable. The countryside is, on the whole, failing to replace the pioneer practitioners of an earlier generation. The truth is that men with modern training are not attracted to rural practice. They are not satisfied with the income. They want hospital connections, professional comradeship and, for their families, the opportunities of education, society, and recreation which towns and cities afford. There is no reason to suppose that a cheaper, more "practical" kind of medical education would turn out doctors who would be willing to go to the country.

There is another factor which must be reckoned with. A credulous public opinion permits the spread of cults, quackeries, and fanaticisms which increase the difficulties of well-trained and conscientious physicians. Modern medicine depends for its success upon a public that understands and appreciates. It must be admitted that the medical profession is not wholly blameless for the gullible state of the public mind. Neglect of the psychic side of medicine, failure to help educate individuals and public, narrowly conceived professional policies, shortcomings in the knowledge, skill or integrity of some doctors have had their part in producing the present situation. The chief responsibility, however, rests with the whole educational and social system. It is reflected not only in the popular attitude towards medicine, but in that towards science generally and in all forms of thinking and feeling.

Out of conditions such as those that have been enumerated no one type of doctor will, of course, emerge in the future. There are now pretty clearly recognized kinds of physicians. They fall into four groups: (1) the professorial doctor, who teaches and investigates, (2) the specialist, (3) the socialized or full-time salaried doctor, and (4) the individual, independent general practitioner.

The teachers and investigators will always form an element relatively small in numbers, but of

\* Abstract of an address delivered at the Annual Meeting of the Medical Society of the State of New York at Syracuse May 13 1925

vital importance. They will give more and more time to research and instruction. While a few will give all their time to such duties, the larger number will continue private consultations which will have a bearing on their teaching and investigative work.

The specialist is an inevitable outcome of the growth in knowledge, experience and technique. In all probability there will be a steady increase in the numbers and in the prestige of doctors of this kind. They are likely to be better organized and to have private clinics and hospitals, although for the time being the tendency towards group practice seems to have received a check. Standards of specialized efficiency are likely to be formulated and increasingly enforced. Voluntary professional associations will do something. University degrees will do more. State requirements may ultimately prescribe standards when these have been worked out by the profession and by university medical schools. There may be delay, but the time will surely come when only tully qualified and certified surgeons, for example, will be legally permitted to perform major operations.

The institutional salaried doctor has come to stay. Army, Navy, hospitals, dispensaries, asylums, industries, school systems, insurance companies are multiplying the demand for men and women who will devote themselves exclusively to social service on a salaried basis. Already a considerable percentage of the medical profession sustain a whole or a part-time relation to institutions.

In spite of the growth of the other types, the individual general practitioners constitute by far the largest group of doctors, perhaps 75 per cent of all. Except in emergencies the great mass of the population look to the general practitioner. When the word doctor is mentioned, it is he who comes to the mind of the average citizen.

The well-trained, properly equipped, experienced general practitioner of ability, character, personality, is a fundamentally valuable person. He is a good diagnostician. He sees his patient as a whole. He knows his peculiarities and circumstances. He can decide when to refer him to a specialist and when to protect him against the very real danger which is threatened by a narrowly specialistic point of view. He cheers and encourages, or warns and commands. He is not only a physician, but a friend and counsellor. He is a good citizen and an asset to the community. Too much cannot be said in praise of the individual general practitioner of the best type.

The problem of the American doctor in the future largely resolves itself into this: can the general practitioner be reproduced on a high level of efficiency, and can he survive under the conditions which he is likely to face in the future? These questions involve at once medical education and the organization of medical service.

There is widespread dissatisfaction with the medical curriculum. Critics say that it is too crowded, too theoretical, that the student is "spoon fed," given too little opportunity to think for himself and to develop initiative. There is too much tendency to have in mind the training of medical scientists and specialists rather than of the general practitioner. Reformers are insisting upon a thorough-going revision, upon a reduction in kinds and amount of instruction, upon a clear differentiation between undergraduate training which should aim at turning out the general practitioner and graduate training which should be reserved for the medical scientist and the specialist.

The general practitioner will survive only on the terms upon which any social functionary holds his own. He must gain social esteem or prestige, and be able to make a living. Many assert that the general practitioner is doomed to disappear, that his opportunities are being constantly restricted so that in the future he will be unable to win confidence and a livelihood.

It may be admitted that the general practitioner as now equipped and related to the profession faces serious and probably increasingly difficult handicaps. He is over-shadowed by the prestige of the specialist. He cannot as an individual afford the cost of modern equipment and technical resources. In the case of perhaps half of the general practitioners there is no genuine hospital connection which affords opportunity for continued education and professional stimulus. The growth of institutional and of preventive medicine is constantly encroaching upon the ordinary fields of curative medicine.

The disappearance of the general practitioner would be a serious loss. Such an outcome is not to be contemplated without deep concern. The underlying American philosophy of individualism with its insistence upon independence, initiative, ambition, seems to be embodied in the general practitioner. Are there ways in which he may readjust himself to the new and changing social situation?

The general practitioner may hope to survive if he will submit to a measure of organization and team-play in the co-operative use of laboratories and other resources, in meeting the demand for spreading costs of sickness over large groups through readjusted forms of compensation, and especially if he will become a practitioner of preventive medicine.

The doctor may make a place for himself as a counsellor of health. Personal hygiene will always remain the largest part of a public health program. After the environment has been sanitized and communicable diseases subjected to the maximum control, there will remain the vast field of personal health for which no organized public functionaries can assume responsibility. If the

general practitioner will recognize this opportunity, if medical schools will prepare him for the service, if the community will recognize his value in this new relationship, an inspiring career of opportunity and usefulness will open up before him. This will mean, however, a gradual change of attitude, an increasing interest in the normal, a study of the effects upon health of diet, exercise, mental attitudes, recreation, family and social life. All the finest qualities which have made the general practitioner successful in the past may be trained to even greater account in the future.

In view of all these contingencies, a confident prediction would be hazardous. The public demand for efficient service, for special skill, for reduced costs, is likely to increase. Gradually—very gradually—public intelligence and discrimination may improve. It is to be hoped that in time people will give more than lip service to the ideal of prevention. The day may come when men will treat their bodies almost as wisely as they do their motor cars.

In such circumstances a better and more economical organization of medical service will be inevitable. No thoughtful person can welcome the extension of state medicine beyond the legitimate and necessary field of public health activity. But, if private initiative and voluntary co-operation fail, it may be impossible to resist the demand for governmental intervention. This has happened in Germany and England, in backward

colonial possessions, and even in new European states. A persistent social need will demand satisfaction, if not in one way, then in another.

The medical profession, then, has a heavy responsibility and an inspiring opportunity. Will it recognize the tendencies of today and the demands of tomorrow? Will it take the long view, the socially conscious attitude? Will it see that the best service must be made available to the great masses of the people on terms that they can afford to meet, that no medical mechanism can efficiently replace skilful and sympathetic human care and guidance, that prevention of disease must be more and more a dominant motive, that the general practitioner, if he is to survive, must be readjusted to new times, trained, esteemed and rewarded as a vital factor in the medicine of the future?

You will rightly reply that the responsibility rests only in part on the medical profession. You will properly ask: "Will family life, schools, colleges, universities, the press, the platform, social standards, public opinion, offer an environment in which well-trained, wisely organized, and high-minded doctors can do their work honestly and efficiently, protected against ignorance, prejudice, and fanaticism?" Yes, it is a social problem which involves our whole civilization. To analyze it is not to solve it. We can only hope that clearer vision may kindle imagination and strengthen resolution.

---

## THE ANNUAL MEETING

The One Hundred and Nineteenth Annual Meeting of the Medical Society of the State of New York was held in Syracuse for four days, beginning on Monday, May 11, 1925. This meeting was one of the best that was ever held. We are tempted to say that it was the very best, but in the progress that has been made in every branch of medicine, it would be expected that the standards of the meetings of the State Medical Society should be progressively higher and higher.

The total registration was 1,229, which is an extremely high figure.

The headquarters of the Society were in the Hotel Syracuse, and the entire tenth floor was given over to the Society. Nearly all the meetings were held on that floor, and the management was excellent. The principal mistakes were those of judging the size of the audiences of the sections, and in assigning a proper room to each. However, the errors were excusable, for the attendance in most sections was larger than previous experience had suggested.

All the commercial exhibits were in the corridors of the tenth floor, and were readily accessi-

ble to the doctors. They seemed to be well patronized by the visiting physicians.

The opening session was that of the House of Delegates, which met on Monday afternoon and evening and Tuesday morning. The legislative machinery functioned perfectly with Dr. E. Eliot Harris as the fatherly genius who kept all parts in motion without friction. The House of Delegates in his hands was like an orchestra under an expert leader. There was no doubt who was doing the leading, or that perfect harmony was produced to the great satisfaction and enjoyment of the players.

An unusually wide range of topics was discussed, and practically all the recommendations of the officers and committees were adopted. Graduate Education seemed to be the big new feature which is being promoted by the State Medical Society, and, after all, the education of physicians to practice modern aspects of medicine is the principal object of the State Society.

Harmony and good feeling prevailed throughout the deliberations of the House of Delegates. When a discussion of the annual registration of

physicians took place on Monday evening, and it seemed to indicate that the physicians were divided over a minor point which concerned themselves alone, the speaker wisely excluded everybody except the accredited delegates, and the discussion ended amicably without even smoke being produced

The principal business of the House of Delegates consisted in receiving the reports of the officers, referring them to reference committees for consideration, and acting on their recommendations. The final actions of the House of Delegates fixed the policies of the Medical Society of the State of New York for the coming year. The policies adopted were all in the line of progress, and will be found set forth in the minutes which are printed in this issue, page 802.

The annual dinner was held on Tuesday evening, and was notable for its large attendance, its sociability, and its excellent speeches. (See report on page 762.)

The formal Annual Meeting took place on Wednesday evening. Some may wonder why that evening's ceremonies were called the Annual Meeting. The Charter of the Medical Society of the State of New York requires that an annual meeting shall be held, but it does not say what kind of a meeting it shall be. The custom has been to make the formal annual meeting a popular one to which the public is invited. The principal features of this year's meeting were a practical address by the President, Dr. Owen E. Jones, on "The State of the Society," and an address by Dr. George E. Vincent, on "The Doctor of the Future." These addresses are printed on pages 755 and 758 of this JOURNAL.

The meetings of the several sections were unusually well attended, and the programs were carried out practically as they were announced in the JOURNAL of April 3rd. Nothing new of a spectacular nature was announced, but the speakers set forth the modern ideas of medical practice along their special lines.

The papers read before the several sections became the property of the Medical Society of the State of New York, and will be published in the JOURNAL during the coming year.

The new feature of devoting the last day of the meeting to the general consideration of one subject proved a great success. Tuberculosis was the topic chosen, and all phases of the disease and the methods of its control were shown practically as was announced in the April 17th issue of this JOURNAL. Specimens, both gross and microscopic, and X-ray photographs, were on exhibition, and methods of heliotherapy were illustrated by pictures and by happy children clad in breech cloths.

A special feature of the day was the exhibition of a moving picture film showing the development of the disease in the body, and the methods of detecting and combating it. This film was pre-

pared by Dr. L. Gregory Cole, of New York City, and required an hour to show. It is available for tuberculosis committees throughout the state, through the American Medical Films, Inc., 350 Madison Avenue, New York.

Another feature was a new invention called the multiple stethophone, by means of which a whole room full of students may listen to the sounds of the lungs and heart at the same time. It consists of an amplifier like that used in radio, and from it wires lead out to the audience, and each listener connects his stethoscope to a sounder like the ear-piece of a radio outfit. The room in which this device was shown was constantly crowded to its utmost capacity.

A scientific session relating to tuberculosis was held in a room which was packed while a big crowd waited outside. The attendance was unexpectedly large, and over 150 physicians registered for the day only.

The Committee, who successfully planned and conducted the demonstration, consisted of Dr. Edward R. Baldwin, Superintendent of Trudeau Sanatorium, Saranac, Dr. Harry A. Bray, Superintendent of the State Tuberculosis Hospital at Ray Brook, Dr. Harry J. Brayton, Superintendent of the Tuberculosis Sanatorium of Onondago County, Dr. William E. Lawson, Director of Tuberculosis Work of Albany County, and Dr. John J. Lloyd, Superintendent of the Monroe County Tuberculosis Sanatorium.

The success of the tuberculosis demonstration has led the Scientific Committee of the State Society to consider holding a similar demonstration on syphilis next year, and demonstrations on other diseases in the succeeding years.

The thanks of the Society are due to Dr. Frederick H. Flaherty and his associates on the Committee of Arrangements, for the perfection of the arrangements for the comfort and convenience of the visiting doctors and their wives. Everybody had a good time and will want to come to Syracuse again.

The peculiar function of the Executive Editor was to act as press agent to the reporters of the newspapers. The reporters of the four Syracuse dailies were extremely kind and considerate. We took them into our confidence, and they fully respected it, and we take this opportunity to extend the sincere thanks of the Medical Society of the State of New York to them and to the editors of the papers for their kindness and consideration.

We also thank the physicians who kindly gave their time in explaining medical movements to the reporters. We asked several prominent medical men to explain the doctors' point of view regarding nursing, mental clinics, and other popular movements in medicine, and we believe the kindness of both the interviewed and the interviewers resulted in a closer contact of the medical men with the newspapers and the public.

## MEETING OF THE SECRETARIES OF COUNTY MEDICAL SOCIETIES

A special feature of the meeting of the Medical Society of the State of New York was a dinner and conference of the secretaries of the county medical societies on Wednesday noon. A few of the secretaries had met at dinner during previous annual meetings of the State Society, and had maintained an organization, but nothing practical had come from it. Formal notices were sent out this year by Dr J S Lawrence, Executive Officer of the State Society, inviting all the secretaries to be present at this conference and dinner. Those who responded were

Dr John H Steward, Chenango County  
 Dr L A Schiff, Clinton County  
 Dr A. M. Loope, Cortland County  
 Dr William B Brooks, Herkimer County  
 Dr W S. Atkinson, Jefferson County  
 Dr A D Jaques, Nassau County  
 Dr D S Dougherty, New York County  
 Dr William Hall, Jr, Oneida County  
 Dr J S Thomas, Queens County  
 Dr B R Wakeman, Steuben County  
 Dr Frank Overton, Suffolk County  
 Dr W A Moulton, Tioga County  
 Dr Wilbur G Fish, Tompkins County  
 Dr F H Voss, Ulster County

Dr S J Banker, Washington County  
 Dr Harrison Betts, Westchester County  
 Dr F J Snell, Niagara County

Dr Van Etten, the newly elected President of the State Society, Dr Dougherty, the new Secretary, and Dr Harris, Speaker of the House of Delegates, spoke of the importance of the office of Secretary of every county medical society, and considered a meeting of the secretaries of great importance. A resolution was passed that the Council of the State Society be asked to authorize a formal meeting of all the secretaries some time next Fall.

A tentative organization of the secretaries was perfected with Dr Harrison Betts, President, and Dr J S Thomas, Vice-President.

The secretaries of county societies are the leaders who keep things moving in their organization. A good secretary is worth his weight in gold, and it is to the credit of many of the societies that they keep their secretaries in office year after year. Some have rounded out twenty-five years of service, and are still going strong. The proposed meeting of the secretaries of the county societies is an extremely good sign of progress in the affairs of the Medical Society of the State of New York. F O

---

## THE ANNUAL DINNER

An evening devoted to a formal dinner is one of the features of every annual meeting of the Medical Society of the State of New York. The dinner this year was held in the Grand Ball Room of the Hotel Syracuse, and was one of the most enjoyable and profitable that has ever been held. The room was filled to overflowing, and extra tables had to be provided. The service was excellent, and the hotel managers are to be congratulated on the pleasing manner in which they provided for an unexpectedly large gathering.

The program of the after-dinner speaking was as follows:

Toastmaster, Dr F H Flaherty, Syracuse, Chairman of the General Committee of Arrangements.

Address, Dr Owen E Jones, President of the Medical Society of the State of New York.

Greetings from Dr Nathan B Van Etten, newly elected President of the Medical Society of the State of New York.

Address, Chancellor Charles W Flint, of Syracuse University.

Address, Thurman ("Dusty") Miller, Editor of the *Daily News Journal*, Wilmington, Ohio.

Address, Hon James A Hamilton, Commissioner of Labor of the State of New York.

Dr Owen E Jones spoke of the increased interest shown by physicians generally in the county medical societies, and in the State Society, and called attention to the faithful work of the various officers and members of committees of the Medical Society of the State of New York.

The address of Dr Van Etten was, in fact, a brief inaugural statement—the only induction ceremony provided by the custom of the State Society. Dr Van Etten said that the new president always found the policies of the Society formulated and stabilized by the former president, and that he would be gratified if he could continue the lines of work that have already been happily outlined by his predecessor, Dr Jones. But new problems develop in the natural evolution of medicine, and the new president hoped to do more than ride the crest of the most advanced wave of new administrative measures, he wishes to swell the quiet tide of permanent progress.

Chancellor Flint, who was a former minister of the Gospel, compared the work of a pastor with that of a physician, and pointed out their similarity in seven respects.



1 Both originated in magic

2 Both have the motive that is stated by Dr Osler, in his history of medicine "Medicine arose out of the primal sympathy of man for man, to help those in sorrow and distress"

3 They have a common philosophy Both the priest and the physician come face to face with life and its varied relations When they see the body at its worst, and the soul beclouded by bodily imperfections, they either grow proud, materialistic, and cynical, or become humble co-workers with the Eternal in seeking to perfect the human race

4 Both have a sacrificial quality The martyrs to science are as holy as the martyrs to creed Physicians are always to be found who are willing to lay down their lives in order to show the way of life to others

5 Both share in an altruistic aim—not to be ministered unto, but to minister

6 Both have a moral régime, but the code of ethics of physicians is more highly developed than that of any other profession The splitting of fees, for example, is perfectly legal, but it is not at all ethical The Hippocratic Oath is a high obligation to service, and some of its phrases are of daily application, as, for example, this "With purity and holiness I will pass my life and practice my art" A physician who takes that oath seriously is close to the Kingdom of Heaven, but if he assumes it hypocritically, he is nearer the gates of Hell

7 Both professions seek to develop the spiritual side of man's nature Religious convictions, attitudes, and instincts have a direct effect on the mental and emotional status and indirectly on physical conditions No one can be a complete man unless he has a spiritual nature No one can delegate it to another, but each must

experience it himself The spiritual is significant to the physician because it sets free inhibitions, and broadens and prolongs life The perfection of the physical means the release of the soul that it may give real satisfaction Any one who would help mankind must have an awareness of the spiritual in order to render the best service

In closing, the Chancellor said "I salute you physicians as co-workers with the Eternal in perfecting the master-piece of the creation"

The burden of the speech of "Dusty" Miller (he said all millers were dusty) was strikingly like that of Chancellor Flint, but it was given in a diametrically opposite manner While the Chancellor's message was like a grand oratorio, that of Miller was like a simple Sunday School song Miller kept his audience in an uproar of laughter for half an hour while he talked on the theme "I do" at the rate of three hundred words a minute to the accompaniment of apt stories that flowed like a rippling brook He gave some extremely powerful doses in honeyed form, and the doctors cried for more.

"Dusty's" speech centered around three ms which he said might keep you out—indecision, indifference, and intolerance, and as he developed his sermonette, there were some physicians who were so unkind as to name others whom it hit He divided members of medical societies into the "Poor Me" group and the "I Do," and closed with the words of the wise men to Solomon's son, Rheoboam "If thou wilt be a servant to these people and serve them, then they will be thy servants"

Commissioner Hamilton described the work of the Labor Department in improving the living conditions of laborers, and said that eighty per cent of the work of the Department was medical

F O

# Medical Society of the State of New York

## ANNUAL REPORTS

### 1924

#### REPORT OF THE SPEAKER

##### *To the House of Delegates*

May I call the attention of the House of Delegates to the responsibility that devolves upon its members—less than two hundred in number—charged with the general management, superintendence, and control of the Society and its affairs and authorized to legislate in the interest of over ten thousand members of the Society throughout the State. As to the method of conducting this important business, the Speaker would be glad to receive constructive criticism from the members regarding the method of the work of the House of Delegates, in the hope that it may become more and more efficient in meeting the duties and obligations imposed by the Constitution and By-Laws.

The House of Delegates should emphasize as of first importance that the individual members of the medical profession of the State should be properly informed of the aims, purposes and accomplishments of the Society and the many advantages of membership therein, as the State Medical Society represents the strength of the organized profession.

It is the duty of the Councillors to visit the County Societies of their districts at least once a year, and I feel that the House of Delegates in the past has not given sufficient encouragement and support to the Councillors who are specially delegated to bring the message of organized medicine to the local societies of the State. Heretofore the reports of the Councillors have been referred to the reference committees without being read, and little attention has been given to the work of the District Branches and their Component County Societies by the House of Delegates. Let us study, aid and support the work of the Councillors and County Societies. We are fortunate in having a progressive and efficient executive officer in Dr. Joseph S. Lawrence, who has the ability and personality to splendidly cooperate with the Councillors and county societies in their work of bringing the message of organized medicine to the local physicians and public, with a result of adding desirable physicians to our membership and

weakening the public support of the cults, your consideration of the question would be timely.

The reports of the standing committees should receive careful attention by the members of the House of Delegates. The discussion of their reports and the final action thereon should reflect the deep interest and careful study of the work of our standing committees. I might cite in corroboration the work of the Committee on Legislation in bringing to the notice of the several counties of the State the importance of understanding and acting effectively on the many medical bills which come before the Legislature each year. The improvement exhibited in the mental grasp of the Legislative work by the county committees at their yearly meetings with the State Committee on Legislation is very evident to those who have watched the growth of the good work inaugurated by the chairman, Dr. James N. Vander Veer. The House of Delegates should request that other standing committees should also extend their work by cooperating with county societies of the state.

The sum of money derived from the increase of dues will give the council and the executive committee opportunity to extend the usefulness of the Society along lines voted by the House of Delegates. Although the House of Delegates does not appropriate any money the council is charged in Section 24 of the By-Laws with carrying out and giving full effect to any resolution or vote of the House of Delegates but such resolution or vote must not contain an appropriation of money. Within the past few years it has been found necessary to raise the dues of several of the State societies. For your information, I shall mention some of those which have come to my notice. In 1923 Oregon raised the dues from \$5 to \$20 a year. Wisconsin in 1923 raised annual dues from \$4 to \$9. Texas and Arizona each raised its dues to \$15 annually. The representatives of the states that have increased the annual dues agree that where the dues are trivial, the value of the State society to its members is correspondingly small, and that the improved quality of the service rendered

by the State Society justifies the increased dues to its membership. Some of the State Societies are considering the question of following the lead of the Texas State Association which has established a Board of Trustees for the purpose of studying and controlling the finances of the Association, such as investments, budget and all appropriation of money.

As the County Societies uphold the State Society, so should the latter support the American Medical Association by endeavoring to increase its fellowship in this State. I recommend that the President appoint a committee large enough to conveniently canvass the State in the interest of adding to the fellowship of the American Medical Association. At the last meeting of the House of Delegates the recommendation of the speaker authorizing the removal of the petty redundancies from the State law relating to the Medical Society of the State of New York was adopted. As a beginning Mr Whiteside prepared a bill which was presented to the Legislature repealing the clause which required the Society to elect annually the Censors of the Society—that bill passed both Houses and was signed by the Governor. I recommend the striking out, as not now being necessary, of the last sentence of Article SIX of the Constitution as follows: "The House of Delegates shall elect them annually," and Section 17 of the By-Laws "The Censors shall be nominated as provided in Article SIX of the Constitution and elected by a majority vote without ballot." The amendment cannot be considered this year, but is to be recorded as a proposed amendment to the Constitution and By-Laws to be acted on next year.

It is quite unnecessary to write a eulogy for the House of Delegates upon the work of Miss Lily D. Baldwin, who this year completes twenty-five years of giving her best self to the State Medical Society. If there be any member not acquainted with her work, he should visit the office of the State Society and see for himself the perfect organization that Miss Baldwin has at her command. There are complete files of letters written and received which are available at any mo-

ment, the Treasurer's department includes lists of all members who have paid as well as those who have not paid their dues, the Secretary's department shows classified records and general and special correspondence files, lists of physicians registered in the county clerk's office kept up to date, the data of each registered physician revised each year for the purposes of the Medical Directory, a list of the Fellows of the American Medical Association, not the least is the files of accumulated decisions on medical preparations offered for advertising. Miss Baldwin conducts a large amount of correspondence in answer to inquiries from officers, members of committees and secretaries of county societies. She has entire charge of the advertising in the Journal and Directory, she assists the editor in classifying papers, reading the proof, making up the Journal and mailing it to the members and she manages all the work connected with the publishing of the Medical Directory. She directs all business of the annual meetings of the Society and of the House of Delegates, in short, Miss Baldwin is the general manager and supervisor of all the business of the State Society, and she certainly knows the work. Miss Baldwin is always present and is most helpful at the meetings of the council and executive committee, and she prepares the budget for the executive committee and the council. For all this work she has no title, therefore I recommend that Miss Lily D. Baldwin be authorized to use the title of General Supervisor of the Medical Society of the State of New York as a reward for many years of good, faithful, obliging and efficient service to the Society.

The consideration and support the Speaker has received from the members of the House of Delegates is cordially acknowledged, and please be assured that they add to the pleasure of functioning as presiding officer.

Respectfully submitted,

E. ELIOT HARRIS,

*Speaker*

April 15, 1925

The Reference Committee approved all the recommendations of the Speaker, and in addition it recommended that an honorarium of five hundred dollars be given to Miss Baldwin for her faithful and efficient services (see page 804).

## REPORT OF THE PRESIDENT

### *To the House of Delegates*

In reviewing the activities of the Medical Society during the year which has just passed into history, we are gratified to note that there has been manifested a substantial and healthy growth in keeping with the Society's past traditions and highest ideals. While no particular activity was, perhaps, of sufficient importance to make it stand out above the rest, this is largely due to the fact that the general advancement has been so evident.

I am very happy to report that prompted not only by my own observations, but by comments of others, a very desirable spirit of harmony pervades the entire Society today. The efforts of the State Society in past years to bring about a clear understanding of the mutual relationship between the County Societies and the State Society, are developing in a very encouraging manner. This condition may be considered more remarkable, too, considering that it was feared by some that raising the dues of the State Society would tend to discourage membership in the County Societies. That this fear was unfounded is abundantly proven by the fact that the State Treasurer has received the dues of a larger number of members this year, to date, than he had received at the same date last year. The increased finances of the Society have enabled it to broaden its field of activities and the first step has been in the direction of cementing the relationship with the County Societies and encouraging the same among themselves.

### COUNTY SOCIETIES

There is a marked increase of interest manifested by the County Societies. During the year five different Societies have notified us of their intention to increase the number of meetings held annually. All of them have either considered a program or have adopted a scheme which they are now developing into a program for promoting physical examinations of the apparently well among their patients. Some have undertaken membership campaigns, an activity which should be urged upon every Society. There are in the State more than 16,000 physicians and only about two-thirds of these are members of the Society. While each County Society is the judge of its own membership and should be encouraged to maintain its standards, admitting to membership only those physicians who are adequately qualified, yet there must be among the 5,000 physicians in the State who are not members, many whose membership would be a credit to any Society. These should be sought out by the individual County Societies and their affiliation encouraged. One County reports 73

out of 75 physicians as members of the Society. Twenty others have at least 75 per cent of the physicians in their Counties enrolled in the Society.

More County Societies should be encouraged to increase the number of meetings held annually. Approximately 30 per cent of them have as few as two meetings a year, while another 40 per cent have four meetings a year, thus only 30 per cent hold bi-monthly meetings. It is conceivable that the interest of the Society may be increased by an increase in the number of meetings.

### COMMITTEES

The Committee on Legislation has continued its splendid work through another year. Its success in consolidating the interests of the County Societies through the conferences it has held with the chairmen of the Legislative Committees of the County Societies, was more marked this year than ever before and proves conclusively that similar activities undertaken by other committees are desirable.

Too much credit cannot be given to Dr. James Vander Veer for his loyalty and enthusiasm. He has cheerfully made an inestimable sacrifice in order that the Society's interests might be protected and advanced in the legislature. Realizing deeply the hardship that serving on this committee has meant to Dr. Vander Veer, I am, nevertheless, constrained to urge that he be persuaded to continue the chairmanship for another year.

The Committee on Scientific Work deserves commendation for its activity. It has by a great deal of effort prepared this year an unusually interesting and instructive program.

All of the special committees were unusually active and I want especially to call your attention to the reports of the special Committees on Medical Education and Nursing, and urge that steps be taken to realize the features they recommend.

### THE JOURNAL

The JOURNAL is steadily increasing in popularity and usefulness. It has increased its value to the physicians by its timely editorials and its special sections on legal medicine, public health and County Societies. Another section is to be added in the near future which will make the JOURNAL the equal of any of its contemporaries.

The medical surveys undertaken by the executive editor have been an exceedingly valuable feature and should be continued until the entire State is covered.

### LEGAL DEPARTMENT

We are greatly indebted to our counsel, Mr. George W. Whiteside, for services he has rendered during the past year. His remarkable success in our defense continues undiminished, but the demands upon him are growing so rapidly that they will soon outgrow his capacity. His services have not been limited to pleading our cases before the courts, but we are greatly indebted for his wise guidance and judgment both personally in our committee meetings and through his excellent articles in the columns of the JOURNAL.

I wish to take this occasion to urge that every member of the Society, if he has not already insured himself against loss from malpractice suits, do so at his earliest opportunity. Every member of our Society should possess such insurance for his own protection.

### EXECUTIVE OFFICER

During the year, Dr. Joseph Lawrence, who had been with the Department of Health, was appointed to the position of executive officer, provision for which had been made by your body at the last annual meeting. He began his duties the first of November. By the reports which reach me, I am convinced that we have done wisely in creating this position, and believe that it is one of the most important steps the Society has taken in recent years towards successfully amalgamating the County Societies and the State Society into the great Medical Society we should constitute. The work he has accomplished has justified the wisdom of those through whose efforts it became possible for the creation of this office.

There are certain recommendations I should like to offer.

My first recommendation is that the JOURNAL should be published semi-monthly throughout the year, providing sufficient funds are available, except during the session of the legislature, when its weekly publication, as was the custom in the past two years, should be resumed.

amount of work, both in detail and in the execution.

The second recommendation pertains to the manner of electing a president. It is a serious handicap for any man to assume the duties as president of this Society who has not had an opportunity of familiarizing himself with the great task of a broad general program, that the presidency in this Society entails.

To keep pace with our ever increasing duties and obligations to those whom we serve, it appears to me that this can better be done by making certain changes in the Constitution and By-Laws of our Society which will provide for the creation of the office of a President-elect.

My third recommendation is that the Society provide for itself a Board of Trustees, whose duties will be to study the needs and guide and control the expenditure of the Treasury's funds, the reasons for which must be apparent to all.

I therefore recommend that the President be empowered to appoint a committee, including our legal counsel, to take the necessary steps to so change our Constitution and By-Laws whereby this can be brought about.

In closing this, I wish to express to you my great appreciation for the high honor you have conferred upon me by electing me to the Presidency of the Society. The performance of the duties of this office have been made pleasant by the courteous and hearty support and cooperation received from all with whom I have been associated.

I shall always recall with much pleasure the cordiality extended to me by the County Societies and the District Branches which I have visited. My one regret is that time did not permit me to visit all of them.

I am moved by a deep feeling of gratitude for the assistance and aid given me by every officer of this Society and the loyal support I have received in the discharge of my duties.

OWEN E. JONES,  
*President*

April 15, 1925

The Reference Committee approved the suggestion that the JOURNAL be published semi-monthly, and that steps be taken to establish the office of President-elect and to create a Board of Trustees for the Society (see page 805).

## REPORT OF THE TREASURER

CHARLES GORDON HEYD, *Treasurer*, In Account with THE MEDICAL SOCIETY OF THE STATE OF  
New York

Cr

CASH RECEIPTS, YEAR ENDED DEC 31, 1924		CASH PAYMENTS, YEAR ENDED, DEC. 31, 1924	
Balance, January 1, 1924	\$16,193 58	Rent	\$1,600 00
Directory Advertising, 1922	360 01	Telephone	198 28
Directory Advertising, 1923	755 00	Salaries, General	4,406 33
Directory Advertising, 1924	2,450 00	Insurance	5 64
Directory Sales, 1923	703 00	Journal Postage	1,315 69
Directory Sales, 1924	2,322 00	Journal Commission	2,353 81
Annual Dues, 1923	1,430 00	Journal Salaries	3,899 17
Annual Dues, 1924	49,184 00	Journal Expenses	392 57
Annual Dues, 1925	1,915 00	Journal Publication	22,642 88
Arrears	331 00	Executive Editor	5,058 22
Clerical Work	303 81	Journal Discount	625 83
Telephone	24 65	Postage	244 70
Interest on Deposits	409 07	Furniture and Fixtures	121 50
Journal Subscription and Sales	335 64	Union Dime Savings Institution	118 33
Journal Advertising	14,611 22	Traveling Expenses, General	1,755 57
Journal Expense	2 50	A M A Delegates	828 68
Interest on Mortgage Certificates	118 33	General Expense	301 07
Refund Traveling Expense	52 07	Stationery and Printing	609 86
Brooklyn Bureau of Charities for Reprints	9 00	Carfares	27 35
Refund Express	45	Express	23 18
Lucien Howe Prize Fund	100 00	Honorarium	500 00
Interest on 4th Liberty Loan 4¼% Bonds	425 00	Committee on Legislation	155 25
Interest on 3d Liberty Loan 4¼% Bonds	4 25	Council Meeting May 11	40 64
Committee on Legislation	11 39	Premium Treasurer's Bond	12 50
Annual Meeting, 1924—Exhibits	3,570 00	Lucien Howe Prize Fund	100 00
Annual Meeting, 1924—Delegates' Dinners	345 00	Audit	300 00
Annual Meeting, 1924—Incidentals	98	Clerical Work	6 20
	<u>\$79,773 37</u>	Annual Meeting, 1924	3,589 33
		Annual Meeting, 1925	60 50
		Legal Expense	15,118 03
		Committee on Legislation	6,434 16
		District Branches	737 88
		Secretary	500 00
		Annual Dues, 1924 Overpayments	12 00
		Committee on Medical Economics	148 00
		Directory Commissions	544 35
		Directory Incidentals	74 31
		Directory Postage	585 50
		Directory Delivery	1,018 14
		Directory Discounts	137 93
		Directory Printing	9,053 36
		Directory Stationery and Printing	319 00
		Directory Salaries	4,784 02
		Executive Officer	1,579 45
			<u>\$92,339 21</u>
		Balance on Deposit with Guaranty Trust Company, Dec. 31, 1924	
		General	\$3,152 70
		Committee on Medical Research	465 47
			<u>\$3,618 17</u>
		Balance, Petty Cash	9 57
			<u>\$3,627 74</u>
			<u>\$95,966 95</u>

\$95,966 95

\$95,966 95

ANNUAL DUES, 1924				ANNUAL DUES, 1924—(Continued)			
County	Amt Paid	County	Amt Paid				
Albany	\$1,090 00	Lewis	\$75 00	Schuyler	55 00	Warren	160 00
Allegany	160 00	Livingston	105 00	Seneca	115 00	Washington	180 00
Bronx	2,865 00	Madison	142 00	Steuben	380 00	Wayne	180 00
Broome	460 00	Monroe	2,075 00	Suffolk	510 00	Westchester	1,505 00
Cattaraugus	132 00	Montgomery	250 00	Sullivan	150 00	Wyoming	120 00
Cayuga	245 00	Nassau	505 00	Tioga	130 00	Yates	65 00
Chautauqua	420 00	New York	15,750 00	Tompkins	285 00		
Chemung	215 00	Niagara	405 00	Ulster	325 00	Total	\$49,184 00
Chenango	185 00	Oneida	915 00				
Clinton	115 00	Onondaga	1,420 00				
Columbia	185 00	Ontario	345 00	County	Amt Paid	County	Amt Paid
Cortland	115 00	Orange	465 00	Albany	\$60 00	Niagara	40 00
Delaware	45 00	Orleans	70 00	Bronx	210 00	Orange	20 00
Dutchess-Putnam	555 00	Oswego	260 00	Broome	10 00	Queens	35 00
Erie	3,125 00	Otsego	205 00	Cattaraugus	40 00	Richmond	30 00
Essex	120 00	Queens	1,115 00	Columbia	10 00	Rockland	10 00
Franklin	235 00	Rensselaer	525 00	Erie	30 00	Schenectady	10 00
Fulton	175 00	Richmond	335 00	Herkimer	70 00	Schoharie	10 00
Genesee	123 00	Rockland	195 00	Kings	360 00	Washington	10 00
Greene	105 00	St Lawrence	260 00	Madison	20 00	Westchester	20 00
Herkimer	285 00	Saratoga	210 00	Monroe	10 00		
Jefferson	342 00	Schenectady	550 00	Montgomery	10 00		
Kings	7,465 00	Schoharie	85 00	New York	870 00	Total	\$1,915 00

## REPORT OF THE TREASURER—Continued

Cr

Dr

## DIRECTORY ACCOUNT

<i>Income</i>		<i>Expenditures</i>	
Advertisements	\$3,447 71	Printing	\$9,053 36
Sales	3,008 50	Salaries	4,784 02
		Incidentals	74 31
	\$6,456 21	Commissions	544 35
		Discounts	137 93
Cost of Directory	10,060 40	Postage	585 50
		Delivery	1,018 14
		Stationery and Printing	319 00
	\$16,516 61		\$16,516 61

## JOURNAL ACCOUNT, YEAR ENDED, DECEMBER 31, 1924

<i>Income</i>		<i>Expenditures</i>	
Advertisements	\$14,995 15	Publication	\$22,642 88
Sales	335 64	Postage	1,315 69
	\$15,330 79	Expenses	390 07
		Salaries	3,899 17
Cost of Journal	21,447 69	Executive Editor	5,058 22
		Commissions	2,350 81
		Discounts	625 83
		Bad Debts	495 81
	\$36,778 48		\$36,778 48

## BALANCE SHEET, DECEMBER 31, 1924

<i>Assets</i>		<i>Liabilities</i>	
<i>Current</i>		<i>Current</i>	
Petty Cash	\$9 57	Advance Dues, 1925	\$1,915 00
Cash in Bank	3,613 20	Committee on Medical Research	465 47
Accounts Receivable			\$2,380 47
Journal Advertising	334 79	<i>Trust Funds</i>	
Directory Advertising	105 00	Lucien Howe Prize Fund	\$2,660 10
Inventories		Merritt H. Cash Prize Fund	1,213 69
Directory	683 50	Special Fund	105 55
Directory Advertising	1,000 00		\$3,979 34
	\$1,683 50	<i>Surplus</i>	
Liberty Bonds	9,841 26	Balance, January 1, 1924	\$28,949 15
Accrued Interest on Liberty Bonds	125 73	Less Excess of Expenditures over Income	13,601 27
<i>Deferred Charges</i>			\$15,347 88
Annual Meeting, 1925	60 50		
<i>Trust Fund Investments</i>			
Union Dime Savings Bank,			
Lucien Howe Prize Fund	\$889 48		
Merritt H. Cash Prize Fund	456 81		
Liberty Bonds	599 34		
Guarantee Mortgage Certificate	2,000 00		
Accrued Interest			
Guaranteed Mortgage Certificate	27 50		
Liberty Bonds	1 24		
Cash, General	4 97		
	\$3,979 34		
Furniture and Fixtures	1,954 80		
	\$21,707 69		\$21,707 69

Respectfully submitted, S. E. HENDERSON & CO.,  
Public Accountants

## INCOME AND EXPENDITURES, YEAR ENDING DECEMBER 31, 1924

<i>Income</i>		<i>Expenditures</i>	
Annual Dues, Arrears	\$331 00	Committee on Medical Economics	\$148 00
Annual Dues, 1923	1,430 00	Legislative Expenses	6,578 02
Annual Dues, 1924	50,192 00	Secretary	500 00
Clerical Work	297 61	Honorarium	500 00
Interests on Deposits	409 07	Salaries—General	4,406 33
Annual Meeting, 1924	251 15	Rent	1,600 00
Interest on Liberty Bonds	425 00	Telephone	173 63
		Stationery and Printing	600 86
	\$53,335 83	Postage	244 70
Excess of Expenditures over Income	13,601 27	Expenses	301 07
	\$66,937 10	Insurance	5 64
		Auditing	300 00
		Legal Expenses	15,118 03
		Traveling Expenses	2,532 18
		District Branches	737 88
		Express	22 73
		Premium—Treasurer's Bond	12 50
		Carfares	27 35
		Council Meeting, May 11	40 64
		Executive Officer	1,579 45
		Cost of Directory	10,060 40
		Cost of Journal	21,447 69
			\$66,937 10

## REPORT OF THE SECRETARY

*To the House of Delegates*

In compliance with Section 37 of the By-Laws, the Secretary submits the following report for the year ending December 31st, 1924 —

Membership, Dec 31, 1924	9,567	
New Members, 1924	694	
Reinstated Members, 1924	332	10,593
		<hr/>
Deaths	134	
Resignations	40	
Expulsions	2	176
		<hr/>
		10,417
Dropped for non-payment of dues, Dec 31, 1924		385
		<hr/>
		10,032
Elected after Oct 1, 1924, and credited as of 1925		212
		<hr/>
Membership, Jan. 1, 1925		10,244

The membership on January 1, 1925, is the largest every attained, it shows an increase of 496 over the year previous. Of the members dropped during 1923 more than two-thirds have been reinstated. It is a pleasure to report that in spite of the increase in the State assessment, the dues received by the State Treasurer are in excess of those received at the same date last year.

The list of honor counties whose membership shows all dues paid for the year is as follows: Columbia, Essex, Franklin, Herkimer, Greene, Lewis, Montgomery, Oneida, Richmond, Schuyler, Steuben and Tioga.

One of the most important acts of the Society during the year, and one which promises much for the future has been the appointment of an Executive Officer. He has assisted the Chairman of the Committee on Legislation during the Legislative Session and has devoted the remainder of the year to visiting the county societies. He has assisted the officers in perfecting and carrying out plans for the betterment of the organization and he has stimulated the interest of the individual members. His appointment has been fully justified and his work has been valuable and important.

The Committee on Legislation deserves the highest praise, it has done most efficient work during the year and has kept the members of the Society thoroughly informed in regard to bills introduced in the Legislature.

I would like to call the attention of the House of Delegates to the condition of the Treasury.

Legislation enacted in the House of Delegates last year raised the dues. This resulted in doubling the income of the Society in the present calendar year. Such a sudden and large income always results disastrously. There are those members who opposed the increase in dues and who now feel that the receipts will so far exceed the

expenditures that a reduction in dues should be contemplated. There is another class of members who feel that a large surplus warrants greater and more radical expenditures. There is still another class of members, who, as a result of a doubled income, are prepared to vote increased salaries to many connected with the Society. These three classes who threaten the treasury have all formulated plans in several directions which plans if heeded will bankrupt the treasury.

The Society is steadily growing in importance and in influence. Its growth and increasing power calls for a larger income. There is no more reason to consider extraordinary expenses than there is justification for an increase in salaries. It is not true that the surplus is unwieldy.

I am very strongly in favor of establishing a sinking fund for future reforms and emergencies. The present, seems to me, an opportune time to establish such a fund. A sinking fund which every Society needs would silence those who favor a lowering of dues and would be an unanswerable argument to those who favor a raise in salaries, finally it would curb extravagance and place the Society in a sound and conservative position.

I therefore *recommend* that this House of Delegates recommend to the Council the setting aside of a sum for the establishment of a sinking fund. If this is done and a budget is carefully worked out, it will be found that neither those who are clamoring for lower dues nor others who are planning extravagances and demanding increased salaries will have any argument on which to base their contentions.

In accordance with the resolutions of the House of Delegates the following special committees have been appointed by the President —

Committee on the Nurses Problem, Committee on Post-Graduate Medical Instruction.

I recommend that the House of Delegates make a careful study of the reports of these committees.

The JOURNAL has steadily improved during the year. Plans are already formed to add a Scientific Department so that in time it will take its place among the best medical journals in the country.

It is with great sorrow that I have to chronicle the death of Dr. W. Dewey Alsever of Syracuse. At the time of his death, Dr. Alsever was Chairman of the Committee on Arrangements and a member of the Council. He was also a past President of the Fifth District Branch. His untiring efforts for both the State and County Societies are well known. I *recommend* that when the House of Delegates adjourns at the evening session it do so in memory of Dr. Alsever.

EDWARD LIVINGSTON HUNT,  
Secretary

April 15, 1925



## REPORT OF THE COUNCIL

### *To the House of Delegates*

The Council of the Medical Society of the State of New York takes pleasure in presenting the following report

In accordance with the By-Laws, the Council has held regular meetings On April 23, 1924, in Rochester, on May 11, 1924, in Albany, and on December 12, 1924, in New York City

A special meeting of the Council was held in New York City on February 18, 1925 At this meeting the Council went on record as approving the Karle-Dunmore Bill, and ordered a referendum vote of the House of Delegates on it The result of this vote showed that 106 members voted in favor of the bill, and 31 against

The Executive Committee has held regular meetings during the year, and a referendum vote of the Council has been taken on all matters of importance, which have come before it

The following reprint received from the Bureau of Legal Medicine and Legislation of the American Medical Association is respectfully referred to the House of Delegates by the Council

### THE REORGANIZATION BILL AGAIN

January 30, Senator Smoot of Utah moved that the Senate proceed to consider the so-called reorganization bill, S 3445, already discussed in the JOURNAL The bill proposed to tear the Public Health Service from its moorings in the Treasury Department and to launch it as a part of a new craft, in a bureau devoted primarily to "education and relief" The motion to take this bill up for enactment in the dying hours of an expiring Congress was defeated The defeat must not be accepted, however, as having put a final quietus on the bill, and another effort will probably be made to obtain consideration If it should pass the House of Representatives, where it is now on the calendar as H R 9629, it may come before the Senate with added prestige A resolution, H Res 395, has already been introduced by Representative Mapes of Michigan, to give the bill the right of way in the House Senator Smoot, in supporting his resolution, charged that "many leading men of the country

who are interested in the public health of the nation are opposed to this measure because of the fact that they have never taken into consideration what the bill proposed to do in relation to the Public Health Service" Unfortunately for Senator Smoot's charge, that is exactly what they have taken into consideration—and that is why they are protesting Senator Smoot in answer to letters objecting to the bill, had stated he said, "just what the bill provides," and then received replies that his correspondents had no objection It would be interesting, of course, to know just what presentation of the case produced such a sudden change of opinion, but it is immaterial If this bill is passed, the meaning of the law must be found within the law itself The Public Health Service, will be removed from the Treasury Department and incorporated in a bureau in the projected Department of Education and Relief No other agency of the government recognizable as a health agency is to be transferred to the new bureau or even to the new department There will be appointed an assistant secretary for public health to look after the affairs of the new bureau That is all the pending bill calls for so far as the public health activities of the government are concerned The proponents of this measure may have intended to write something more into it Unfortunately, that does not help the matter Occult meanings should be made clear, so that all may understand, not merely the fortunate few who were engaged in drafting the bill The criticisms brought against the bill have in no way been met Enactment in its present form may be counted on to delay indefinitely a rational reorganization of public health activities Physicians and all other public spirited persons, individually and as organizations, should at once protest to their Senators and Representatives, against such a miscarriage of legislation Protests already made should be renewed and made stronger

Respectfully submitted,

EDWARD LIVINGSTON HUNT,  
ORRIN SAGE WIGHTMAN,  
GEORGE M FISHER

April 18, 1925

## REPORT OF THE COMMITTEE ON PUBLICATION TO THE EXECUTIVE COMMITTEE OF THE COUNCIL

### JOURNAL

The cost of the JOURNAL to the Society in 1924 was \$21,447 00, an increase of \$14,000 00 This increase is not large when one realizes that during 1924 the JOURNAL was published weekly during the season of the Legislature, making an edition of twenty-one issues instead of only twelve as in 1923

The receipts from advertisements and sales in

the JOURNAL has been about the same as the previous year, the increase in the revenue from these sources for the weekly JOURNAL being only a little over \$1,800 00 in excess of those for the monthly Few of the advertisers care to avail themselves of the weekly publication, most of them prefer to continue as before with only one insertion a month

The JOURNAL was published weekly during the early months of 1925 the same as in 1924 All

papers read at the Annual Meeting of the State Society have been published and the same general policy continued as in 1924

Several new features have been added, among which is a special department, "Medical Surveys" of the different cities and counties of the State

The cost of the JOURNAL to the Society for the year, including the editor's salary, has averaged about \$1,000 00 per issue

Of the 92 advertisers in the JOURNAL, only 8 took advantage of the weekly publication, and 9 others authorized an insertion of their advertisements every other week, leaving 75 advertisers who continued with only one insertion a month. Also, when new advertisements were obtained, in only three instances was the advertiser willing to give a contract for the weekly publication and then for only three or four issues, the others all deciding on monthly insertions

#### DIRECTORY

The Directory was published on time, at a cost to the Society of \$10,000 00. The increase of \$2,000 00 in the cost of publication of the Directory over that of 1923 is due not only to the necessity of publishing a larger edition, owing to the increase in the membership of the State Society, but also to the increase in the size of the book due to the addition of five hundred more practicing physicians in New York, New Jersey and Connecticut, than in 1923. The receipts from advertisements and sales was practically the same as in 1923

It is hoped this year to be able to increase the value of the Directory even more, by again publishing the list of hospitals in the State, as these are of great value to the members of the

Society and were only temporarily omitted owing to war-time conditions

Among the many activities of the Executive Editor which have appeared from time to time in the JOURNAL, are the medical surveys and the reports of the Meetings of the County Societies throughout the State, the data for which he obtains by personally attending the meetings. In regard to the medical surveys the following quoted from the *American Medical Association Bulletin* is an expression of the general appreciation of the work of the Executive Editor, Dr Frank Overton

"For some months the NEW YORK STATE JOURNAL OF MEDICINE has had a department called 'Medical Survey,' to which from two to six pages are devoted in each number. In this department data pertaining to the conditions of medical practice, the number and distribution of physicians, medical societies, hospitals, sanitation, nurses, population, etc, etc, for one or more counties in New York are presented each month

"THE NEW YORK STATE JOURNAL OF MEDICINE is doing a splendid work in making this survey, and in compiling a permanent record of the information thus secured, which is valuable for present purposes as well as for future use. When it is completed for the whole State, the Medical Society of the State of New York will be in possession of facts that every State Medical Association should have about conditions in its own State"

Respectfully submitted,

E. ELIOT HARRIS, *Chairman*,

ORRIN SAGE WIGHTMAN,

EDWARD LIVINGSTON HUNT

April 15, 1925

### REPORT OF THE EXECUTIVE OFFICER

#### To the Council

Your Executive Officer begs leave to offer the following report of his activities since his appointment, November 1, 1924

In accordance with instructions received from the Executive Committee, he immediately set about developing plans that would engender a closer relationship between the County Societies and the State Society. He accepted many invitations, when not prevented by conflict of engagements, to visit County Societies at the time of their meetings and to discuss with them the general subject of "The Relation of a County Society to the State Society." Owing to the fact that many of the County Societies hold their meetings on the same day of the week and month, it was impossible to accept all of the invitations received, nevertheless, in the six months he has been able to attend 19 different County Society meetings, one District Branch meeting, and 5 meetings of other Medical Societies. Of this

number he has had the opportunity of taking a place on 15 programs. He has had several opportunities for addressing lay audiences, which he has accepted

During the first three months of 1925 approximately his entire time was given over to assisting the Committee on Legislation by representing it in the legislative halls of the Capitol. As a lobbyist he devoted most of his time to developing acquaintance and friendship with the legislators and stimulating in them to a high degree the respect and appreciation for the services of the well qualified, conscientious physician, rather than attacking the aims of the ambitious, unqualified representatives of unrecognized cults. His work proved to be very pleasant, for happily he did not find many men lacking in appreciation of the medical man and his profession. Most of them were poorly informed as to the legislative needs of the medical profession and owing to the efforts of those seeking cult legislation, many

had perverted ideas of the aims of the medical profession, as well as a light regard for medical ethics as compared with business ethics. Some of those who were, on first approach, most antagonistic to the desires of the medical profession, later became ardent defenders of its desires. While technically the Medical Society has failed again this year in its effort to secure favorable legislation, it really has advanced its own cause very materially, as was evidenced by the staunch support given by the Assembly to the Department of Education's effort to amend the medical practice act. There is abundant reason to believe that a very satisfactory majority of the Senators were in complete accord with the action taken by the Assembly.

As a member ex-officio of other committees, your Executive Officer has assisted the chairman of the Committee on Scientific Work in developing his program, giving special attention to the preparation of the tuberculosis demonstration for the third day of the annual meeting.

He also met and advised with the special committee on Workman's Compensation Laws, and the chairman of the Committee on Public Health and Medical Education.

In accordance with instruction from the Executive Committee, your Executive Officer took over from the State Department of Health the work it had been doing in locating physicians seeking a practice and supplying localities with physicians where desired. In developing this function as a clearing house, the Executive Officer has relied implicitly upon the advice given him by the Secretaries of the County Societies as to the needs of communities in their jurisdiction.

The functions of the Executive Officer are as yet rather vague and not well defined, but this indefiniteness is not due to a lack, but rather to an abundance of opportunities where immediate work is demanded. His first and prime function is the coordination of the aims and activities of County Societies among themselves and with the State Society. In order to efficiently accomplish this, it seems to the Executive Officer that

*First*—He should be intimately associated with the President of the Society and at all times at his service in the development of his program,

*Second*—He should be ex-officio member of all standing and special committees. He should not take over completely the functions of any committee in the Society, nor the responsibility for any committee's activity, except as he may assist the appointed chairman. Because of his full time service, he can materially aid the chairmen of all committees in constructing a program, securing data and developing its details,

*Third*—He should be the Society's representative at the Capitol during the sessions of the legislature,

*Fourth*—He should visit all County Societies as frequently as possible, making it an aim to visit each Society not less than once in two years,

*Fifth*—He should attend all meetings of the district branches,

*Sixth*—His office should serve as a clearing house for all transactions between the State Society and the County Societies, charitable organizations, the state departments (particularly of health and education), and Societies of other states, by arranging that all communications reach the proper individuals or committees within the Society and by collecting such data as committees may request.

The function of the Executive Officer will eventually, because it is a full time position, so intimately relate itself with every activity of the State Society, that its development should be carefully studied and outlined. Your present Executive Officer appreciates this thoroughly and will most conscientiously and diligently consider every suggested activity before it is undertaken.

Respectfully submitted,

JOSEPH S. LAWRENCE,

April 15, 1925

*Executive Officer*

## REPORT OF COMMITTEE ON ARRANGEMENTS

### *To the House of Delegates*

The Committee on Arrangements submits the following report:

We were very fortunate in obtaining the entire tenth floor of the new Syracuse Hotel for our meeting. This will enable us to have our headquarters and all our meetings in one place.

We have arranged for our banquet to be held on Tuesday evening, May the 12th, and have included an invitation to all the women interested in our meeting. We feel that this will be an advantage in many ways and will afford the wives and ladies attending an enjoyable evening. Dr. Charles W. Flint, Chancellor of Syracuse

University, will address us. Other prominent speakers and entertainers will be present.

The public meeting on Wednesday evening in the ballroom of the Syracuse Hotel will be addressed by Dr. George E. Vincent of the Rockefeller Foundation. This, we believe, will give the society and public a real treat and assures us the success of the public meeting.

We have a very strong Women's Committee under the chairmanship of Mrs. Herman Weiskotten. This committee has made arrangements to provide entertainment for all women attending the meeting. Tuesday afternoon a reception at the home of Chancellor and Mrs. Charles W.

Flint on Walnut Avenue On Wednesday afternoon, automobiles will be provided to give the women a ride through one of central New York's prettiest drives, with luncheon at the famous "Krebs" in Skaneateles

Any members who desire an afternoon at golf

are advised to bring their sticks Arrangements will be made so that they may play on any of the golf links of Syracuse

FREDERICK H. FLAHERTY,  
Chairman.

April 15, 1925

## REPORT OF COMMITTEE ON SCIENTIFIC WORK

### To the House of Delegates

The Committee on Scientific Work reports that they have had two meetings during the year The first meeting was in Albany in November when the outlines of the section-programs were formulated and the second meeting in the Hotel Syracuse, Syracuse, on February 7, 1925, when the programs and all final arrangements for the meetings were completed

The Committee after much consideration has made a decided innovation in the scientific program Thursday, May 14th, has been given over to the complete consideration of tuberculosis in all its protean aspects

At the morning session there will be demonstrations of all phases of this disease pathological and bacteriological, X-ray interpretations and moving pictures of tuberculosis, determinations of physical signs on patients by the stethophone and other methods and the practical value of heliotherapy and the mercury lamp In short everything that the physician desires to know about tuberculosis will be demonstrated

The afternoon session will be given over to fifteen-minute addresses without discussion by outstanding specialists on tuberculosis

It is expected that these two sessions will furnish the most complete presentation of the entire subject of tuberculosis from every standpoint, and will be so valuable and helpful that no live physician can afford to miss them

The Committee has been fortunate in having the assistance of a special committee of which Dr E. R. Baldwin of Saranac Lake, is chairman, in formulating this program

The Committee believes that it would be wise if each section elected its secretary for three years so that there might be harmonious continuity in the sectional work They also recommend that the expenses of program guests from outside of the State be paid also the expenses of laboratory workers, not in practice, from within the State

ANDREW MACFARLANE,  
Chairman.

The recommendations were approved (see page 807)

## REPORT OF THE COMMITTEE ON PUBLIC HEALTH AND MEDICAL EDUCATION

Societies and the relation of individual members to such work

6 The problem of greater availability of hospitals throughout the State for post graduate teaching

7 The problem of post graduate work for physicians in the smaller centers and county districts

8 Relation of the State to the general question of the scope of medical and pre-medical examinations for persons practicing the healing art, in point of its application to all such acquaintances

and Study of the problems of medical treatment for people in sections of the State too well settled to support a physician  
Propriety of publishing a manual for qualified making health examinations  
His with regrets that this cannot be more than a report of progress, it is respectfully submitted by

JOSHUA M. VAN COTT,  
Chairman

The Reference Committee recommended the of periodic examinations and graduate as major activities (see page 814)

## REPORT OF COMMITTEE ON LEGISLATION

### *To the House of Delegates*

Once more your Committee on Legislation submits its report to you for the year just past

Your Committee has worked assiduously in such measures as have been delegated to it by the Council of the State Society and has attempted to continue the work along the lines originally laid down, together with such variations as have seemed wise, whereby greater interest and activity would be forthcoming from the individual members of the Society as a whole

This year has seen the same conditions maintain in legislative matters in virtually all respects as in the years gone by

There has been a gain, we believe, however, in the enthusiasm shown by the different County Societies and various individuals within the same, which has recompensed your Committee to a very large degree for the efforts demanded of them in their efforts

It has been pleasing to note that many of the adjunct committees have been up and doing, thus bringing credit to the practice of medicine as a whole and to the creation of a greater respect for the medical profession on the part of more and more laymen who have become interested

The various state departments have undoubtedly been in closer touch with the State Society than in years past—a factor sought continuously in our efforts and one which we trust the Society may enjoy upon our successors to continue

While differences of opinion in legislative procedures and questions as to the public good may arise between the Society and some state departments, there is, nevertheless, the unchallengeable fact that personal differences have not entered in and that the questions under consideration have been dealt with purely from a broad viewpoint

A summary of the work is but a compilation of that which has appeared in the JOURNAL during the year and is here appended

1 There were introduced in the Senate 1,474 bills, all of which have been gone over by your Committee on Legislation, and from the number as originally introduced or later amended, 45 bills were followed throughout the course of the legislative session

In the Assembly there were introduced 1,712 bills, and of this number 73 were kept on our lists, though not necessarily actively, until the session adjourned

The usual pernicious bills appeared in the legislature, such as the chiropractic bills of which there were eight different varieties, the antivivisection bill, which died in committee, the Birth Control Bill, several amendments to the Workmen's Compensation Law which of necessity were opposed by your committee

Bills which would have been of benefit to the

interest of public health appeared and were favored by your Committee and their passage worked for But few of these bills were passed The Karle-Dunmore Bill, which provided for more strict regulation of the practice of medicine, unfortunately failed of passage in the closing days of the session through the opposition of Senators George R Fearon of Onondaga County, and Leonard W H Gibbs of Erie County, both of whom were sponsors of cult bills

Assemblyman Charles P Miller of Genesee County, introduced a bill amending the Workmen's Compensation Law by providing for the appointment of a physician as Medical Advisor to be chosen from a list submitted by the Medical Society of the State of New York This bill to a large degree would solve the crux of the conflict which has existed in the labor laws relative to medical attendance, judgment, supervision, advice to the industrial board, examination of fee bills, examining physicians, employment of specialists and the like. Congratulation of this House of Delegates is due Mr Miller for his sound thinking and his attempt to place the burden of the medical features of the board squarely where they belong Unfortunately, this bill failed of passage, but it is hoped that a similar measure will appear early in the next session of the legislature and that the State Society will strongly back such a measure for the benefit of the public

2 It was necessary to draw up, write, and file 12 briefs in opposition to bills presented, and 8 briefs in favor of bills presented in which the State Society took a special interest This did not constitute the entire work in briefing, as it is necessary to arrange the arguments in as few words as possible and in many instances to appear before the various committees and file a brief in duplicate with the Senate and Assembly committees acting on the concurrent bills

3 About 15 hearings were attended by your Executive Officer under the direction of your Committee on Legislation, and filing of briefs which had been drawn up relative to the questions at hand, as well as presenting verbal argumentation, were necessary adjuncts

4 In the matter of correspondence it may be of interest to know the number of pieces of mail handled by your Legislative Bureau From April 15, 1924, to April 1, 1925, approximately 6,000 pieces of first class mail have been sent out, consisting of letters dictated by your Committee on Legislation or by the Executive Officer under the supervision of the Chairman of the Committee on Legislation, in the same time 3,000 pieces of first class mail have been received, and 1,000 pieces of second class, as well as a large number of magazines which were all read and salient articles noted

Early in November, 1924, 60 sets of pamphlets (12 each) were sent to the County Legislative Chairmen, in February, 1925, 200 sets of pamphlets (4 each) were sent to the individual members of the Legislature, four form telegrams were sent to the County Chairmen during the legislative session, and 22 different form letters went out at various times during the year to the County Chairmen, Secretaries and Presidents of County Societies

In a Special Bulletin issued November 7, 1924, we stated that the State Society Journal and the A M A publication "Hygeia" would be sent to influential groups, or citizens, in the various Counties, if the County Legislative Chairmen would but send in their lists. It is interesting to note that we had but two requests for these—one from Clinton County and one from Orange County

Eleven bulletins were issued weekly during the legislative session, beginning on January 17, 1925, and ending on March 28, 1925

With the opening of the session the Legislative Bureau furnished to each officer of the State Society and to the County Legislative Chairmen and Advisory Committee, copies of the Governor's Message, the Clerk's Manual, the Little White Book, and lists of the Standing Committees of the Legislature, to be used for reference during the legislative session. This was done as a matter of courtesy to the individual County Societies, since such information and pamphlets are gladly furnished by each legislator when asked so to do by any one of his constituents. We have, however, been asked for such information by many of our members who do not know the routine of legislation, or who have been averse to exerting themselves to write their own legislators even if they knew them

Whenever bills of extreme interest were introduced sufficient copies of the same were obtained and sent broadcast to each County Chairman, to the Advisory Committee, Council, and officers of the State Society, in order that there might be no misunderstanding in the subject matter when spoken of later

Your Legislative Bureau has also subscribed this year to a press clipping bureau, and over a thousand clippings have been received and perused and notations made of the same for publication in the JOURNAL, or been forwarded to the editorial board of the JOURNAL

5 A large amount of time has been spent by your Chairman of the Committee on Legislation in editing the legislative notes which appeared in the JOURNAL. How many pages of this editorial matter have been put out can be estimated by those who care to enumerate the same in the JOURNAL as they have appeared

Your Chairman has been aided in this matter to no small degree by your Executive Editor of the JOURNAL and the Executive Officer of the

Society, but even with this help there is a vast amount of work which it seems might be handled in some other manner than the taking of time by your Chairman. And yet it is questionable as to who is in better touch with the problems under discussion than your Chairman in conjunction with the Executive Officer

It would seem that the House of Delegates, through its reference committee, could suggest a plan to obviate the large amount of time necessarily spent by your Chairman of the Committee on Legislation in such editorial work.

6 Your Chairman has visited during the year a number of County Societies wherever it was possible for him to devote the time from his personal practice in addition to his other duties pertaining to the Society. This is at great personal sacrifice, but may be said to go with the honor of the position, and in the visitations there is much of social pleasures enjoyed in meeting the physicians throughout the State, which fully repays the time so spent. Your present Chairman of the Committee on Legislation has now conducted the Legislative Bureau for four years and believes that his release should be granted and a successor elected

The Society at large should be pleased to know that no fewer than 10 states are publishing bulletins and medical literature throughout their states and thus instructing their citizens after the pattern of our own legislative bureau

On the 4th of March, the usual Conference of the County Legislative Chairmen and the officers and Council of the State Society was held in Albany—in the planning of which much preliminary work had to be done by your Committee on Legislation and your Executive Officer. That it was a success there is no doubt and your JOURNAL will contain the salient features of what occurred at this meeting

The following officers and members of the Council were present: Drs Owen E Jones, George A Leitner, E Eliot Harris, George M Fisher, Edward Livingston Hunt, Arthur J Bedell, Nelson O Brooks, Harry R Trick, Orrin Sage Wightman, Dr Joseph S Lawrence, Executive Officer, and Dr Frank Overton, Executive Editor of the JOURNAL, and Mr George W Whiteside, Counsel of the State Society

The following members of the Advisory Committee were present: Drs Daniel S Dougherty, Arthur D Jaques, James F Rooney, W Warren Britt, and Homer J Knickerbocker

The following County Legislative Chairmen were present: Drs B E Kinne, Albany County, F H Van Orsdale, Allegany County, E R Cuniffe, Bronx County, H B Marvin, Broome County, H D Chapman, Cayuga County, R H Loomis, Chenango County, R S McDonald, Clinton County, Robert Brittain, Delaware County, J A Card, Dutchess County, G R

Critchlow, Erie County, Peter Noe, Jr, Essex County, John White, Franklin County, Woodard Shaw, Fulton County, J W LeSeur, Genesee County, P G Waller, Greene County, W W Hall, Jefferson County, J A Driscoll, Kings County, P von Zierolshofen, Lewis County, N O Brooks, Madison County, W A Calhan, Monroe County, H Hicks, Montgomery County, Richard Derby, Nassau County, D S Dougherty, New York County, F J Schnell, Niagara County, G M Fisher, Oneida County, H J Knickerbocker, Ontario County, J K Durling, Orleans County, W H Kidder, Oswego County, J C Smith, Otsego County, D J McMahon, Queens County, V G Smith, Richmond County, C D Kline, Rockland County, W J Maby, Saratoga County, H R Bentley, Schoharie County, F W Lester, Seneca County, L M Kysor, Steuben County, W H Ross, Suffolk County, L C Payne, Sullivan County, W A Leonard, Washington County, Ralph Sheldon, Wayne County, C C Sweet, Westchester County, J W LeSeur, representing Wayne County, G H Leader, Yates County

Addresses were delivered at the opening of the Conference by

Owen E Jones, M D, President Medical Society, State of New York

James N Vander Veer, M D, Chairman Committee on Legislation, Medical Society of the State of New York

Joseph S Lawrence, M D, Executive Officer, Medical Society of the State of New York

Dr Augustus S Downing, Assistant Commissioner for Higher Education and Director of Professional Education, University of the State of New York

Matthias Nicoll, Jr, M D, Commissioner of Health, State of New York

William A Howe, M D, State Medical Inspector of Schools, University of the State of New York

Following these addresses an executive session was held and discussion entered into relative to the different bills that were pending, and the following recommendations were made by the Conference relative to legislation

1 That in the proposed County Public Health Nurse Bills, changes be made whereby nurses should not be given the prerogatives of physicians This was adhered to in the legislature and eventually this bill, as amended, became a law in line with the majority thoughts of the Medical Society

2 The Conference went on record as recommending that action on the bill relative to changes in the management of the State Hospital for the Care of Crippled and Deformed Children at West Haverstraw, and the bill making changes in the management of the State Institute for the Study of Malignant Disease at Buffalo, be deferred

until next year by requesting the legislature so to do This was done at the request of a number of members who asked that the proper committees in the State Society study the matter and be prepared to report to the Council or governing body before their introduction next year

3 The Conference went on record as unalterably opposed to the proposition advanced by the State Department of Health, that doctors pay for supplies of antitoxin and the like, in instances where they had neglected to file certain data

4 Quite an amount of discussion was indulged in relative to the various cult bills which had been introduced, and the bill introduced by the State Department of Education, known as the Karle-Dunmore Bill From the tone of the discussion it was very evident that a large majority of the County Chairmen were opposed to all of the cult bills, though a few favored acceptance of the Fearon Bill The Conference, however, went on record as opposed to all cult bills, and in favor of the Karle-Dunmore Bill

5 The following bills which would amend the Workmen's Compensation Law, by providing an injured employee may select his own physician

S Int 380, by Senator Daniel F Farrell, of Kings County, conc A 570, by Assemblyman Gerald F Dunne of Kings County

S Int 594, by Senator Wm L Love of Kings County, conc A 301, by Assemblyman Frank H Lattin, of Orleans County

were then considered by the Conference, and a partial report of the Committee appointed by President Jones, of which Dr J Richard Kevin was Chairman, was read by Dr James E Sadler in Dr Kevin's absence, and contained the thought that it was right and proper for a workman to have free choice of his physician The Conference recommended that the Committee on Legislation take a referendum vote of the County Legislative Chairmen when it seemed advisable

Your Committee on Legislation would ask for instructions from the House of Delegates relative to a bill of this type, particularly as to the thought contained therein

6 The Conference went on record as being in favor of the bill introduced in relation to habit-forming drugs

The Conference adjourned at 1 30 P M and proceeded to the Capitol where the hearing was held on the various cult bills and the medical practice act—a short resume of which will appear in the JOURNAL.

In the judgment of your Committee on Legislation this question will be one of the most important ones at the next session of the legislature and should be carefully considered as to what position the Society will take for the coming year

It must be distinctly understood by the mem-

bers of the Medical Society of the State of New York, that the Committee on Legislation and the various County Legislative Chairmen cannot control the political phase of legislation in such matters, and that many legislators consider the position only from the standpoint of their constituents at home and those from whom they hear

Charity therefore must be accorded to that State Committee on Legislation which happens to be under appointment should a political fiasco occur and cult bills of the same type as those introduced this year be passed

May the day never come when the individual members of the Medical Society of the State of New York agree to a compromise feature or lose the confidence of the majority of the people of the State through the misfortune of the loud cries of an insistent minority overweighing the opposition of the people of the State in the breaking down of the bulwarks so far builded against charlatanism

Much greater enthusiasm has been shown by the Chairmen of the various County Societies in legislative work, yet again some County Societies have seen fit to elect men who have done absolutely no work, as evidenced by the fact that several legislators requested explanations concerning the Karle-Dunmore Bill, and they together with others, made the bold statement that they had not been interviewed by any physicians relative to legislative matters

Many of the communications to the County Legislative Chairmen have been unanswered, and this detracts from the enthusiasm of legislation, when we of the Committee or the Bureau can not get needed information as to how a County Society stands in relation to legislative subjects

It is to be hoped that the Executive Officer may visit these County Societies during this coming year and without fear or favor show them the type of men they have put into office and the disadvantage at which the State officers work, for purely honorary positions, when some parts of the machinery do not function

More County Societies, however, than in previous years have seen the wisdom of sending out small bulletins containing bits of information, not necessarily legislative in character, but all of the efforts of this kind combine to lead up to the ultimate end of education of the people of this State toward what they should demand in public health work

Your Legislative Bureau has been in close touch through correspondence with the Bureau of Legal Medicine and Legislation of the American Medical Association, and it has been a pleasure to realize how much of interest is being taken by the national body relative to the legislative work of this our own Medical Society of this State

Your Legislative Bureau has expended this year some \$6,200 00 which does not equal the budget as passed upon last year, and in the main has stayed within the various appropriations asked for. Of this amount, however, it is estimated that some seven or eight hundred dollars has been expended on behalf of the duties performed by your Executive Officer in the matter of correspondence, telephone calls, extra stenographic services, necessary extra furniture, and so forth, so that once more the expenditures actually chargeable to the Legislative Bureau have not come up to the sum appropriated by your Council. This is no criterion, however, as from year to year the expenditures of such a Bureau must necessarily increase in proportion to the work done, and the time is not far distant when plans must be made for establishing the Bureau on a more firm basis with a regular full time person in charge

Your Committee on Legislation would ask for thoughts from the House of Delegates on this question

It would seem that one of the great efforts of the coming year of your Legislative Bureau or some committee fashioned thereafter, is to reach certain classes of individuals within the State whose consideration of legislative matters and efforts for rightful legislation would be of extreme value

In perusing previous reports of Committees on Legislation the thought has occurred to your present Committee that it would be of the utmost value during the coming summer to have a resumé of legislative effort on the part of the Medical Society indexed and carded for reference, as the subject matter brought forth in legislative and other committee reports to your House of Delegates is now becoming of extreme importance and must needs be correlated for ready reference in order to offset supposed new thoughts which are brought up in succeeding legislatures. At present, a committee on legislation must needs wade through a mass of material in order to ascertain what has been the previous attitude of the State Society or various committees on the same subject throughout the years of our existence

Your Committee on Legislation has been embarrassed in several instances by a lack of unanimity in legislative questions when a majority of the County Societies have been in favor or against certain measures, while a minority group of the County Societies have taken opposite views, and in several instances pressure has been brought to bear on legislators by groups of physicians in affiliation individually or in the whole with the County Society or with the State organization. Your Committee on Legislation asks discussion by the House of Delegates as to how such a condition shall be dealt with,



remembering that the function of the Committee on Legislation is to try and forward or to defeat measures which come up and which are of simple dealings when it knows the sentiment of the Society through the House of Delegates on the bills under discussion.

Your Committee on Legislation would suggest that the House of Delegates tender its thanks to Governor Alfred E. Smith, who has shown by his actions his sane, sincere desire to give to the people of this state the best that could be obtained in the way of public health. This was evidenced by the space devoted in his annual message to the Legislature on questions of public health, and his constant watchfulness and effort throughout the legislative session, and as well should be mentioned his emergency message to the Senate on the last day of the session urging that they report and pass the Karle-Dunmore bill for the better protection of the people of this State. Your Committee on Legislation feels that to him the House of Delegates should accord a communication expressing the sentiment of the Society as a whole.

The appreciation of the State Society is also due Senator John L. Karle, who introduced the State Department of Education Bill amending the Medical Practice Act, and to Assemblyman Russell G. Dunmore, who introduced the companion bill in the Assembly.

It is also suggested that the thanks of this Society be transmitted to Senators Bernard Downing, Nathan Straus, Morton J. Kennedy, Henry G. Schackno, J. Griswold Webb, Ernest G. Cole, Homer A. E. Dick, and to Assemblymen Simon L. Adler, Howard N. Allen, Jerome G. Ambro, Julius S. Berg, Morris Block, John Boyle, Jr., William Breitenbach, John L. Buckley, Frank A. Carlin, Robert A. Catchpole, Edward J. Coughlin, Louis A. Cuvillier, F. Trubee Davison, Daniel L. Dayton, Owen J. Dever, Edward J. Donohue, Russell G. Dunmore, Gerald F. Dunne, Nicholas J. Eberhard, Marcellus H. Evans, Clarence L. Fisher, Frank R. Galgano, Alexander H. Garnjost, Joseph H. Gavan, Abraham Grenthal, Delbert C. Hall, Lewis F. Harder, John P. Hayes, J. Murray Hearn, John J. Howard, Henry W. Hutt, Adolf F. Johnson, Paul T. Kammerer, Jr., Joseph E. Kinsley, J. Maxwell Knapp, Mark T. Lambert, Frank H. Lattin, Frederick B. Linen, Ralph H. Loomis, Bert Lord, Thomas J. McDonald, John J. Meegan, Charles P. Miller, Frank A. Miller, John P. Nugent, Lester W. Patterson, John F. Reidy, Michael J. Reilly, Joseph F. Ricca, James R. Robinson, Frederick J. Slater, Frank M. Smith, Lewis G. Stapley, William D. Thomas, Richard D. Tonry, Morris Weinfeld, William Wickham, John R. Yale, to these men we, as physicians, are indebted for their sound thinking, wise counsel and staunch support or opposition in such measures of public health which your

State Society has deemed to be of value to, or detrimental to the citizens of the State. Were it not for these men who patiently listened and then had the courage to act, this State of New York might be in the same position as many states now are where political opportunities have been seized upon to the detriment of the people of those states. We undoubtedly have overlooked some—but it is of the pen unwittingly and not of the mind.

We desire at this point to speak of the cordiality of the individual legislators especially, and in fact of the majority of those with whom we have come in contact personally or through correspondence. Your Executive Officer will speak of this at greater length, but your Committee on Legislation desires to make mention of that fact here.

It would be amiss as well not to mention those legislators who, for reasons known only to themselves have, in the minds of your medical thinkers, lost their sense of perspective and have voted or worked for the destruction by legislation of our medical laws, our State Department of Health, our State Department of Education, our State Hospital system, as well as the individual governmental functions of local boards and institutions. These men who have though their support of legislative matters along such lines would be of more worth to the State have been Senators Arthur F. Bouton, George R. Fearon, Leonard W. H. Gibbs, Edmund B. Jenks—but from the standpoint of the Medical Society their position most certainly can be questioned by the majority or their constituents.

#### RECOMMENDATIONS

Your Committee on Legislation recommends to the House of Delegates of the Medical Society of the State of New York, for their action, the following:

- 1 That the Legislative Bureau be continued, and a sufficient appropriation, under a budget system to be offered by the new Chairman of the Committee on Legislation, be allowed.
- 2 That provision be made for one or more conferences of County Legislative Chairmen, as in the past.
- 3 That some provision be made whereby your Committee on Legislation may co-operate with physicians who have grouped themselves into special societies, usually with community interest, some of whose members are not members of the State Society, in legislative matters. I believe this will be spoken of in another report, but your committee on Legislation would recommend that the proper changes be made in our constitution and by-laws for some type of legislative representation of such societies.

- 4 That your Executive Editor be directed to come to Albany during the legislative session and spend one or more days in Albany each week at the expense of the Society, thus becoming more familiar with legislative matters and being able the more to edit legislative articles for the benefit of the JOURNAL
- 5 As before, we again recommend a broad dissemination of education on public health questions through the public press by means of someone of the adjunct committees of the State Society—thus laying a better foundation for the legislation which may come up, and would respectfully suggest
  - (a) That the JOURNAL of the State Society be sent during the legislative session to all the legislators, to the newspapers published in this State, to the officers and members of the Executive Committees of the allied professions, State or District Societies of nurses, dentists, school medical inspectors, health officers' associations and the like, and to a selected group of lay societies
  - (b) That conferences be held in the Council of the Society as to certain other selected medical and educative publications which should be sent to these groups

Several of these recommendations were favorably passed upon last year by the House of Delegates, but unfortunately your Executive Committee negated the will of the House of Delegates and as a result the JOURNAL of the State Society did not reach the legislators except in a few instances where it was specifically asked that it be sent. This was not called to the attention of your Chairman or the Committee on Legislation, and under the impression that the JOURNAL was being sent to the legislators, many of the articles written by the Chairman were so phrased as to show the legislators that the physicians of the State had nothing to hide, but were sending these Journals to them in order that they might be read and the legislators inform themselves as to the viewpoint of physicians in relation to much of the matter under discussion

- 6 We would again recommend that the same rule be adopted in relation to physicians—members of the State Society—appearing before committees of the legislature without first consulting with the Chairman of the Committee on Legislation

It has been intimated that such a recommendation tends to stifle certain criticisms, but we have yet to hear of a single physician being refused introduction on the part of the Committee on Legislation when he has asked honestly to be so presented. There have been present, however, at a number of committee hearings, members of the State Society who probably were unaware of the

rule, but who have caused some inconvenience to your committee, in that a legislator who might wish to indulge in sharp practice could easily point out that the members of the medical profession were woefully divided on important questions of the day whereas the individual physician so appearing might be only giving his personal views, and under this rule would be forbidden to boldly state that he was appearing for a recognized group of physicians when such was not the case, or when such a group did not exist

In this connection it is recommended that the Secretary of the Medical Society of the State of New York be directed to write any physician who so appears before a committee and to officially call his attention to the action of the State Society in relation to this rule

- 7 That the County Societies be urged to meet with their legislators in the fall or at some convenient time in a social way and that it be obligatory on the Council Society to so report to the Council or Committee on Legislation, since much good has come from the meetings so held by many County Societies but, unfortunately, the reports of such meetings only reach the Legislative Bureau in a roundabout manner
- 8 That legislation which is sought by County Societies and individual members be sent in to the Bureau in the early fall, so that the Counsel of the Society may draw up in proper form such legislation and submit it to the Council and Committee on Legislation before the opening of the session, and that any legislative suggestion or thought within or by a County Society shall be in the hands of the Council for approval or disapproval not later than September 1st, 1925
- 9 That the Council of the Society be directed to form some type of Advisory Committee of the profession of this State which shall eventually become an Advisory Council to governmental officers or departments when advice is so sought, since in many instances some physicians in private meetings with legislators hold themselves out to be representatives of many of these bodies and would convey to the individual legislators the thought of their importance of position, thus negating the efforts of the duly accredited officers of the various and individual professional societies. This does not work for a harmonious entity in matters of public health legislation, but by such a movement a body would be created which can speak with authority in allied matters of public health from all angles pertaining to the people of this State

- 10 That the position of the State Society in relation to legislation as it may appear in the legislature be the same on such similar matters as has maintained in the past years unless a specific resolution be passed by the House of Delegates, by referendum vote, or by the Council, thus changing the position of the Society without placing the burden of such change alone on the Committee on Legislation.
- 11 That legislation which has come up in the past session in reference to the State Institute for the Study of Malignant Disease at Buffalo, and the State Hospital for Crippled and Deformed Children at West Haverstraw, be referred by this House of Delegates to the proper committee of the Society for study and suggestions as to action for your next Committee on Legislation. The same report to be given to the Council by September 1st, 1925, that they may act upon it for the guidance of the Committee on Legislation
- 12 That this House of Delegates discuss the old and familiar bills as to Birth Control, Anti-vivisection, Child Experimentation, amendments to the Medical Practice Act, and place on the records of the House of Delegates what action shall be taken by the Committee on Legislation during the coming year so far as can be determined in the light of past legislation
- 13 That this House of Delegates go on record as favoring a bill similar to Assemblyman Charles P. Miller's bill, A. Int. 1351, and direct your Committee on Legislation to confer with the County Legislative Chairmen and legislators urging the passage of the same or some similar measure
- 14 That this House of Delegates approve or disapprove of the wording and legislative thought contained in the Kennedy-Weinfeld bill concerning habit-forming drugs
- 15 That this House of Delegates record itself as for or against the free choice of physician by an injured workman
- 16 That the Committee which was appointed to study the Workmen's Compensation Law be continued or a similar committee be appointed, and that they be directed to place in the hands of the Council their recommendations for amendments to the Workmen's Compensation Law in relation to the medical features thereof by September 1st, 1925, in order that the Council may draft the proper bills for introduction, and submit them to the Council by the 1st of December, 1925, should the Council pass favorably upon their introduction
- 17 That any legislative suggestion or thought within or by a County Society shall be in the hands of the Council for approval or disapproval not later than September 1st, 1925
- 18 That the House of Delegates direct that the services of the Executive Officer shall be wholly under the direction of the Committee on Legislation from the 1st day of December until one month after the closing of the legislative session
- 19 That some means be devised whereby articles on medical topics may be syndicated to newspapers through the editorial office of the JOURNAL or a Press Bureau to be established within one of the standing committees of the Society, from whence can be sent to newspapers, lay organizations, churches, schools and the like, authentic and interesting articles concerning the public health and the duty of the individual in relation to the health of his neighbor. This is one of the crying needs of the Society at the present time and it might be of advantage to the Society were some journalist engaged upon half or full time to help the committee upon whom such work would fall

Respectfully submitted,

JAMES N. VANDER VEER, *Chairman*,  
GEORGE R. CRITCHLOW,  
WALTER H. CONLEY

For report of the Reference Committee see page 809

## REPORT OF COMMITTEE ON MEDICAL RESEARCH

*To the House of Delegates*

Your Committee has functioned by gathering data and preparing to oppose the usual attempts to interfere, by legislation, with the necessary and orderly scientific experimentation on animals as at present conducted by properly authorized Medical Schools

An amendment to the Penal Code of the State was introduced in the Legislature which, if passed, would prohibit any investigations or experiments on living dogs

This amendment, owing to the accumulation of other matters, was not reported out of committee and as no hearing was called on the bill, your Committee did not find it necessary to appear at Albany

Respectfully submitted,

W. MORTIMER BROWN,  
*Chairman*

April 15, 1925

4 That your Executive Editor be directed to come to Albany during the legislative session and spend one or more days in Albany each week at the expense of the Society, thus becoming more familiar with legislative matters and being able the more to edit legislative articles for the benefit of the JOURNAL

5 As before, we again recommend a broad dissemination of education on public health questions through the public press by means of someone of the adjunct committees of the State Society—thus laying a better foundation for the legislation which may come up, and would respectfully suggest

(a) That the JOURNAL of the State Society be sent during the legislative session to all the legislators, to the newspapers published in this State, to the officers and members of the Executive Committees of the allied professions, State or District Societies of nurses, dentists, school medical inspectors, health officers' associations and the like, and to a selected group of lay societies

(b) That conferences be held in the Council of the Society as to certain other selected medical and educative publications which should be sent to these groups

Several of these recommendations were favorably passed upon last year by the House of Delegates, but unfortunately your Executive Committee negated the will of the House of Delegates and as a result the JOURNAL of the State Society did not reach the legislators except in a few instances where it was specifically asked that it be sent. This was not called to the attention of your Chairman or the Committee on Legislation, and under the impression that the JOURNAL was being sent to the legislators, many of the articles written by the Chairman were so phrased as to show the legislators that the physicians of the State had nothing to hide, but were sending these Journals to them in order that they might be read and the legislators inform themselves as to the viewpoint of physicians in relation to much of the matter under discussion

6 We would again recommend that the same rule be adopted in relation to physicians—members of the State Society—appearing before committees of the legislature without first consulting with the Chairman of the Committee on Legislation

It has been intimated that such a recommendation tends to stifle certain criticisms, but we have yet to hear of a single physician being refused introduction on the part of the Committee on Legislation when he has asked honestly to be so presented. There have been present, however, at a number of committee hearings, members of the State Society who probably were unaware of the

rule, but who have caused some inconvenience to your committee, in that a legislator who might wish to indulge in sharp practice could easily point out that the members of the medical profession were woefully divided on important questions of the day whereas the individual physician so appearing might be only giving his personal views, and under this rule would be forbidden to boldly state that he was appearing for a recognized group of physicians when such was not the case, or when such a group did not exist

In this connection it is recommended that the Secretary of the Medical Society of the State of New York be directed to write any physician who so appears before a committee and to officially call his attention to the action of the State Society in relation to this rule

7 That the County Societies be urged to meet with their legislators in the fall or at some convenient time in a social way and that it be obligatory on the Council Society to so report to the Council or Committee on Legislation, since much good has come from the meetings so held by many County Societies but, unfortunately, the reports of such meetings only reach the Legislative Bureau in a roundabout manner

8 That legislation which is sought by County Societies and individual members be sent in to the Bureau in the early fall, so that the Counsel of the Society may draw up in proper form such legislation and submit it to the Council and Committee on Legislation before the opening of the session, and that any legislative suggestion or thought within or by a County Society shall be in the hands of the Council for approval or disapproval not later than September 1st, 1925

9 That the Council of the Society be directed to form some type of Advisory Committee of the profession of this State which shall eventually become an Advisory Council to governmental officers or departments when advice is so sought, since in many instances some physicians in private meetings with legislators hold themselves out to be representatives of many of these bodies and would convey to the individual legislators the thought of their importance of position, thus negating the efforts of the duly accredited officers of the various and individual professional societies. This does not work for a harmonious entity in matters of public health legislation, but by such a movement a body would be created which can speak with authority in allied matters of public health from all angles pertaining to the people of this State

- 10 That the position of the State Society in relation to legislation as it may appear in the legislature be the same on such similar matters as has maintained in the past years unless a specific resolution be passed by the House of Delegates, by referendum vote, or by the Council, thus changing the position of the Society without placing the burden of such change alone on the Committee on Legislation
- 11 That legislation which has come up in the past session in reference to the State Institute for the Study of Malignant Disease at Buffalo, and the State Hospital for Crippled and Deformed Children at West Haverstraw, be referred by this House of Delegates to the proper committee of the Society for study and suggestions as to action for your next Committee on Legislation. The same report to be given to the Council by September 1st, 1925, that they may act upon it for the guidance of the Committee on Legislation.
- 12 That this House of Delegates discuss the old and familiar bills as to Birth Control, Anti-vivisection, Child Experimentation, amendments to the Medical Practice Act, and place on the records of the House of Delegates what action shall be taken by the Committee on Legislation during the coming year so far as can be determined in the light of past legislation
- 13 That this House of Delegates go on record as favoring a bill similar to Assemblyman Charles P. Miller's bill, A. Int 1351, and direct your Committee on Legislation to confer with the County Legislative Chairmen and legislators urging the passage of the same or some similar measure
- 14 That this House of Delegates approve or disapprove of the wording and legislative thought contained in the Kennedy-Weinfeld bill concerning habit-forming drugs
- 15 That this House of Delegates record itself as for or against the free choice of physician by an injured workman
- 16 That the Committee which was appointed to study the Workmen's Compensation Law be continued or a similar committee be appointed, and that they be directed to place in the hands of the Council their recommendations for amendments to the Workmen's Compensation Law in relation to the medical features thereof by September 1st, 1925, in order that the Council may draft the proper bills for introduction, and submit them to the Council by the 1st of December, 1925, should the Council pass favorably upon their introduction
- 17 That any legislative suggestion or thought within or by a County Society shall be in the hands of the Council for approval or disapproval not later than September 1st, 1925
- 18 That the House of Delegates direct that the services of the Executive Officer shall be wholly under the direction of the Committee on Legislation from the 1st day of December until one month after the closing of the legislative session
- 19 That some means be devised whereby articles on medical topics may be syndicated to newspapers through the editorial office of the JOURNAL or a Press Bureau to be established within one of the standing committees of the Society, from whence can be sent to newspapers, lay organizations, churches, schools and the like, authentic and interesting articles concerning the public health and the duty of the individual in relation to the health of his neighbor. This is one of the crying needs of the Society at the present time and it might be of advantage to the Society were some journalist engaged upon half or full time to help the committee upon whom such work would fall

Respectfully submitted,

JAMES N. VANDER VEER, *Chairman*,  
GEORGE R. CRITCHLOW,  
WALTER H. CONLEY

For report of the Reference Committee see page 809

## REPORT OF COMMITTEE ON MEDICAL RESEARCH

To the House of Delegates

Your Committee has functioned by gathering data and preparing to oppose the usual attempts to interfere, by legislation, with the necessary and orderly scientific experimentation on animals as at present conducted by properly authorized Medical Schools

An amendment to the Penal Code of the State was introduced in the Legislature which, it passed, would prohibit any investigations or experiments on living dogs

This amendment, owing to the accumulation of other matters, was not reported out of committee and as no hearing was called on the bill, your Committee did not find it necessary to appear at Albany

Respectfully submitted,

W. MORTIMER BROWN,  
*Chairman*

April 15, 1925

## REPORT OF COMMITTEE ON NURSE PROBLEM

### *To the House of Delegates*

At the annual meeting of the House of Delegates held at Rochester in 1924 the following Resolution was presented

Dr Critchlow, Erie I wish to present the following resolution, passed by the Society of the County of Erie

WHEREAS, Deplorable conditions have developed and now obtain in an ever increasing degree in the relations existing between the group of Registered Nurses on the one hand, the physicians and the general public on the other, and

WHEREAS, We feel that the laws of the State of New York now governing the training of nurses are serving to educate a group of women beyond the point of practical usefulness in the actual care of the sick, and

WHEREAS, A large percentage of such highly educated nurses elect to follow the work of public health nursing, institutional instruction and other lines of work than actual nursing of the sick, and

WHEREAS, We feel that the lines of work just mentioned do perhaps require education and training of the kind now conducted in our registered schools, but

INASMUCH as there is a crying need for a group of women who shall be trained in the practical duties pertaining to a real nurse, and who shall be thoroughly imbued with the idea that the first and greatest function of a nurse is to care for the sick, and

INASMUCH as it is generally agreed by the medical profession throughout the country that women may be properly and thoroughly trained for such duties in a much shorter time than is now required for the graduation of Registered Nurses, and that a curriculum requiring less theoretical teaching and more bedside training can be adopted that would develop efficient nurses in from nine months to a year, and

INASMUCH as such hospitals as attempt to carry out such a course of instruction are hampered in their work by opposition from the Department of Education, now, therefore, be it

*Resolved*, That the delegates of the Medical Society of the County of Erie be and hereby are instructed to bring this matter before the House of Delegates at its annual meeting in the City of Rochester on April 21st, 1924, and urge upon that body the advisability of the Medical Society of the State of New York as a body attacking this problem and supporting, by every means in its power, legislation looking toward an amelioration of the conditions now existing

This was referred to Reference Committee B which reported as follows

Dr Sadlier In relation to the resolution introduced by Erie County, through Dr Critchlow, with reference to the question of the nursing situation, we believe that the first four paragraphs of the resolution are in accordance with the ideas of the medical profession in general. We disagree with part of the sixth paragraph, and would suggest that you introduce after "registered nurse" the following "In order to meet the demands of suffering humanity and at the same time not interfere too radically with the present teaching of pupil nurses, we suggest that the preliminary educational requirements for entrance into training schools be modified so as to make graduates of eighth grade eligible for acceptance in the training schools of the State, and that the required course of instruction throughout the State be reduced to two years, with a lessened amount of theoretical teaching and a more intense course of bedside training"

We disagree with the sixth paragraph, in so far as it

asserts that efficient nurses could be developed in from nine to twelve months, and feel that this type of nurse is cared for by provisions of the law in reference to trained attendants

We recommend that the President of the State Medical Society appoint a committee of three to confer with the Department of Education with a view to legislation along the lines suggested by this resolution of Erie County and revised by this Reference Committee.

The House of Delegates adopted this report and a Committee was duly appointed by the President

The Committee has sought information on this topic from various sources to enable it to discuss the matter intelligently with the State Education Department We carefully studied the present Nurse Law of the State of New York, also all available published reports and statistics This was supplemented by correspondence and interviews with many physicians, nurses and superintendents of Nurse Training Schools Finally we held lengthy conferences with the proper authorities in the State Education Department From every source it was admitted that the general situation was not entirely satisfactory We also ascertained that the problem of the trained nurse, especially in her relations to the public and the profession, is not confined to New York State alone, but is exciting serious attention generally throughout the United States in many parts of which, not nearly so high requirements and standards obtain

A brief retrospect of the progress of Nurse Education in New York State shows that prior to 1903, there was no standard curriculum The degrees of discipline and thoroughness of training varied widely and were dependent upon the particular kind and amount of clinical experience each individual hospital provided, and upon the ideals, initiative and character of the superintendent of nurses

At that time several Correspondence Schools of Nursing flourished and produced many "graduates" who were allowed to practice as trained nurses There was no law to prevent this A number of hospitals, not all of them small ones, maintained training schools in name only, furnishing the most mediocre courses of instruction and oftentimes an unbalanced clinical experience Too frequently the young women were exploited Under the guise of disciplinary training, they were required to do a large share of the housework of the wards Many were improperly housed and cared for, and subjected to prolonged and exhausting hours on duty

The prevalence of these abuses prompted a demand for reform by intelligent groups of physicians, nurses and educators In 1903, a Nurse Law was passed designed to regulate the training of the Nurse and to place her calling on a dignified plane The State Education Department

was authorized to prepare a curriculum and such necessary rules and regulations, as might be required under the circumstances, to ensure adequate education, bedside experience, and proper living conditions to protect the health and morals of the nurse in training. These were compiled and adopted only after careful and conscientious study by a committee of physicians, trained nurses and representatives of incorporated hospitals who advised the Department on the questions involved.

Whatever provisions were instituted, as a direct result of this law, were made to apply so gradually as not to disturb too abruptly the existing order of things or methods of training, then in vogue, in the better class of hospitals. Liberal concessions and extensions of time were granted to many hospitals which, for good and sufficient reasons, were physically unable to comply at once with the necessary requirements.

A waiver clause was provided to fully protect the rights of all nurses then actually in practice. For several years following the passage of this law, there were no restrictions on the use of the term *Trained Nurse*, provided the nurse had graduated from a hospital training school. The acquiring of an *R N* degree by State examinations was purely optional until 1920, when an amendment to the law was enacted, which restricted the use of the titles "trained, certified, graduate or registered nurse" to those who were graduates of Training Schools registered by the Education Department, and had passed the Nurse Examination Board. However, a waiver was in force until January 1923 to enable any nurse to register who had actually carried on nursing for the previous five years in this State. This allowed even practical nurses of experience to register. There was manifest a very liberal spirit on the part of the Education Department to allow ample time and opportunity for registration and readjustment.

At no time in the past or at present has any person been prevented by this law from engaging in nurse practice. The registration of schools of nursing is not compulsory, but since 1920, only graduates of schools approved by the Education Department are eligible for entrance to the licensing examinations. In short, the Department concerns itself solely with such schools and graduates as voluntarily elect to comply with the rules governing State registration. There is nothing in the law to prevent hospitals conducting training schools in any manner they see fit. However, such institutions cannot receive the official approval of the Department unless certain minimum standards are maintained. Obviously, when not maintained, the graduates of such are presumably of inferior training and cannot apply to themselves the specific terms "trained, certified, graduate or registered nurse," as these terms are

now, by law, an indication of having had a definite degree of general education, hospital training and bedside experience of a uniform quality and quantity throughout the entire State.

From time to time, as conditions appeared to warrant, the curriculum, prescribed by the State Education Department, has been modified. The alternative of three courses is allowed. One of two years training, one of two years and four months, and one of three years. The same amount of theory is required in all three types. The chief advantage of the longer course being that the work is more distributed and opportunity provided for a broader culture and study in advanced subjects from the optional group. In any of the courses, the total number of hours of didactic or theoretical instruction is about four hundred which would be approximately 7 per cent of the time in the case of a two years and four months course, thus allowing 93 per cent of the time for bedside practice. This does not take into consideration the four hours a week which the nurse should devote to study in her room or the study hall when off duty.

The Department requires of all registered schools an adequate course of nursing experience in surgery, obstetrics, medicine, pediatrics, dietetics and massage. Whenever the hospital cannot provide sufficient practical experience in one or more of these branches, the student must be sent to an approved hospital where she can gain this experience. This matter of affiliation presents certain difficulties. To leave one school and enter another temporarily is a serious interruption, but if we are to give the nurses a comprehensive training and practical experience in all branches, it appears to be the only method of procedure when the hospital is other than a general one, well supplied with clinical material of all kinds.

The Education Department is absolutely correct in this matter. Much of the criticism and complaint of the Department's "hampering methods" has emanated from the hospitals which were loath to affiliate their students with other hospitals for needed experience. The very element of training now so strenuously advocated—practical bedside experience, is just what the Department has found its greatest difficulty in securing for the pupil nurse in a great many instances.

According to the present syllabus which is now being revised, theoretical instruction is required in the following subjects

- 1 Nursing Principles and Methods
- 2 Anatomy and Physiology
- 3 Bacteriology
- 4 Nutrition and Cookery
- 5 Hygiene, Public Sanitation
- 6 Materia Medica

7 Nursing in Medical Diseases (including communicable diseases)

8 Nursing in Surgical Diseases (including operating room technic and gynecological nursing)

9 Obstetric Nursing

10 Nursing of Children

11 Nursing in Nervous and Mental Diseases

In all, approximately 400 hours time of lectures and classroom

The State Board Examinations are based upon the assumption that all candidates have been satisfactorily instructed in the subjects above enumerated

The minimum educational requirement to enter an approved school is one year of high school or its equivalent

143 Hospital Training Schools are now registered with the Education Department as approved schools. In 1914 there were 3,976 students training in approved schools, while in 1924 there were 5,246—an increase of 31 per cent. In this same period the increase of occupied beds in the hospitals was 29 per cent.

Over a recent period of twelve months, 767 pupil nurses left training for various reasons. Fifty-six per cent of these left on account of dislike of work, incompetence, not fitted for work, unable to carry theory, and misconduct. The percentage of those unable to carry theory was slightly under 9 per cent of all who left school. However, 90 per cent of those who left from this cause were admitted to the schools on only one year of high school or its equivalent.

There are now eighteen Hospital Training Schools in the State not registered. There are eight Registered Schools for training "Attendants." It is estimated that 1,000 pupils are training in non-registered schools. Of this number, the larger share is in the State Hospital group.

Since 1903 the Department has issued a total of 43,903 registered nurse certificates of which about 25,000 were granted through examinations. Over 17,000 were issued between 1920 and 1923 under the waiver clause. Included in the above are 8,346 graduate nurses from other states. In addition, the Department has issued 1,462 certificates to graduates of the State Hospital Schools for the care of the insane.

From the above figures it is readily seen that a generous proportion of nurses, now in actual practice, are *not* the product or end result of the training required by the Department, but are holding the R. N. certificate through the waiver clause demanded for those who became nurses before 1920. This fact deserves special emphasis when discussing the present program of supervision of registered nurse training. Manifestly, the Department cannot be condemned for the character and general attitude of registered

nurses who were educated and trained outside its domain.

The specific duty imposed upon this committee was to confer with the Department of Education with a view to legislation along the lines suggested by resolution of Erie County and revised by the Reference Committee. We are able to report that such conferences were held and that the attitude of the Department was one of willingness to confer with authorized committees of the Medical Society of the State of New York for the purpose of modifying any part of the curriculum when such seemed best for the promotion of nurse training and establishing better relations between the nurse and the Medical profession.

We ascertained that all of the suggestions contained in both the resolution and the Reference Committee report could be carried out, if wise, without resorting to legislative act. The present law appears to be sufficiently elastic to permit this.

Whatever differences may now exist between the Education Department and certain groups of physicians are purely due to a wide variance of ideals and opinions as to the status of the trained nurse.

When the Department established a definite curriculum designed to give adequate education and practical bedside training to create a trained nurse, it made at the same time ample provision for the training of young women to be known as Trained Attendants. The amount of training of this latter group corresponds very closely to that proposed as an abbreviated course in the original Resolution and Reference Committee report. As a matter of fact, it is possible for any hospital, at the present time, to conduct this short course of training without any unreasonable restrictions from the Department. However, the graduates of these will not be allowed to sail under false colors by calling themselves anything else than "Trained Attendants" or "Nurse," as they have not had sufficient education or experience to warrant being called by any other name.

The matter of employing a descriptive title should always take into consideration the accepted meaning of the words from long usage in our language. Such terms as trained, certified or graduate nurse imply and suggest thorough training, efficiency, dependability and knowledge born of theory correlated with experience. In a recent bulletin of the Erie County Society an entirely new set of technical terms was suggested, viz "qualified nurse," with a privilege of using the degree "Registered Qualified Nurse," and "master nurse," with the privilege of using the degree of "Registered Master Nurse." Each of these degrees to indicate a specified amount of training and varying proportions of theory and practice. The chief criticisms of this nomen-



clature are that they are entirely new and untried terms, without equivalent in other states, and that the public would be unable to comprehend their technical significance or differential values. To add these new terms to the category would only serve to further confuse and perplex.

It is the opinion of this committee that the accepted uses of the words "trained," "certified," "graduate," and "registered" nurse should be continued as in the past to indicate a certain type of intelligent woman, capable of attending the sick and co-operating with the attending physician, and that the words "trained attendant" should stand for a woman who has had a relatively briefer course, principally confined to bedside service.

We believe there are grounds for honest differences of opinion as to the amount of so-called theory to be included in the instruction of the trained nurse.

From the State Education Department we ascertained that its idea of including in the curriculum the amount of theoretical instruction now prescribed (only 7 per cent of the total time) is that the public has a right to expect the nurse to know something of *why* as well as *how* to carry out nursing procedures, observe symptoms and appreciate their significance.

After a careful survey of the various subjects included in the theoretical instruction, we feel that none could be entirely omitted, but that it would be desirable to modify the amount and degree of some. A perusal of the suggested and required textbooks shows beyond all doubt that the nurses are now required to study from essentially advanced scientific works, far beyond the practical needs of a trained nurse and of such a character that, to properly assimilate them would require entirely too much time and energy of the student. We believe the ends to be obtained in educating the nurse could be accomplished by more simplified forms. We received assurances from the Education Department that this important matter would be given careful consideration during the process of revision of the syllabus and that advice from a committee of the State Society would be welcomed and desired.

After reading several examination question papers submitted to the nurses by the State, the committee believes the general character of these should be more practical. It was suggested that physicians should edit these questions, but this is not the unanimous opinion of the committee. It should be borne in mind, however, that the physicians, themselves, as lecturers to the nurses have a definite responsibility in the selection and character of the instruction, and ought to be consulted, in an advisory capacity at least, concerning the questions to be asked.

We do not consider from our investigations that the present curriculum overeducates the nurse in the theoretical part, to such an extent that

she is useless in the sick room. As already stated, 93 per cent of her time is devoted to bedside training and experience. The Education Department insists that this shall be comprehensive and shall include actual nursing experience in surgery, internal medicine, pediatrics, obstetrics, dietetics and massage. It is not logical to say that an intelligent woman, drilled in these for the better part of two years will leave the training school unfit for service in the sick room.

There is not a physician who reads this report but would, in case of personal illness or sickness in his own family, select a registered trained nurse in preference to one of less training.

We do not agree that the present standard of education and training is responsible for a large proportion of registered nurses deserting the sick room for Public Health and Institutional teaching. According to a committee report of the Philadelphia County Medical Society, only about 15 per cent so elect. The real reason is that these activities offer distinct advantages such as definite and shorter hours, steady and assured income, and a certain degree of independence which every normal person craves. We fail to understand how any amount of training in the practical duties of a "real nurse" will imbue her with the idea that "the first and greatest function of a nurse is to care for the sick." No amount of moral suasion can overcome the practical fact that Public Health and Institutional service have very attractive features not possessed by plain nursing of the sick. As regards the depletion of nurse supply by these agencies, it must not be overlooked that they are of distinct economic value to the community, in that they reduce greatly the incidence of illness and infection which, if not prevented, would add infinitely to the general nursing requirements.

Possibly one of the most important topics brought to our attention by Reference Committee B was that referring to preliminary educational requirements for entrance into training schools. It was suggested that graduates of the 8th grade should be eligible for acceptance in the nurse training schools.

We are convinced that this would be unwise. It is manifestly unfair to admit young women into the nursing profession today who have not the necessary background of education to give them a fair chance of grasping the problems which they are undertaking. In view of the fact that high school advantages are available for nearly all today, whether living in towns or country, one may well inquire, do we want girls as nurses who are so devoid of ambition as to rest content with the limitations of the eighth grade which is usually attained at the age of 13 or 14? Statistics from the State Education Department are very enlightening on this topic. During the past four years 45 per cent of the students entering the approved training schools had from two

to four years of high-school instruction, and 90 per cent of the number of students leaving the schools because they were unable to carry the theoretical work were those admitted on a one year of high school or its equivalent

No one can appreciate the advantages of a good fundamental education better than the superintendents of nurses. They will invariably prefer a high school graduate if obtainable.

We all recognize that education has civilized the world and lifted us from barbarism. Generally speaking, it is commendable for all walks of life. This is particularly true of nursing.

This committee is unalterably opposed to lowering the standards of preliminary educational requirements. We are strongly in favor of raising the present requirements to at least two years high school and preferably a full high school course.

In this connection, it has recently been advocated to provide a preliminary course to nursing in our high schools—one including anatomy, physiology and hygiene, chemistry, home economics and such other subjects useful in a nurse's life. Once this course became generally established, the burden of education in these branches would be lifted from the hospitals. Furthermore it would serve to retain the attention and interest of prospective candidates for nurse training during the period between grammar school and the age of 18 when they first enter the hospital for training. We recommend that this project receive serious consideration by the Society.

The first paragraph of the resolution states "Deplorable conditions now obtain in the relations between the group of registered nurses on the one hand, the physicians and the general public on the other." With what follows, the purport is that the State of New York, through its Department of Education, is largely responsible for this situation on account of the high standards exacted of the schools of nurse training. It is implied that this training produces a super-nurse totally unfitted and unwilling to care for the sick. The suggested remedy is to substitute the present system by one which takes girls whose education terminated at fourteen years of age, and makes efficient nurses of them in a period of nine months to a year. Relative to this, a prominent member of Erie County has stated in a published article, "Any intelligent girl can be taught the proper nursing care of the sick in a year's time." If such were humanly possible, the committee feels it would be the most happy solution of the problem. We would again remind such, as advocate this or similar plans, that there is nothing in the present law to prevent them from making the experiment. We have assurances from the Education Department that there would be no official interference.

The committee cannot subscribe to the idea

that higher education is largely responsible for the "deplorable conditions" which we interpret to mean, the twelve hour schedule, scarcity of nurses, exorbitant fees, unwillingness to do domiciliary nursing, and selective choice of cases. To all of which might be added "the apparent growth of the mind on the part of many nurses to exercise the functions of a physician rather than a nurse." That these faults sometimes do exist must be admitted, but a critical analysis of them shows conclusively they are purely economic in origin rather than due to cultural influences.

The same complaint is heard from all parts of the country, regardless of educational restrictions. We do not believe the problem can be readily solved by quantity production of cheap nurses, that is, nurses of inferior education and limited training.

The present demand for nurses is tremendous, arising partly from necessity, but in no mean proportion from one of our greatest national faults, a love of luxury. The absorption of the supply of nurses by the rich, and too often by those who can ill afford it, when their cases do not require a "special" is a common event in hospital practice. Under the present system of exclusive use of a nurse's whole time by an individual case, it is doubtful if it were ever possible to fully satisfy the demand. A more intelligent and efficient disposal of our present supply of nurses would go far toward solving the problem of dearth. This can be accomplished, partly at least, by group nursing and by the medical profession frowning upon the use of valuable nurses on simple and uncomplicated cases. The employment of trained attendants in this type of cases should be encouraged.

The great increase of fees appears to be noted chiefly in the larger cities where there are greater demands for nurses and a larger wealthy class willing to pay the price when necessity arises. These two factors determine the price of everything. The ability to get the price plus the increased cost of living have prompted the nurse, like all other personal service groups, to raise the fees. At this point we desire to call attention to the methods of the commercial nurse registries. They derive their income by collecting a percentage of the first week's fees of the nurse. Needless to add they do not encourage moderate fees or long hours. By utilizing this type of nurse registry, the medical man has unwittingly fostered a vicious system. Many of these refuse to submit the qualifications of the nurses they supply, and it is known that they send incompetent and unregistered nurses who have no legal right to assume the name of trained nurse.

The hospital or professional nurse registries send only trained nurses or trained attendants as such, and in some instances, send practical

nurses but properly labeled. They charge only a nominal fee annually and endeavor to exert a proper influence over their registrants as regards reasonable fees and service

Bearing on this topic, we refer to the recommendations adopted by the New York State Nurses' Association

(a) That professional registries change their names to that of Official Registry

(b) That where there are two or more registries in a community, they combine to form one central registry

(c) That the central registries register and send out for employment licensed nurses, trained nurses (State Hospital graduates) trained attendants, and practical nurses, all groups to be controlled by certain rules and regulations applicable to their own amount of experience

(d) The registry board shall be composed of licensed nurses of the State of New York and there shall be an Advisory Council to the Governing Board representing the medical profession and the laity

The above excerpts from a set of resolutions indicate that the nurses, themselves, are trying to remedy an evil we are all aware of and anxious to correct

We commend to the medical profession an attitude of co-operation in this movement instituted by the nurses

The twelve hour schedule presents the greatest difficulties and a problem which we frankly admit we are unable to solve. It is natural that a nurse should endeavor to adjust her life to that of her sister who gains her living in other fields, and is able to do so with less hours of labor and often under more agreeable surroundings. A fair regard for the health and physical endurance of the nurse should enter into the equation. Patients and some physicians have been most unreasonable in their demands upon the nurse in respect to hours of service, and doubtless these facts have contributed in no small measure to the present movement for shorter hours. We deplore, however, an arbitrary rule or demand for a limit of twelve hours duty. We feel that circumstances

and reasonable schedules to fit the individual case should determine in every instance

As regards disinclination to do certain types of nursing and assumption of the role of the physician, we believe these to be less frequent than asserted. They are, in any event, an expression of the personality of some individuals and beyond the power of anyone to control

After all, the nurse is quite as much concerned in these matters as the physician or the public. She is entitled to be heard, and should have opportunity to give expression to her ideals of training and of service after being trained

In regard to increasing the number of nurses for domiciliary service, much can be done both by the public and physicians to make this department of nursing more attractive than it is at present.

The committee believes a more general use of the "Trained Attendant" in ordinary and simple cases is desirable, and it is suggested that the small hospital which in the very nature of things cannot hope to conduct schools for registered nurses, might profitably conduct schools for "Attendants" and endeavor to dignify this type to the place it deserves in general scheme

We regard the Nurse Problem possibly the most important economic questions now confronting us. We therefore recommend

(a) That a Nurse Committee be appointed by the President to work in conjunction with the Committee on Economics to study the problems of the nurse and report annually or oftener to the Society

(b) That the same committee be authorized to confer with the State Education Department on matters concerning Nurse Education, and especially on that which concerns the proper balance of theoretical and practical training and instruction

Respectfully submitted,

ARTHUR W. BOOTH, *Chairman*,  
GEORGE W. KOSMAK,  
ALBERT T. LYTLE.

April 15, 1925

The Reference Committee recommended that a committee be formed to continue the study of the nursing problem (see page 814)

## REPORT OF THE COMMITTEE ON MEDICAL ECONOMICS

*To the House of Delegates*

At the closing of the meeting of the House of Delegates in 1924 this Committee was left with seven economic problems for its further consideration and report

They were

- 1 The Work of the New York State Council of Rural Workers
- 2 Nursing Problems
- 3 Health Insurance
- 4 Workman's Compensation
- 5 The Medical Practice Act
- 6 Health Centers with special reference to the plan adopted by the Medical Society of the State of California
- 7 Pay Clinics

During the current year the increased activities of the advocates of birth control have attracted notice and your committee has had the subject under consideration

A special committee was appointed by the House of Delegates to consider the nursing problem. As this committee has not communicated with the Committee on Economics, we assume that its functions were concerned with specific problems and that our reports will not conflict

1 The work of the New York State Committee of Rural Workers was participated in by your committee. The group forming the Committee of Rural Workers was acting under direction of the General Education Board and the specific problems were those associated with the distribution of physicians in New York State, a part of a general survey covering the United States. In its completed form the report was published by Drs Lewis Mayers and Leonard V Harrison, under the title "The Distribution of Physicians in the United States"

Aside from general discussion within your Committee, the entire work was done by one member, Dr Stanton. When it is understood that data such as these form the bases of the activities of social welfare workers you will realize that the methods of the collection of these and similar data as well as the very nature of the data is wholly subject to the discretion of the collector. Therefore that those unaccustomed to or for any reason unfamiliar with data bearing upon any specific problems and to their evaluation are open to mistakes which may provide useless and misleading statistics. The importance of the work done by Dr Stanton in advising in the above particulars is difficult to overestimate. Your committee urges that this Society go on rec-

ord as seeking to cooperate in any preliminary work of a social character which may be undertaken by any established and ethical group of social workers. In making this recommendation your committee recalls that when it requested the privilege of following the work herein reported, the House of Delegates, by specific action, restricted its activities

2 The Nursing Problem. Before submitting its report the chairman of your committee wishes to correct an error in the report of last year. The report contained the statement that an advance in prices was made at the direction of the State Society of Registered Nurses. This report was so made to the chairman by members of one of the component parts of the state organization, when, as a matter of fact, the action was taken only by the local Society and not recommended by the State Society of Registered Nurses.

The nurse problem is not unique in the field of supply of necessities of all kinds, it is merely the furnishing of adequate nursing care at a cost which can be met. The preparation of the nurse is, perhaps, somewhat more complicated than that of other commodities, but the same factors influence for or against. They are getting the raw material, shaping it for distribution and delivering it at the market.

According to the report of the Schools of Nursing, issued by the State Department of Education, the raw material is not lacking, the number of pupil nurses entering training in 1924 was 31 per cent more than in 1914, while the number of occupied hospital beds, which means teaching facilities, have increased only 29 per cent.

Primarily the problem is the preparation of our raw material for the market. There is no difference of opinion regarding the shortage of nurses. Accepting the above statistics there is only one answer to the problem, we must have more training facilities.

The simplest, cheapest and promptest remedy for this deficiency is shortening the course of study and thus enabling the training of a greater number of pupil nurses. Your committee is unable to quote the exact preponderance of the three-year course, but it is considerable. An immediate reduction of the course to two years in all training schools would increase facilities tremendously.

Further study of the figures given in the above mentioned reports shows that 14 plus per cent of girls who enter training in 1924 have dropped from the rolls for one reason or another. Fifty-six per cent of the number left training for reasons which, it would appear,

could have been foreseen, they either disliked the work, were not fitted for it, were incompetent, or guilty of misconduct. More care on the part of the admitting officers would therefore increase the effectiveness of our present facilities very considerably. The second method for increasing training facilities is, obviously, the building of more training schools. Just as obviously this will be a matter of slow growth, a feature of the general evolution of the hospital, not a problem of economists.

Unfortunately there are wide differences of opinion regarding the wisdom of such a move. But these differences are of scientific interest only and our need is too great for progress to wait upon scientific moot points. They can be just as interestingly discussed after the system is changed.

Many suggestions have come from as many sources, presenting methods by which nursing courses may be shortened. Last year your committee stated its opinion that the specific problems of nurse training are local. While our survey is far from complete it appears that more than 90 per cent of graduate nurses who continue practice remain in the districts in which they were trained.

This being the case the inference is that the training in the local schools, representing as it does the scope of the practice of the physicians working in the community, is sufficient to meet all requirements. Today the State Board of Regents requires pupil nurses in schools in small cities which do not include certain special nursing in their curricula, to spend certain months of their undergraduate lives in the schools of larger cities, pursuing the courses not given in their own schools. For the reason stated it is very improbable that the nurse will ever be called upon to utilize this special nursing. Such courses are practically economic losses, the nurses are absent from their own schools at periods in their training when they would be most useful, and are using room in larger schools which might be utilized to some practical end.

It does not appear from statistics that there is any general shortage of applicants for nurse-training. The subject of preliminary education is, therefore, not important at the present time. Even those who advocate reducing the educational requirements for admission to nurse training do not refute the fact that education is desirable if it can be had without interfering with the number of pupil nurses.

We find in occasional localities, however, that educational requirements do disbar some desirable material.

As a remedy for these conditions, remem-

bering our opinion that the problems are local, we advise that the system of entrance requirements be revised and examinations held, as is now done for Civil Service positions, in which other qualifications than education are given sufficient proportion of the total required minimum mark so that lack of high school education cannot in itself disbar the applicant from entrance to training schools. We present this as a recommendation to the House of Delegates.

In the matter of special nursing your Committee considers it an advanced subject and very probably and preferably post-graduate work. We believe that such classification leaves the choice of special subject to the nurse and thereby guarantees a much higher type of special nursing than it is possible to secure under present conditions. The economic loss at present entailed, as previously stated, is eliminated.

3 Health Insurance. Your Committee is of the opinion that Health Insurance, as such, is a dead issue in the United States. They are, however, many indications in the activities of various groups of social workers that Unemployment Insurance of some type is being sought. Care of the unemployed sick has been one phase of the subject which has had considerable attention and which will continue to be an important part of the whole subject. The stand taken against health insurance by the medical profession in New York State undoubtedly had a far reaching influence and did more to unify the profession than any other one thing in the history of medicine. It is not conceivable that any serious effort will again be made to subsidize medicine as the hand-maiden of the public. But it is essential, if we are to maintain the position which we have won by our unified fight, that we should show ourselves willing to become a deciding and guiding factor in any social efforts which we consider will be of benefit to the public of the State. We recommend, therefore, that if any definite effort is made toward the above ends this Society indicate its desire to be considered willing to participate in general discussions and to act in an advisory capacity where occasion offers.

4 Workmen's Compensation. Last year your committee expressed itself opposed to the proposed amendment to the Workmen's Compensation Law enabling free choice of physicians by the injured, giving the reason that, while the present system was open to irregularities, the employer and interested insurance carriers were in better position to select competent surgeons than the individual employee. This was not approved. The

amended bill presented at the last session of the Legislature, giving free choice of physicians, was ably supported by the Committee on Legislation. The bill was defeated.

Your Committee acknowledges the importance of the general principle involved. That is that the best interest of our form of Government is served by the fullest exercise of personal liberties, but in this instance a survey made of an up-state county decided your committee that the position which it took and continues to hold is productive of most good.

We find, in this instance, that the objects aimed at, i.e., the promptest return to work of the injured person, with a minimum of permanent damage from his accident, are probably being attained at present. The opinion is based upon the relative amount of surgical experience of all the practitioners in the district and that of those few who were selected by the employers to do the bulk of the work. Added to this your committee was able to estimate roughly the distribution of the general practice amongst the several physicians. From these inquiries, we find that, provided the majority of injured persons sought the services of their family physicians which we assume that they would do, they would fall into less expert hands than they do now under the present arrangement.

We repeat, therefore, our recommendations of last year that the amendment to the Workmen's Compensation Law permitting free choice of physicians is not desirable.

5 The Medical Practice Act. Members of your committee disagree concerning the advisability of the Medical Practice Act as embodied in the Karle-Dunmore bills presented at the last session of the Legislature.

Three opinions were presented. One in favor of the bill. One opposed to it on the ground that it taxed the medical profession for the benefit of the public and put upon it certain responsibilities of law enforcement which were unjust. Those in favor of the bill, including the chairman who acted as chairman of the committee which made the original draft of the bill a number of years ago in co-operation with the State Department of Education, favored it because it appears to be the only method of gaining the full support of the State Board of Regents and prompt prosecution of illegal practitioners. While taking this position for the reasons stated, the chairman feels that the blame for the present unfortunate conditions rests entirely with the Board of Regents. That body has been placed in supreme authority by law. It has accepted its obligation only in part. It has made certain definite regulations governing the granting of licenses to practice medicine. Perhaps wisely and

with the advice and approval of some of our medical colleges, but certainly very positively and at times even arrogantly, it has from time to time increased the requirements necessary to registration. It holds the power of revocation of license and exercises it. In brief, it holds the practitioner of medicine in the hollow of its hand and then it sits quietly down and refuses the physician who has complied with all its regulations at the expense of great labor and money, protection from the competition of illegal practitioners, of the followers of cults and of criminals of similar activities. Except that the majority of mankind is inherently decent there would be no legal practitioners of medicine for the Board of Regents to license. Certainly they offer no inducement to a man to follow a prescribed course of study and live up to regulations while the individual who has no sense of decency or of responsibility to his fellow men can enjoy greater financial gains in doing the same which the licensed physician is doing and without the slightest interference—unless he happens to kill a patient or otherwise attract the attention of the police.

The law places the prosecution of illegal practitioners with the district attorneys of the several counties. It does not, however, compel him to go out and get evidence until a case is presented to him. The moral responsibility for procuring and presenting evidence rests upon the Board of Regents. It is its duty to and is within its power to rid the state of those who continue to menace the public health by their illegal activities. The practical attitude of the representatives of the Board of Regents has been that until the medical practice act could be so amended that the medical profession could furnish the first information of illegal practitioners, the Board would take no action. It is only after years of personal effort to secure the passage of better medical legislation and an act similar to the Karle-Dunmore bill of last session that the chairman of your committee has reached the conclusion that such legislation is next to impossible, and that attempted co-operation of the Medical Society of the State of New York with the State Board of Regents to attain such ends is futile. He takes this opportunity, therefore, to present his views for which he assumes sole responsibility. Whether the balance of the Committee would subscribe to the foregoing or not has not been ascertained.

Opposition to the Karle-Dunmore bill from another member of the Committee is offered on the basis of previous experience in failure to enforce medical practice acts and the results of such failure. Such efforts have usually meant that the prosecuted practitioner easily assumed the role of martyr and the reaction has done more harm than good to the medical profession. He offers as a remedy for the existing evil the

passage of a law making possible civil suit for mal-practice where injury is done an individual by an illegal practitioner. He cites the recent case in Utica of *Brown vs. Shane*, a chiropractor, in which a verdict of \$10,000 was obtained against Shane for mal-practice. In this case Judge Edcomb ruled that practicing medicine without a license is in itself evidence of negligence, and that acceptance of treatment by an illegal practitioner is not in itself contributory negligence. Whether this will stand an appeal is, of course, uncertain, but whether it is good law or not, it is good sense that where the State permits such practitioners to openly advertise and pretend to cure disease it can not be expected that the average citizen can be aware of the danger which he runs in consulting such a person. The English law has long placed the illegal practitioner in a position where he is practically unable to defend himself against mal-practice suits and the general results have been satisfactory. Dr. Stanton, of your Committee, proposes the following amendment to the Medical Practice Act

"No provision of the act shall be construed as in any way preventing an individual who may have been injured as a result of unskilled advice or treatment entering suit for civil damages against a person practicing medicine who has not complied with the requirements for licenses as defined in this act. In case such a suit is instituted against one practicing medicine without a license the fact that the defendant has not complied with the educational and other requirements for licenses shall be interpreted as presumptuous evidence of negligence on the part of the defendant."

The above is subject to legal phrasing

The adoption of such an amendment as that practically removes any defense which the defendant may assume to have

The menace in malpractice suits is appreciated by B. J. Palmer, Secretary of the Universal Chiropractors' Association, in an open letter to members of that cult in which he urges them to join the Association, and thus avail themselves of the services of attorneys especially qualified to defend such activities. It is the opinion of your committee that this foregoing is worthy of serious consideration.

**6 Health Centers** The situation so far as state control of health centers is concerned has remained unchanged.

It will be recalled that three years ago your committee reported on the resolution passed by the Medical Society of the State of California requesting cooperation of the members in a plan which practically made every physician's office a "health center." By this plan each member was to undertake to see that any one calling upon him, regardless of the appli-

cant's financial status, should be put in the way of securing adequate medical care. In this manner it was expected that it could be demonstrated that no person or group of persons or any organizations or State department need be interposed between the physician and the patient. The plan reduced the adequate care of the sick to the simplest possible form, and, should it prove successful, would be one great step toward complete control of all medical activities by physicians in active practice, a most desirable thing from a humanitarian as well as an economic viewpoint. Your committee last year reported progress in California. That is all it can do this year because the secretary of California Medical Society has not made a final report. As we view this method we consider that one of the practical obstacles in its progress is difficulty of advertising. It is going to take the people who would benefit most a long time to know what they can expect.

Today we are awaiting the development of a great medical center. If the prestige of associations with educational institutions and educators of first rank can guarantee success, the Columbia College-Presbyterian Hospital Center must succeed.

Unlike other medical centers this presents no economic problems for the medical profession. Its educational position is beyond question and it should be regarded as the real beginning of America's rise to its logical position as the medical center of the world. It would be a remarkable achievement if some association of the State Society with the center could be brought about. If it could be no closer than the mere meeting of our scientific sections at the Center the influence upon medical practice in the State would effect more rapid advances than could be expected from almost any other plan with which we are familiar.

**Pay Clinics** Under this heading we have previously considered the Cornell Medical College Clinic. While every attempt has been made to avoid competition with physicians in private practice, there are some points at which such competition occurs. Complaints from physicians have become less frequent, however. We are unable to judge whether this is because the newness is wearing off or because the institution has become generally accepted as another economic evil which has to be endured. Your committee has no recommendation to offer. It is our opinion that, at present, we cannot offer our official endorsement of the movement. The report for the current year has not been received.

**Birth Control** During the current year the advocates of birth control have increased their

activities The strength behind their legislative efforts was not inconsiderable, though at no time was there any serious possibility of their bill being enacted The arguments for birth control are too well known and of too little real consequence to require discussion in this report Your committee recommends, however, that the House of Delegates record itself in opposition to the measure

**Occupational Instruction** The Federal Government is enlarging its staff of instructors for manual training amongst—or those who are, for one reason or another, entitled to such training This field offers an opportunity for both men and women who wish to enter a field which is practically a branch of nursing The medical profession can be of assistance to the Government by advising eligible persons of the existence of this work Training in this field will prepare for private vocational work, especially among the insane, where the value of this form of therapy is constantly receiving more recognition

**Fee-Splitting** A communication on this subject was received by your Committee from the Bronx County Medical Society, but after investigation your Committee considered that this matter had better be presented by the delegates from Bronx County and have advised that body to that effect

We reached this conclusion because we are unable to agree as to proper recommendation to the House of Delegates The college of surgeons has, of course, the privilege of making whatever rules it may for its own members, but it is our judgment that the Bronx County Society is following the proper course in asking the House of Delegates to pass upon a question of ethics As a matter of custom the American Medical Association, and its constituent state societies, has the authority to establish a code of ethics, and it is very

questionable if any special society is not arrogating to itself privileges to which it has no legitimate claim when it attempts to promulgate an ethical code It may make rules for its own members only It is the opinion of the majority of your committee that matters of ethics interesting special societies should be introduced only through the House of Delegates of the American Medical Association, where, if favorably passed upon, they will become parts of the code of ethics of that body, to which all state societies subscribe

In the opinion of your committee a grave question of ethics is involved in the publications, in lay journals of the articles referred to in the communication from the Bronx County Society If the articles were either prepared or sponsored by the American College of Surgeons it is the majority opinion of your committee that the college is not above reproof We are, however, unable to decide upon this point Some members of your committee are sure that the College was unaware of the publication, and others, claiming to speak with definite knowledge, state that the articles were inspired by that body

Because of these differences your committee is only prepared to recommend that this matter be given the serious consideration of the House of Delegates

The foregoing is respectfully submitted,

Henry Lyle Winter, *Chairman*  
J. Richard Kevin,  
George W. Kosmak  
William H. Purdy  
Edwin MacD. Stanton

The Chairman of the Committee on Medical Economics has an individual report to submit As this contains no recommendation for action of the House of Delegates, he begs the privilege of presenting same through column of the Journal

Report referred to Council



## REPORT OF COMMITTEE ON POST-GRADUATE MEDICAL INSTRUCTION

### *To the House of Delegates*

The Committee on Post-Graduate Medical Instruction reports that they have considered carefully much data on Post-Graduate Medical Instruction in the different states and have had informal talks with officials in the State Education Department and State Department of Health who are decidedly in sympathy with this movement and who would be helpful if some method of graduate instruction should be put into action

In 1912-1913 Germany inaugurated a system of Post-Graduate study University Professors visited remote country districts and delivered clinical lectures to physicians who could not afford to study away from home This scheme was to have been a prominent feature at the International Medical Congress which terminated dramatically in London in August, 1914

### WISCONSIN

The University of Wisconsin began actual graduate medical teaching in September, 1917, in ten of the largest cities of the state This work has continued most successfully and has been increased in its scope from year to year "Interest has grown and there is no question as to how the physicians throughout the state feel about the work"

### PENNSYLVANIA

The University of Pennsylvania with the Medical Society of the State has initiated a plan of University Extension Post-Graduate Instruction

Under the plan a sharp distinction is drawn between the character of the teaching in Philadelphia (and perhaps later, Pittsburgh) and that conducted in other extension centers "Physicians throughout Pennsylvania have shown the keenest interest in our plan of University Extension Post-Graduate Instruction" The need and the desire both exist and the difficulties met all center around the question of expending enough money to produce true efficiency

### NORTH CAROLINA

In 1916 Post-Graduate courses in pediatrics were given in twelve communities of North Carolina under the auspices of the State Board of Health and the Medical Department and Extension Division of the University of North Carolina Two instructors from Boston and Chicago respectively were appointed and each assigned to six centers which were covered daily in rotation every week for four months

The war interrupted further work and it was not until 1921 that it was again taken up

Internal medicine was now chosen and two

instructors from outside the State (Boston and Chicago) were assigned to two circuits of six centers in 1922 for 12 exercises

"The work has shown a steady growth in both interest and attendance Doctors have had to drive on the average twenty miles each way in order to attend lectures and clinics" "Our work has passed the experimental state and we know that there is a real field for this kind of program We expect to put on two circuits covering twelve centers every Summer"

### BROOKLYN EXTENSION PLAN

Joint Graduate Education by the Medical Society of the County of Kings and the Long Island College Hospital

(1) Practical lectures at 5 p m for one hour on Fridays during a spring and a fall term

"Each talk was simple, practical, clinical and fundamentally sound There was no discussion but questions were encouraged The program met instant and lasting success At every meeting the auditorium was filled to overflowing and at some lectures a great many turned away"

(2) Graduate Courses Seven intensive and twenty-seven extensive courses "Our experience indicates that this type of work is appreciated by the profession" "Our next problem is its extension into the dispensary and also some consideration of the re-arrangement of hours for the greater convenience of the busy practitioner" "We are also sensing a demand for more advanced work of an intensive character which it is our hope to meet"

Your committee feels that as education in medicine is never finished and as a large majority of the profession desires to keep pace with the science of medicine which in the last twenty years has undergone a development probably not equalled or even approached by any other science that some determined effort must be made to render the practical results of this scientific progress available to practicing physician—the man behind the gun

The value of the discoveries by splendidly endowed research laboratories and well equipped hospitals for the direct benefit of mankind is inestimable and yet how little of this knowledge seeps through to the practicing physician and how much is therefore out of the research of the public In spite of millions spent in research no effort has been made to carry the great truths discovered in medicine to the cross-roads physician (both in the country and city) who is every day striving with all his might to fight off death and to relieve suffering

Continuous and effective education of the

practicing physicians must be recognized as the greatest possible contribution that can be made to the public health. This committee therefore believes and recommends that the Medical Society of the State of New York should take immediate steps to organize an efficient and practical system of graduate medical instruction which will place within reach of every physician for the service of his patients and the state all the usable results of the tremendous progress constantly being made by medical science.

This committee also urges and recommends that a special committee be appointed with power to put into immediate effect a plan of

graduate medical extension instruction which will meet the greatest need today in the medical profession and which will place this, the Empire State, in the van of constructive and efficient medical service.

Respectfully submitted,

ANDREW MACFARLANE,  
*Chairman*

GRANT C. MADILL,  
JOSEPH C. PALMER,  
CHARLES STOVER,  
GROVER W. WENDE

The recommendations were approved (see page 807)

## REPORT OF COUNSEL FOR THE PERIOD FROM MARCH 1, 1924, TO APRIL 1, 1925

### To the House of Delegates

Counsel herewith submits his report for the period of thirteen months since the last annual meeting of the House of Delegates covering the various phases of his activities.

TABLE I

	Suits Instituted	Suits Dis- posed of
Mar 1922 to Apr 1923	121	40
Apr 1923 to Mar 1924	108	56
Mar 1924 to Apr 1925	181	129
<b>Totals</b>	<b>410</b>	<b>225</b>
Excess of suits instituted over suits dis- posed of from Mar 1922 to Apr 1925		185
Pending Mar 1922		99
Pending Apr 1925		284

An examination of this table indicates that since March, 1922, despite the fact that we have disposed of 225 suits, that there has been an excess of suits received over those disposed of, of 185. This means that there is a constantly increasing congestion of these cases in our office and that until the number of cases received drops to a level with our present capacity to dispose of the business, that our calendars will remain clogged. To dispose of the present pending calendar, were no new cases to be received, it would take approximately two years with two active trial lawyers participating in the trial of the cases. It is our plan to add a third trial man in our office to assist in cutting down this pending calendar.

TABLE II  
COMPARISON OF NUMBER OF SUITS INSTITUTED AND  
DISPOSED OF

	Instituted 1923- 1924	1924- 1925	Disposed of 1923 1924	1924- 1925
1 Fractures, etc.	17	14	1	25
2 Obstetrics, etc.	11	26	7	20
3 Amputations	1	0	0	1
4 Burns, X-ray, etc.	11	16	3	9
5 Operations—abdominal, eye, tonsil, ear, etc.	25	36	14	21
6 Needles breaking	0	4	1	2
7 Infections	2	9	6	7
8 Eye infections	1	2	1	3
9 Diagnosis	7	10	4	8
10 Lunacy commitments	0	2	6	3
11 Unclassified—medical	13	20	5	8
12 Loss of services, wife, child	20	42	8	22
<b>Totals</b>	<b>108</b>	<b>181</b>	<b>56</b>	<b>129</b>
<i>Further comparisons</i>				
Action for death	7	15	5	10
Infant actions	8	17	5	15
	<b>15</b>	<b>32</b>	<b>10</b>	<b>25</b>
<i>How disposed of</i>				
Settled				7
Dismissed, discontinued or tried (verdict for defend- ant)				92
Judgment for plaintiff				00
Dormant cases—marked off ac- tive list				30
<b>Totals</b>		<b>181</b>		<b>129</b>
Pending on March 31, 1925		<b>284</b>		

An analysis of the cases instituted and disposed of according to the different types is usually of interest to the physicians. It will be noted from examining Table II that the number of death actions last year was about twice that of the previous year and the actions by infants also twice that of the previous year, and similarly with actions based upon obstetrical and gynecological procedures, ac-

tions based upon operations increased 40 per cent, those arising by reason of infections were four times as many as the previous year, actions based upon diagnosis increased 40 per cent, the division of actions between general practitioners and specialists is about half and half, there being 92 actions against specialists and 89 actions against general practitioners, whereas in the disposition of cases we disposed of 55 actions against specialists and 74 against general practitioners, whereas fractures have always been a fruitful source of malpractice actions, the past year has shown a decrease over the previous period in actual numbers of cases received. This fact is quite significant when one considers that the normal increase in cases received during 1924-1925 over the previous year was about 70 per cent and at that rate the normal number of fracture cases to keep pace with such general increase in the number of cases would have been twice the number that actually were instituted. This shows a healthier condition from a malpractice standpoint in the fracture field. The increase in the obstetrics is a little more than normal in comparison with the general increase. The increase in suits based on infection is quite out of proportion with the general increase.

In the disposition of cases, it will be noted that no case was lost, although 7 were settled and 92 were disposed of by dismissals or successful trial. The cases that are marked dormant, numbering 30, that are marked off the active list, are a number of old actions which have not been moved for trial by the plaintiffs and probably never will be. These were marked off as a merchant would mark off bad debts, so as not to carry them over each year.

TABLE III  
APPEALS

	1923 1924	1924 1925
Appeals taken	9	3
Affirmed for plaintiff	0	0
Affirmed for defendant	0	0
Plaintiffs judgment reversed	0	2
Defendants judgment reversed	0	4
Withdrawn	0	2

It will be noted in Table III that three appeals were taken during this period, and that cases which were lost in the lower court were won on appeal in two instances, and cases won in the lower court were reversed on appeal and new trials ordered in four instances, and two appeals were disposed of by plaintiff withdrawing the appeal, so that there was a total of eight appeals disposed of during the last year.

By reason of the showing that we have been able to make in the past year, despite the substantial amounts that have had to be paid in the settlement of the seven cases mentioned, it will not be necessary to raise the rates for the

group insurance during the coming year. This group insurance plan is being carried out in accordance with the understanding originally had, to the end that there may be made available to the members of this Society malpractice indemnity of the highest type based upon actual cost computation and backed by a responsible company.

TABLE IV

Counties	1925	
	No. of Members in County Society	No. of Members Insured Percentage Insured
Albany	225	126
Allegany	33	8
Bronx	631	275
Broome	99	51
Cattaraugus	45	27
Cayuga	52	32
Chautaugua	82	31
Chemung	49	33
Chenango	35	16
Clinton	32	16
Columbia	36	19
Cortland	25	11
Delaware	20	1
Dutchess-Putnam	115	51
Erie	653	443
Essex	23	11
Franklin	51	17
Fulton	37	23
Genesee	23	9
Greene	22	12
Herkimer	55	30
Jefferson	69	38
Kings	1,570	757
Lewis	14	5
Livingston	29	10
Madison	32	15
Monroe	434	235
Montgomery	52	24
Nassau	105	51
New York	3,338	1,735
Niagara	85	48
Oneida	189	77
Onondago	312	164
Ontario	71	39
Orange	104	65
Orleans	17	3
Oswego	53	33
Otsego	42	24
Queens	244	122
Rensselaer	106	56
Richmond	74	39
Rockland	39	22
St. Lawrence	58	19
Saratoga	44	27
Schenectady	109	91
Schoharie	18	7
Schuyler	11	5
Seneca	21	4
Steuben	75	37
Suffolk	108	40
Sullivan	29	18
Tioga	27	9
Tompkins	59	22
Ulster	64	25
Warren	38	25
Washington	40	17
Wayne	36	16
Westchester	308	135
Wyoming	26	9
Yates	17	13
Totals	10,410	5,323
		51

It will be noted from this table in comparison with the total number insured under the group plan in March, 1924, that it shows a net increase or gain of 584 over the previous period

TABLE V

COLUMNS A —Being Limits of Liability for Any One Claim or Suit

LINES B Being Limits of Liability for All Claims or Suits During Any One Policy Year

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$40,000	\$50,000
\$15000	24 00	29 76	34 56					
20000	25 20	30 96	35 76	38 88				
25000	26 16	32 00	36 72	39 84	42 72			
30000	27 12	32 88	37 68	40 80	43 68	45 84		
35000	28 08	33 84	38 64	41 76	44 64	46 80		
40000	28 80	34 56	39 36	42 48	45 36	47 52	50 16	
45000	29 52	35 28	40 08	43 20	46 08	48 24	50 88	
50000	30 00	35 76	40 56	43 68	46 56	48 72	51 36	52 08
60000	30 96	36 72	41 52	44 64	47 52	49 68	52 32	53 04
70000	31 92	37 68	42 48	45 60	48 48	50 64	53 28	54 00
80000	32 64	38 40	43 20	46 32	49 20	51 36	54 00	54 72
90000	33 36	39 12	43 92	47 04	49 92	52 08	54 72	55 44
100000	34 08	39 84	44 64	47 76	50 64	52 80	55 44	56 16

During this period, your counsel has prepared for publication in the Society's Journal, articles in the nature of editorial comment of interest and benefit to the members. The editorials include the following

"Physicians' and Surgeons' Liability Insurance",  
 "Liability When a Physician Leaves a Case in Charge of Another Physician",  
 "Chiropractor Held Liable for Malpractice",  
 "Chiropractor Convicted of Manslaughter",  
 "Interpretation of the Law in Malpractice Cases",  
 "Medical Societies and Their Relation to the Problem of Medical Licensure",  
 "Recovery of Compensation by Physician",  
 "Drop a Nicoll Bill in the Legislative Slot and Receive a Doctor's Degree",  
 "The Nicoll Chiropractic Bill",  
 "Medical Testimony and Comment upon Judge's Charge in a Malpractice Action",  
 "Registration and Other Features of the Karl-Dunmore Bills",  
 "March Fourth at Albany",  
 "Conviction under Harrison Narcotic Law and Its Effect on a Physician's License",  
 "Five Thousand Physicians Should Think This Over",  
 "The Mission of Organized Medicine Today",

Some of the Cases which have been disposed of by Counsel in the past, have been digested and published in the Journal, among which were the following

"Swallowing Foreign Body — Resultant Bronchial Pneumonia and Death",  
 "Claimed Improper Prescribing of Tanningen for Child Suffering from Diarrhoea",  
 "Colles' Fracture",  
 "Breaking Needle in Lumbar Puncture",  
 "Needle Breaking in Pleurisy Aspiration Complicated with Empyema and Pregnancy",  
 "Alleged Abandonment During Confinement",  
 "Treatment by Immobilization of Tubercular Ankle Results in Suit",  
 "Amputation of Finger—Defense of Workmen's Compensation",

"Appendicitis—Alleged Delayed Diagnosis",  
 "Gauze Claimed to Have Been Left in Abdominal Cavity on Performance of Appendix Operation with Resultant Ventral Hernia",  
 "Multiple Extraction of Teeth under General Anesthesia—Gold Crown in Lung with Resultant Death",  
 "Claimed Prong and Cotton Left in Abdominal Cavity upon Appendectomy",  
 "Claimed Conspiracy in Insanity Commitment",  
 "Broken Needle in Abdominal Operation",  
 "Termination of Pregnancy Due to Kidney Trouble Caused by Alleged Improper Treatment of Obstetrician",  
 "Alleged Negligent Attendance of Mother and Child at Childbirth",  
 "Removal of Nasal Hump and Resection of Deviated Septum",  
 "Removal of Uvula in Performance of Tonsillectomy and Adenectomy with Claimed Resultant Impairment of Speech",  
 "Alleged Failure to Have X-Ray Taken and Diagnose Fracture",  
 "Retained Placenta—Puerperal Septicemia—Death"—  
 "Pregnancy—Complicated by Cystitis—Dry Labor—Metastatic Abscesses",  
 "Claimed Wrong Diagnosis of Pregnancy",  
 "Mental Examination Insanity Commitment",  
 "Claimed Nasal Operation on Minor Without Consent of Parent",  
 "Claimed Wrong Diagnosis and Improper Advice",  
 "Operation Without Consent",  
 "Salpingitis Claimed Due From Stem Pessary Inserted by Physician",  
 "Non-Pregnancy Leucorrhoeal Discharge, Attempt to Curette, Subsequent Ovariectomy",  
 "Fractures of Both Femurs Delayed Union, Gangrene of Left Foot and Leg with Amputation",  
 "Prolapsed Uterus"

In addition to the correspondence necessary in the handling of the malpractice cases, general correspondence during the period has included the following

Request for advice regarding ownership of X-ray films—Answer thereto  
 Communication from the President enclosing letter sent to House of Delegates  
 Communications from the office of the Society enclosing report  
 Communication regarding law on X-rays  
 Communication from the Society regarding case to be written up for JOURNAL  
 Communication from the Society regarding action of the Department of Education upon doctors convicted under Harrison Narcotic Law  
 Communication regarding contract of employment of the Executive Office.—Preparation of said contract.  
 Response regarding legal status of men convicted under Harrison Narcotic Law  
 Communication regarding certain insurance claim and answer thereto advising doctor respecting same.  
 Communication regarding article on medical licensure.  
 Communication regarding meeting for the defining of duties of new Executive Officer—Attendance at said meeting thereafter  
 Communication from Kings County Medical Society regarding malpractice insurance.  
 Communication from the Secretary of the Federation of Medical Boards  
 Communication regarding letter of Post Office Inspector  
 Communication regarding issuance binders of insurance to applicants for membership  
 Communication regarding the practice of group medicine in a certain city, requesting advice thereon—Answered

Communication from Connecticut Chamber of Commerce enclosing questionnaire—Answered.  
Communication from the Board of Censors of a County Society regarding action upon a physician.  
Communication regarding chiropractic.  
Communication regarding invitation to address Society of Medical Jurisprudence  
Communication from a Society in regard to automobile insurance—Answer thereto  
Request for information from the American Medical Association—Answer thereto  
Communication from Counsel of the New York County Medical Society and answer thereto  
Communication from the District Attorney of Kings County conveying information regarding an unlawful practitioner in that County  
Communication from the Secretary of the New York Medical Society involving question of medical ethics  
Communication to the Department of Education at Albany regarding status of a claimed medical practitioner—Answer thereto  
Communication from the Secretary of the Medical Society of New York County regarding qualifications of membership  
Communication with the Medical Society of the County of New York regarding amendments to by-laws, with advice thereon  
Communication with attorney for podiatrists regarding use of title Dr  
Communication from Counsel of the New York County Medical Society and answer to inquiry contained therein.  
Communication regarding liability of roentgenologists and answer thereto  
Invitation to address Eastern Section American Roentgen Ray Society  
Receipt of report of committee regarding the nurse question in the County of Erie.  
Communication from the President of the Society regarding bill pending in legislature—Preparation of letter advising regarding said matter  
Invitation to speak before the Sixth District Branch and answer thereto—Further communications respecting same matter  
Invitation to speak before a local medical society and response thereto  
Communication from County of Albany regarding change of by-laws and answer thereto  
Communication from the Department of Health of New York City regarding certain nostrum and answer thereto  
Request for articles by the Counsel on inheritance and transfer tax subject.  
Request for information regarding methods of enforcement of Medical Practice Act—Orange County  
Advice asked concerning possession by doctor of an X-ray plate and answer thereto  
Request for advice on the law respecting operation on minor and answer thereto  
Communication from the State Medical Society regarding communication from the County Society of Schenectady  
Advice to the State Medical Society regarding request of Bronx County Medical Society for ruling on status of dentists as possible associate members of the Medical Society  
Request for advice on possible claim against a physician for the use of X-ray—Advised thereon  
Communication from Dr Hubbard regarding the use of title Dr

Communication regarding medical defense in another State answered with information concerning our experience in New York.  
Communication from physician asking for advice regarding ethical question—Answered.  
Communication seeking advice regarding status and rights of physician on hospital staff—Advice given  
Communication regarding local ordinances restricting doctors and advice thereon.  
Communication regarding unlawful practice in Kings County and reference of matter to the District Attorney of that County  
Communication regarding claim of patient against a physician for malpractice.  
Communication regarding legality of a corporation engaging in X-ray work and answer thereto  
Communication requesting advice regarding methods of prosecution of illegal practitioners and answer thereto  
Request for advice from up-State lawyer regarding claim of malpractice against a physician.  
Three-page opinion with respect to methods of prosecution of illegal practitioners  
Request for a medico-legal opinion.  
Request for legal opinion by physician—Same given—Further communication regarding same.  
Request from up-State physician for advice regarding alleged unethical practice of another physician  
Request for information from Secretary of Board of Medical Examiners of the State of California—Same answered—Further communication with respect to the same matter—Investigation of files of New York County Medical Society and information requested communicated.  
Invitation to speak before the First District Branch—Answer thereto  
Invitation to speak before the Harlem Medical Association and answer thereto  
Request for information as to legal status of officer of a county medical society against whom charges had previously been preferred—Same answered.  
Request from firm of attorneys in Alabama respecting article on liability of physicians written by counsel—Same answered and citation of cases given  
Communication from Post Office Inspector regarding advertising of certain physician and answer thereto  
Communication from a physician heretofore convicted under Harrison Narcotic Law regarding his legal status and answer thereto  
Communication regarding procedure for prosecution of unlicensed practitioners and answer thereto  
Invitation to address a County Medical Society  
Communication with the Legislative Committee.  
Communication from President of the Medical Society regarding inquiry as to the status of osteopaths in city hospitals.  
Legal opinion regarding certain publication in the Medical Journal.  
Communication with American Medical Association regarding model practice act  
Invitation to speak to an up-State County Medical Society on legislative matters  
Request for information regarding right of an alien practitioner to practice here—Answer thereto

The questions referred to in these communications often require considerable investigation and careful thought and frequently involve the giving of legal opinions and careful analysis and interpretation of legal questions

## ATTENDANCE UPON MEETINGS, ETC

Counsel has personally attended or been represented at each of the meetings of the Council and Executive Committee during the year. Some of the matters considered are the following:

At the request of the Medical Society of the County of Queens, interpretation of Section 31, Principles of Professional Conduct Concerning Advertising, particularly relating to signs of doctors which advertise a specialty, such as eye, ear, nose and throat.

Consideration of the correspondence between the University of the State of New York, the Board of Medical Examiners, Assistant Commissioner of Higher Education, Secretary of the Board of Medical Examiners, and the Medical Society of the County of Schenectady upon the question of excluding certain names from the Directory of the Society. Opinions and letters were written upon this subject.

Consideration of proposed amendments to the by-laws of the Medical Society of the County of New York, which was referred to counsel, and advice thereon.

Attended meetings of the Medical Society of the County of New York, Medical Alliance, Society of Medical Jurisprudence—discussed Karle-Dunmore Medical Practice Bill, explaining the position taken by the Medical Society of the State of New York thereon.

Attended a meeting of the Eastern Section of the American Roentgen Ray Society at Atlantic City and read a paper upon "The Legal Hazard of the Roentgenologist in the Practice of X-ray Therapy."

Attended meeting of the First District Branch, was represented at meetings of the Sixth and Eighth District Branches by Mr. Robert Oliver, where my paper was presented entitled "Medical Societies and their Relation to the Problem of Medical Licensure." Mr. Oliver read a paper on "The General Law of Malpractice" at the Harlem Medical Society and the same paper at the meeting of the Society for Clinical Study.

## LEGISLATIVE MATTERS

Counsel, in consultation with the Department of Education and the Department of Health of the State and under the advice and direction of the Executive Committee of the Society, prepared what later became the Karle-Dunmore Medical Practice Bill for the Legislature of 1925. This bill was based in considerable part upon the bill previously introduced known as the Carroll Bill, drafted the substance of a bill eliminating the statutory necessity of electing censors each year, and leaving the manner of their selection to appropriate provision by by-laws of the Society, analyzed

and reported upon the various "cult" bills, including the Nicoll, Esmond, Fearon and Boulton chiropractic or drugless therapy bills, prepared memoranda thereon for the Joint Committee of the Assembly and Senate on Public Health, appeared before the said Committee in the Assembly Chamber and spoke in behalf of the Karle-Dunmore Bill and against the various "cult" bills, and prepared the form of question for referendum vote of the House of Delegates on the Karle-Dunmore Bill, and was a member of the Committee of tellers to consider and count the votes.

Counsel consulted with representatives of certain local medical societies with respect to the Karle-Dunmore Bill, and after a long conference gave written answers to numerous questions submitted, analyzed and reported to the Committee on Legislation upon a bill requiring physicians to furnish certain clinical data when using supplies distributed by the Department of Health. Gave opinion to the Committee on Legislation concerning amendment to Section 188 of the Workmen's Compensation Law, and gave opinion to the Committee on Legislation respecting bill giving right to an injured workman to select his own physician.

During the past year a considerable number of physicians have unselfishly devoted their time in aiding counsel in the preparation of cases by giving advice on medical and surgical procedures and have appeared as expert witnesses at the trials. This service has in each instance been greatly appreciated by the doctor-defendant and has been equally gratifying to counsel. The spirit displayed by these men of pre-eminent ability and outstanding reputation in their various specialties has been a great inspiration to counsel in the work of defense. It is the desire of counsel to express, in this report, his thorough appreciation of their sacrifice and effort in bringing before the courts expert testimony of rare value, based upon truly scientific facts. Were the expert testimony of all branches of law to reach the high level of that which is offered in malpractice cases in behalf of the doctors who have been sued, there would be no stigma attached at any time to that type of testimony, but it would receive the great weight which it justly deserves.

Counsel also desires to express to the Council, Executive Committee and officers of the Society his thanks for their hearty and thorough co-operation in the performance of his task during the past year and to acknowledge the valuable aid given in the performance of all the duties of his office by Mr. Robert Oliver, his associate, as well as by the other associates of counsel in his office. Counsel has also received the active and hearty co-

operation of Mr Harry F Wanvig, who has charge of the administrative details of the group insurance plan in behalf of the Society and of the officers of the Aetna Life Insurance Company, who have co-operated in the handling and disposition of the cases arising under the group insurance plan, to whom he is grateful

The resolutions under which malpractice defense was originally authorized and has continued, particularly to members who have not availed themselves of the group insurance plan, require modification and change Under the group insurance plan, inasmuch as the expense of defense through to the highest court, if necessary, is met by the funds made available by the payment of premiums to the insurance company, the doctors insured under that plan receive the maximum of protection This protection is open to every member of the Society and those, therefore, who desire a type of defense that will carry them through the upper courts, which includes a large outlay for stenographic minutes, printing of records and preparation and printing of briefs, should be sure to procure that protection The Medical Society could hardly afford, under its defense plan for uninsured members, to carry on so expensive a practice In fact, it seems in the past this expense has generally been met in the upper courts by the particular doctor affected.

It is recommended at this time, however, that the resolutions be amended so as clearly to define the rights and privileges of members who do not avail themselves of the insurance plan That recommendation will include the right of such a member to defense through one trial, and the obligation on the part of the members to defray all future expense of the litigation should there be further trials or appeals to the higher courts

It is also recommended that the Executive Committee be given certain discretion in committing the Society to the defense of cases, as instances have arisen where the nature of the case was such as, in the opinion of the counsel, to make it inexpedient and inadvisable for the Society to be committed to the case Accordingly, the adoption of the following resolutions is recommended

"Members shall be entitled to malpractice defense of any suit arising from any one claim in each calendar year of alleged malpractice, error or mistake done in the performance of his profession as a physician

The Society shall not at its own expense ap-

peal from any judgment that may be entered against a member in any malpractice suit

The Executive Committee shall make a rigid examination of all the facts in any alleged malpractice claim or suit and shall also examine into the applicant's membership and standing in the Society and the worthiness of the applicant's case

The Society will not undertake the defense of any member who, after investigation by the Executive Committee, is believed guilty of criminal abortion, feticide, homicide or any criminal act or who has not complied with the recognized ethical laws in regard to these cases The Society will defend only suits brought for any alleged malpractice, error or mistake done or claimed to have been done in the legitimate performance of the duties of his profession as a physician

The Society shall not be obligated to defend any malpractice claim or suit against any member when such claim or suit is covered by any policy of insurance carried by such member But nothing herein contained shall be deemed to curtail, abrogate or restrict the rights of any member under the group insurance plan endorsed by the Society"

It is further recommended that the President of each County Society, during the coming year, preferably by November 1, 1925, shall communicate with the counsel of the State Society, after conference with an appropriate committee of such County Society, as to what, in the opinion of such officer or committee, is the underlying cause of the bringing of malpractice suits against physicians in their particular localities and what steps, if any, can be taken to discourage the bringing of groundless suits of this character, and furthermore, what steps, if any, can be taken to discourage publicity of such suits before actual judgment has been entered It appears that a great injustice is done, to a physician who is sued, by publication of the fact of such suit being brought against him, even though the suit be without merit It appears likewise that some patients bring suits for the purpose of discrediting the physician by such publication rather than by intending in good faith to press the suit to trial

Respectfully submitted,

GEORGE W WHITESIDE,  
*Counsel*

Dated April 1, 1925

The report and its recommendations were heartily approved (see page 809)

## REPORT OF THE COUNCILLOR OF THE THIRD DISTRICT BRANCH

### *To the House of Delegates*

The County Societies of the Third District Branch have not only held their regular meetings but many special ones have added to the scientific advancement of the members

The annual meeting was held at the Loomis Sanatorium, Loomis, Thursday, October 9, 1924 The following program was presented

Address of Welcome to the Loomis Sanatorium.

Bertram H Waters, M D, Physician in Chief

Address of Welcome from the Medical Society of Sullivan County

J Burns Amberson, Jr, M D, President

Artificial Pneumothorax and Surgery in the Treatment of Pulmonary Tuberculosis

Andrew Peters, M D, Loomis

Laboratory Aids in Diagnosis of Tuberculosis

J Stanley Woolley, M D, Loomis

The Differential Diagnosis of Tuberculosis Cavities in the Lungs

J Burns Amberson, Jr, M D, Loomis

Presentation of Cases

Luncheon at 1 30 P M

The State Society

Owen E. Jones, M.D., President Medical Society, State of New York, Rochester

Address

Arthur J Bedell, M D, President Third District Branch, Albany

The following officers were elected President, Dr Charles P McCabe, Greenville, First Vice-President, Dr Edgar Vander Veer, Albany, Second Vice-President, Dr Herbert L Odell, Sharon Springs, Treasurer, Dr Ernest E Billings, Kingston Dr Clark G Rossman, of Hudson, was re-elected Secretary

Respectfully submitted,

ARTHUR J BEDELL,  
*President*

April 15, 1925

## REPORT OF THE COUNCILLOR OF THE FIFTH DISTRICT BRANCH

### *To the House of Delegates*

The Annual Meeting of Fifth District Branch was held at Oneida, Thursday, October 2, 1924 The meeting was held at the recreation rooms of the Presbyterian Church Over one hundred doctors were present during the day Thirty or forty members' wives were present and were entertained by the wives of the local doctors

The ladies were given lunch and automobile drives, taken to the Oneida Community Silverware plant, and by the courtesy of the management were taken through the plant and on leaving were each given a souvenir spoon

A lunch and musical entertainment by the Madison County Medical Society was given the members

The Mayor of the City of Oneida, Arthur J Abbott, welcomed the doctors to the city and commended the profession for the splendid work which was being accomplished by the profession Dr Otto Pfaff, of Oneida, welcomed the men in behalf of the County Society

The President of the Branch recommended

that the members advocate periodic health examinations and also do work in their locality superior to what had been done in the past.

The program was a most interesting one. Dr George W Miles, of Oneida, gave an excellent paper on "The Function of Eating" Discussion opened by Dr Stephen L Taylor, of Sherrill

Dr Edward Livingston Hunt, Secretary Medical Society State of New York, presented a paper on "Poliomyelitis" Dr Charles D Post, of Syracuse, spoke on "Coronary Closure"

Dr Matthias Nicoll, State Health Commissioner, gave a talk on "Public Health"

Dr T Wood Clark, of Utica, spoke on "The Value of Gastro Intestinal X-Ray in the Diseases of Children"

Dr Thornhill also spoke All the papers and discussions were well received

Respectfully submitted,

NELSON O BROOKS,  
*President*

April 15, 1925



## REPORT OF THE COUNCILLOR OF THE SIXTH DISTRICT BRANCH

### *To the House of Delegates*

The last annual meeting of the Sixth District Branch of the State Medical Society was held on October 7, 1924, at Oneonta. Owing to the inclement weather and the geographical location of the meeting place, it was not as largely attended as usual, but what the assemblage lacked in numbers it made up in enthusiasm. A slight departure was made from the usual routine of scientific papers, and the matter of medical legislation was taken up at some length. Dr. Julian Smith of Oneonta, a member of the last Assembly, gave a most interesting and enlightening discourse on the Legislator's viewpoint regarding medical bills, which brought out some very healthy discussion. Thanks to the efforts of Dr. Wilbur Fish of Ithaca, we had the opportunity of seeing some very remarkable moving pictures of the work being done at the Cornell Medical School on the thyroid gland. The meeting this year will be held at Ithaca and doubtless it will be our privilege to see the continuation of this work.

The county societies comprising this Branch

have made a few changes in the number of their meetings. Broome County has changed its by-laws so that a regular meeting will be held every month now instead of four times a year as formerly. The subject of medical legislation has had a very prominent part in many of the programs, and has been the subject of widespread discussion between the members. There was very little opposition to the Dunmore bill and what there was seemed to center around the registration fee clause. To a great many of us, the failure of the Senate to act on the bill was a bitter disappointment.

Democrats and Republicans alike had to agree with the message sent the Senate in its closing hours by the Governor. All of us, however, are deeply grateful to the Legislative Committee for their untiring efforts towards the Dunmore bill and also for their efforts to prevent the passage of the various "cult" bills which came up during the session.

Respectfully submitted,  
GEORGE HENRY FOX,  
*President*

April 15, 1925

## REPORT OF THE COUNCILLOR OF THE SEVENTH DISTRICT BRANCH

### *To the House of Delegates*

I have attended meetings of Wayne County Society twice in the past year, at each meeting there was a good attendance and discussions were general. The younger men do not attend as faithfully as the older men. The membership committee and legislative committee were active and made good reports.

The Livingston County Society usually has a good attendance and last year they declared themselves in favor of the Medical Practice Act and the additional dues. While a small society they always have a good attendance and the scientific discussions are always of interest.

In Ontario County there is a very active

Geneva Hospital organization, which includes most of the county practitioners. They have most successful meetings with a very excellent showing of members and excellent discussions.

The other counties I have failed to meet with. The annual meeting of the Seventh District Branch was held at the Dansville Health Resort and was very successful from every point of view.

Although arrangements have not yet been made it is hoped to have our next district branch meeting at Auburn.

Respectfully submitted,  
WILLIAM I DEAN,  
*President*

April 15, 1925

## REPORT OF THE COUNCILLOR OF THE EIGHTH DISTRICT BRANCH

### *To the House of Delegates*

The morale of the Eighth District Branch is excellent and seems to be largely the result of more business-like methods of administration of the Society's affairs, as evidenced by the installation of an Executive Officer. There has been a prompt and favorable response from the various counties to the request for increased dues of the State Society, which augurs well for an aggressive future. An interesting experiment has

been the grouping of several counties in one meeting. This seems to have increased the interest and attendance.

The programs of several counties have been presented by the local members, which has proved valuable and a pleasing variation.

Respectfully submitted,  
HARRY R. TRICK,  
*President*

April 15, 1925



# HOUSE OF DELEGATES



The Annual Meeting of the House of Delegates of the Medical Society of the State of New York was held at the Hotel Syracuse, Syracuse, New York, Monday afternoon, May 11, 1925, at 2 o'clock, Speaker Dr E Eliot Harris presiding, Dr Edward Livingston Hunt, Secretary. The Speaker announced that the Secretary will call the roll by Counties for the purpose of determining the presence of recognized Delegates, a quorum being present the House is now organized for business.

## MEMORY, DR. W. DEWEY ELSEVER

The Speaker I wish to call your attention to an important matter. Dr W Dewey Elsever, Chairman of the Committee on Arrangements, and a member of the Council of this Society, long respected and beloved by his colleagues, within and beyond the boundaries of the City of Syracuse, died last December. I shall ask the House to rise and remain standing in silence one minute out of respect to the memory of Dr W Dewey Elsever.

Whereupon the House acted as requested.

The Speaker The first is the report of the Committee on Credentials, Dr Hunt, Chairman.

## COMMITTEE ON CREDENTIALS

Dr Hunt Mr Speaker, the report of the Committee on Credentials will be ready tomorrow.

The Speaker The next order of business is the calling of the roll by the Secretary, which will be deferred until tomorrow morning, unless there is some objection. There being none, it is so ordered.

The next is the reading of the minutes of the previous meeting. They have been published, and unless there is some additions or corrections they will stand approved as printed. There being none, they stand approved.

The next is the address of the President, Dr Owen Jones.

Dr Jones Mr Speaker, inasmuch as the report has been printed and is in the hands of all the delegates, I ask that the reading of the report be dispensed with.

The Speaker If there be no objection, the request of the president will be complied with. Hearing none it is so ordered.

The next is the address of the Speaker. As that has already been read—by some, I hope—it will be referred to the Committee on Speaker's Address.

The next is the report of the Committee on Council and Councillors. What is your pleasure, Gentlemen?

Dr Daniel S Dougherty, of New York.

I move that the balance of the printed reports be referred to their respective reference committees.

Motion seconded and carried.

The Speaker The Secretary will please read the names of the members of the reference committees.

## REFERENCE COMMITTEES

The Secretary read the following Reference Committee on the President's Address: Samuel J Kopetzky, New York, Chairman; Cornelius J Egan, Bronx; J Richard Kevin, Kings; Floyd S Winslow, Monroe; William H Purdy, Westchester.

Reference Committee on Speaker's Address: George A Leitner, Rockland, Chairman; Nelson O Brooks, Madison; Henry C Courten, Queens; Carl R Comstock, Saratoga; George E Welker, Yates.

Reference Committee on Reports of Council and Councillors: John E Jennings, Kings, Chairman; Robert W Andrews, Dutchess-Putnam; H Burton Doust, Onondaga; Luther C Payne, Sullivan; Edward W Weber, Westchester.

Reference Committee on Reports of Secretary and Treasurer: James Pedersen, New York, Chairman; Frank M Dyer, Broome; John L Edwards, Columbia; Peter L Harvie, Rensselaer; Robert M Elliott, Seneca.

Reference Committee on Report of the Committee on Scientific Work: Thomas C Chalmers, Queens, Chairman; William B Johnson, Cattaraugus; Henry S Paterson, New York; William A Peart, Niagara; LeRoy Becker, Schoharie.

Reference Committee on Report of the Committee on Legislation: George Kosmak, Chairman; Warren Wooden, Monroe; Robert L Barlett, Oneida; Homer J Kmckerbocker, Ontario; Luther Emerick, Ulster.

Reference Committee on Reports of Committee on Public Health and Medical Education: William H Ross, Suffolk, Chairman; Charles R Borzilleri, Erie; Edward M Cohe, New York; Zenas V D Orton, Washington.

Reference Committee on Report of the Committee on Medical Economics: W Warren Britt, Erie, Chairman; L Whittingham Gorham, Albany; J Lewis Amster, Bronx; Clarence J Whalen, Genesee; Charles R Kingslev, Richmond.

Reference Committee on Report of Special Committee on Nurses: Andrew Sloan, Oneida, Chairman; John A Card, Dutchess-Putnam; Le Rue Colegrove, Chemung; Charles A Gordon, Kings; Edward C Brenner, New York.

Reference Committee on Report of Legal Counsel: Terry M Townsend, New York, Chairman; Nathan B Van Etten, Bronx; Alton B Daley, Greene; Sidney F Blanchet, Franklin; Herbert B Smith, Steuben.

Reference Committee on New Business—A: W Francis Campbell, Kings, Chairman; Chauncey R Bowen, Allegany; Charles B Warner, Essex; George R Critchlow, Erie; Edward C Rushmore, Orange.

Reference Committee on New Business—B: James E Sadlier, Dutchess-Putnam, Chairman; Charles D Ver Nooy, Cortland; Murray M Gardner, Jefferson; E Warren Presley, Richmond; Jerome S Thomas, Queens.

Reference Committee on New Business—C: De Witt Stetten, New York, Chairman; Arthur M Dickinson, Albany; Allen W Holmes, Schuyler; William J Traci, Steuben; Arthur W Hubbard, Wyoming.

Reference Committee on Credentials: E. Livingston Hunt, New York, Chairman; Frank D Jennings, Kings; W Meddaugh Dunning, Bronx; Milton A Bridges, New York; Charles B Story, Queens.

The Speaker We have arrived at Unfinished Business. The matter of by-laws will be referred to Reference Committee A.

## FRAUDULENT PRACTICES (see page 805)

The Speaker We are now under New Business. Dr Dougherty, New York. Under this head New York County desires to present the following resolution: Whereas, there exists in the State of New York today a situation which menaces the public health and threatens to undermine public confidence in the legitimate practice of medicine, and

Whereas there are a large number of individuals and establishments actively opposing the best interests of the ill, the defective and the growing youth, through illegal, deceptive and fraudulent practices; and

Whereas, many of these individuals and establishments appear to be operating under a system of organized charlatanism, whose chief function is to obtain money from the unlettered, the uninformed, the alien and the ignorant through such frauds; and

Whereas, these conditions exist not only in every large city but in many of the small towns and villages

throughout the state, thereby making this problem an issue for the State Society.

Therefore, be it Resolved That the House of Delegates instruct the Council to properly investigate and take such measures as will correct these deplorable conditions.

The Speaker Referred to Reference Committee on New Business A

#### SECTION OF DERMATOLOGY (see page 804)

Dr Louis Tulipan, New York

At the request of the Dermatological staff of the College of Physicians and Surgeons, of the City of New York,

Resolved, that a section on Dermatology and Syphilology be established by the Medical Society of the State of New York.

The Speaker It will be referred to Reference Committee on New Business B

#### TITLE DOCTOR (see page 804)

Dr Dougherty, New York This resolution is introduced by New York County at the request of the New York Department of Health

Whereas, A person practices medicine, within the meaning of Article 8 Section 160, Paragraph 7 of Public Health Act, New York State, who holds himself out as being able to diagnose, treat, operate, or prescribe for any human disease, pain, injury, deformity, or physical condition, and who shall either offer or undertake by any means or method, to diagnose, treat, operate or prescribe, for any human disease, pain injury, deformity or physical condition

Whereas, There are persons using the title "Doctor" in connection with the practice of chiropody or podiatry. And Whereas, The use of the title "Doctor" is not authorized by any law or statute.

And Whereas, There is no statute forbidding the use of such a title, especially when used to deceive the public as to the person who pretends to practice medicine.

And Whereas, Chiropodists or Podiatrists are using the title of "Doctor" for the purpose of deceiving the public by holding themselves out as "Doctor of Medicine."

THEREFORE BE IT RESOLVED That the House of Delegates request the Council to institute legal proceedings to prohibit such unauthorized use of the title Doctor by those conducting an occupation involving or pertaining to the Public Health

The Speaker It will be referred to Reference Committee on New Business C.

#### CONTROL COUNTY SOCIETIES (see page 804)

Dr Orrin Sage Wightman, New York

Resolved that when any action has been taken by the House of Delegates of the Medical of the State of New York in session or by referendum vote by the component County Societies the majority vote so recorded shall determine the attitude of the County Societies, and that any public action or appearance of the individual County Society against the recorded opinion of the State Society's majority vote shall be a breach of Medical Ethics

This resolution is not meant to limit or prevent the expression of anyone's personal opinions or views

The Speaker Referred to Reference Committee on New Business A

Dr Dougherty New York offers the following resolution pursuant to a resolution adopted by the County Society and sent to the A. M. A.

Resolved, that the Medical Society of the State of New York, hereby invites the American Medical Association to hold its 1926 meeting in the City of New York

The Speaker Referred to Reference Committee on New Business B

#### MEDICAL PRACTICE BILL (see pages 812-815)

Dr Chalmers, Queens

Resolved that the Council of the Medical Society of the State of New York be and is hereby instructed to prepare such amendments to the Medical Practice Act as may tend to strengthen the practice of medicine and safeguard the people of the State against illegal practice, and that such amendments shall exclude any provisions requiring re-registration of physicians now in practice or hereafter registered under existing laws and that the bill shall be published in the New York State Journal of Medicine not later than October 1, 1925, and for discussion shall be afforded the columns of the Journal. The Council shall prepare and complete, not later than December 15, 1925 a Referendum, through the mail, to the House of Delegates and procure the introduction of such measure in the Legislature, it approved by a majority of such Delegates voting thereon

The Speaker It will be referred to the reference Committee on Legislation.

#### VOLSTEAD ACT (see page 805)

Dr Chalmers Whereas certain provisions of the Volstead Act and Acts amendatory thereto prohibit, without exception or qualifications, physicians from prescribing more than one pint of spirituous liquor to any patient in ten days, and

Whereas, at a meeting of the House of Delegates of the American Medical Association resolutions were adopted condemnatory of such provisions, and advocating a change in the law and the adoption of proper regulations by the Prohibition Department and the Internal Revenue Commissioners, and

Whereas at the time of the passage of the Volstead Act Regulations, as distinguished from Prohibition could have adequately dealt with the subject and yet have left unimpaired the rights and obligations of physicians to prescribe spirituous liquor for their patients when in their best judgment required, and at the same time have prevented the unworthy practitioner from prescribing liquors for beverage purposes under the guise of legitimate prescriptions, and

Whereas, regulations to that end could still be formulated and promulgated in case such provisions of the said Acts be declared unconstitutional, and should be prepared without further delay, and

Whereas, the present prohibitions have operated mainly to prevent large numbers of physicians of standing and professional integrity from prescribing for their patients in accordance with their best judgment as to their patients' necessities, while the unlawful acts of the unworthy practitioners have been promoted, and the further effect of such prohibitions has been that liquor of standard quality, necessary for medicinal prescription purposes has largely become unprocurable, it is hereby

Resolved, in view of the fact that such portions of the Volstead Act and the Amendatory Acts may be declared unconstitutional that, as a substitute therefor, regulations should be forthwith drafted by the Prohibition Department to the end that the present abuses may be abated, and existing prohibitions as to the practice of medicine removed, and that this Association use all means within its power looking to the preliminary approval of such regulations by the Prohibition Department and the Commissioner of Internal Revenue

In view of the fact that this resolution has a bearing on the suit of the Association of Constitutional Rights (Prohibition Com vs Samuel Lambert) we recommend that this Resolution be forwarded to American Medical Association with the unanimous approval of the House of Delegates

The Speaker The Resolution will be referred to Reference Committee on New Business C

## AMENDMENTS TO CONSTITUTION

Dr Wightman, New York I would like to offer three amendments to the Constitution

*Article IV Council*

Amended to read

The Council shall be composed of

(a) officers of the Society (strike out the word "except" and place instead the word "including") the assistant Secretary and assistant Treasurer

(b) Chairman of the Standing Committees add (including Editor-in-Chief of the State Journal)

*Article V* The officers of the Society shall be a President (add) a President-Elect, etc

To (d) the past Presidents (add) "and Secretaries who shall be life members with voice but without vote."

The Speaker They will be placed on file, please hand them to the Secretary

## BUDGET (see pages 805-813)

Dr Goodrich, Kings Resolved, that the Treasurer of the Medical Society of the State of New York be instructed to place the finances of the Society on a budget basis, that after preparing a budget annually it be submitted to the Council for approval (with such modification as shall be deemed wise and prudent by the majority of the Council)—and that the dues recommended to the Society for each year be based precisely upon the requirements of said budget

The Speaker Referred to Reference Committee on New Business A

President Jones I have here a communication in regard to the nursing question I ask that it may be referred to the proper committee

The Speaker Do you wish it referred without reading?

Dr Jones Yes, it is too long to read

The Speaker The request of the President will be complied with, if there be no objection. The communication is received and referred to the Reference Committee on Nurses

Dr Jewett Kings I have a report here of the Committee on Nurses It has a number of suggestions as to the treatment of the situation as to Nurses

The Speaker If there be no objection it will be referred without reading to the Committee on Nurses There being none it is so ordered

Dr Gardner, Erie I wish to submit a report from the Erie County Society Committee on the Nurse Question I would like to submit their report without reading

The Speaker There being no objection, it is referred to the Reference Committee on Nurses

The Speaker If there are no other resolutions, it would be well to take a recess to give the committee time to do their work.

Upon motion, seconded and carried, a recess was declared at 245 P M

The meeting was called to order at 3 15 P M

The Speaker The Secretary will call the names of the Reference Committees, and ask if any are ready to report

## SECTION ON DERMATOLOGY (see page 803)

Dr Sadlier Reference Committee on New Business B recommends the adoption of the resolution of Dr Louis Tulipan, Delegate from the County of New York, relating to the establishment of a section on Dermatology and Syphilology

Seconded and carried

## INVITATION TO A M A (see page 803)

Dr Sadlier Reference Committee on New Business B recommends the adoption of Dr Dougherty's resolution that the Medical Society of the State of New York invite the American Medical Association to hold its 1926 meeting in the City of New York

I move its adoption

Seconded and carried

## TITLE DOCTOR (see page 803)

Dr Stetten Reference Committee on New Business C approves the Resolution introduced by Dr Hubbard of New York for the New York City Department of Health, in regard to the illegal use of the title "Doctor" by chiropodists or podiatrists, and recommend its adoption by the House of Delegates

Seconded and carried

The Speaker Is there any other reference committee ready to report?

## SPEAKER'S ADDRESS

Dr Leitner, Reference Committee on Speaker's Address

We approve of each and every recommendation made by our Speaker, with the single exception of the one referring to the bestowal of the honorary title of General Supervisor of the Medical Society of the State of New York, upon Miss Lily D Baldwin, and our committee respectfully recommends to the council in its stead the bestowal of an honorarium of Five hundred dollars as an appreciation of the splendid and efficient work done by her for the Medical Society of the State of New York during the past twenty-five years

It was moved and seconded that the report be adopted. Carried unanimously

## CONTROL OVER COUNTY SOCIETIES (see page 808)

Dr Campbell, Chairman Reference Committee on New Business A

'Resolved that when any action has been taken by the House of Delegates of the Medical Society of the State of New York in session or by a referendum vote by the component County Societies, the majority vote so recorded shall determine the attitude of the County Societies, and that any public action or appearance of the individual County Society against the recorded opinion of the State Society's majority vote shall be a breach of Medical Ethics

This resolution is not meant to limit or prevent the expression of anyone's personal opinions or views"

Since it is highly advisable that the Society shall appear before the public and the State Legislature as holding an undivided opinion on matters pertaining to the profession's welfare, your committee recommends the adoption of this resolution

Seconded.

Dr Kevin, Kings I move that we lay this on the table

Seconded

Upon a rising vote the motion was declared lost.

Dr Kevin I arise to a point of order as to whether the resolution is not inconsistent with the constitution and by-laws of the State Society

The Speaker The point of order is not well taken

Dr Frank D Jennings, Kings I rise to a point of information, Mr Speaker May I assume a hypothetical case?

The Speaker Provided it has direct relation to the subject under discussion

Dr Jennings It will, sir, that a given piece of legislation is before the State Legislature, and that my County Society delegates me to talk at a public forum in Brooklyn in opposition to the measure, that the House of Delegates has acted favorably upon it, would I be guilty of a breach of ethics?

The Speaker I am perfectly willing that the Delegate from Kings County should discuss a hypothetical question in relation to the question before the House, but he should not demand a hasty opinion of the Speaker as to the correctness of what he states hypothetically or if it would be a breach of ethics This question of ethics requires considerable thought Even the learned legal counsel at times takes things under consideration before rendering a decision

Dr Jennings In view of that, Mr Speaker and in view of the rather close decision, I move that the question be referred back to the committee

Seconded, and carried

VOLSTEAD ACT (see page 803)

Dr Campbell The report of your committee on the Resolution introduced by Dr Chalmers, concerning the Volstead Act, is as follows In view of the fact that this resolution has a bearing on the suit of the Association of Constitutional Rights (Prohibition Com vs Samuel Lambert), we recommend that this Resolution be forwarded to A M A with the unanimous approval of this House of Delegates"

I move its adoption

Seconded, and carried unanimously

FRAUDULENT PRACTICES (see page 802)

Dr Campbell

Whereas, there exists in the State of New York today, a situation which menaces the public health and threatens to undermine public confidence in the legitimate practice of medicine, and,

Whereas, there are a large number of individuals and establishments actively opposing the best interests of the ill, the defective, and the growing youth, through illegal, deceptive and fraudulent practices, and

Whereas, many of these individuals and establishments appear to be operating under a system of organized charlatantry whose chief function is to obtain money from the unlettered, the uninformed, the alien and the ignorant through such frauds, and

Whereas, the conditions exist not only in every large city but in many of the small towns and villages throughout the state thereby making this problem an issue for the State Society

THEREFORE BE IT RESOLVED That the House of Delegates instruct the Council to properly investigate and take such measures as will correct these deplorable conditions"

Your Committee recommend the endorsement of this resolution.

Seconded, and carried

BUDGET (see page 804)

Dr Campbell Resolved that the Treasurer of the Medical Society of the State of New York be instructed to place the finances of the Society on a budget basis, that after preparing a budget annually he submit this to the Council for approval with such modifications as shall be deemed wise and prudent by the majority of the Council—and that the dues recommended to the Society for each year be based precisely upon the requirements of the budget."

I have the honor to report, Mr Speaker, that a majority of the committee make the following report,—

The Speaker The majority is the report of the committee, and therefore you are reporting for the committee.

Dr Campbell Your committee is in favor of the submission by the Council of an annual budget We question, however, the wisdom of basing the annual dues upon such a budget. We believe that the uncertainty of the amount of dues to be collected each year, as the result of such a proposed procedure, would have an unfavorable effect upon the membership of the Society, present and prospective

I also ask permission of the House to make a minority report,

The Speaker It is rather unusual for a chairman to make a majority and also a minority report of his committee, but in order to get the statement of the minority of the committee before the House it is necessary to have the consent of the House to receive it. It is generally given. All those in favor of receiving the minority report say aye, opposed no

Motion carried

Dr Campbell The minority report states that since there is no reason for the State Society to accumulate funds for sinking fund or other purposes, the dues should be based upon the requirements of the Council's budget,

and thus relieve the County Societies of any extra dues beyond the requirements of the State budget.

Dr Kopetzky, New York. I move the adoption of the majority report.

The Speaker That is the only one before you

Motion seconded

Dr Ludlum, Kings I rise to a point of order I think that Article 8 of the by-laws determines the way in which the decision as to annual dues shall finally be made, regardless of advice given that way, and any change must be made by modification of the by-laws

The Speaker The point of order as applying to a report of a committee is not well taken All those in favor of the report of the committee say aye, those opposed say no The chair is in doubt

Upon a rising vote the motion was carried

The Vice Speaker takes the chair

PRESIDENT'S ADDRESS

Dr Kopetzky The Committee on President's Address is ready to report. Your committee has read and considered the report of the President and finds that his modest report does not do justice to the amount of time and energy and constructive thought which he has given to his duties and the Committee congratulates the Society on the state of its affairs as reported by the President and feels that the Medical Society of the State of New York but inadequately expresses its appreciation of his endeavors by thanking him officially for his work.

In regard to his recommendations we will take them up in detail

JOURNAL PUBLICATION

First —We approve and recommend for adoption that the journal of the State Society should be published semi-monthly throughout the year, providing sufficient funds are available, except during the session of the Legislature, when it shall be published weekly as was the custom in the past two years Your Committee feels that while approving this recommendation they would urge that measures be taken to publish the journal weekly throughout the year, as the increased income from advertising would more than warrant the slightly additional expense, if there be any

That is the first recommendation

The Vice Speaker Gentlemen, what is your pleasure as to the report?

Dr Dougherty A point of information, is this a matter for the House of Delegates, or is it a matter for the Council, as it carries with it the expenditure of money?

The Vice Speaker It is a matter for the Council

Dr Kopetzky This recommendation carries no appropriation, and therefore there is no question for the Council It is a question of the House of Delegates approving the recommendation of the President of the Society which we do

Dr O'Reilly, Kings A point of information If this resolution carries no provision for the expenditure of money, who will take care of the deficit?

The Vice Speaker It is a matter entirely for the Council Dr O'Reilly

Dr Dougherty You having declared it a matter for the Council to decide, it is a matter entirely out of the hands of this body

The Vice Speaker The report carries no appropriation, you are voting on the recommendation of the President No appropriation is carried with this whatever

A Delegate If the paper is issued oftener than it is at the presentation time, whether this report carries an appropriation or not, there will be expense connected with it

The Vice Speaker That is a matter entirely up to the Council.

The Delegate Then we cannot act on it, can we?

The Vice Speaker You can act on the suggestion but you cannot act on the appropriation.

Upon being submitted to a rising vote, the motion was carried

## AMENDMENTS TO CONSTITUTION

Dr Wightman, New York I would like to offer three amendments to the Constitution

*Article IV Council*

Amended to read

The Council shall be composed of

(a) officers of the Society (strike out the word "except" and place instead the word "including") the assistant Secretary and assistant Treasurer

(b) Chairman of the Standing Committees add (including Editor-in-Chief of the State Journal)

*Article V* The officers of the Society shall be a President (add) a President-Elect, etc

To (d) the past Presidents (add) "and Secretaries who shall be life members with voice but without vote."

The Speaker They will be placed on file, please hand them to the Secretary

## BUDGET (see pages 805-813)

Dr Goodrich, Kings Resolved, that the Treasurer of the Medical Society of the State of New York be instructed to place the finances of the Society on a budget basis, that after preparing a budget annually it be submitted to the Council for approval (with such modification as shall be deemed wise and prudent by the majority of the Council)—and that the dues recommended to the Society for each year be based precisely upon the requirements of said budget

The Speaker Referred to Reference Committee on New Business A

President Jones I have here a communication in regard to the nursing question I ask that it may be referred to the proper committee

The Speaker Do you wish it referred without reading?

Dr Jones Yes, it is too long to read

The Speaker The request of the President will be complied with, if there be no objection The communication is received and referred to the Reference Committee on Nurses

Dr Jewett, Kings I have a report here of the Committee on Nurses It has a number of suggestions as to the treatment of the situation as to Nurses

The Speaker If there be no objection it will be referred without reading to the Committee on Nurses There being none it is so ordered

Dr Gardner, Erie I wish to submit a report from the Erie County Society Committee on the Nurse Question I would like to submit their report without reading

The Speaker There being no objection, it is referred to the Reference Committee on Nurses

The Speaker If there are no other resolutions, it would be well to take a recess to give the committee time to do their work

Upon motion, seconded and carried, a recess was declared at 2 45 P M

The meeting was called to order at 3 15 P M

The Speaker The Secretary will call the names of the Reference Committees, and ask if any are ready to report

## SECTION ON DERMATOLOGY (see page 803)

Dr Sadler Reference Committee on New Business B recommends the adoption of the resolution of Dr Louis Tulpan, Delegate from the County of New York, relating to the establishment of a section on Dermatology and Syphilology

Seconded and carried

## INVITATION TO A. M. A. (see page 803)

Dr Sadler Reference Committee on New Business B recommends the adoption of Dr Dougherty's resolution that the Medical Society of the State of New York invite the American Medical Association to hold its 1926 meeting in the City of New York.

I move its adoption

Seconded and carried

## TITLE DOCTOR (see page 803)

Dr Statton Reference Committee on New Business C approves the Resolution introduced by Dr Hubbard of New York for the New York City Department of Health, in regard to the illegal use of the title "Doctor" by chiropodists or podiatrists, and recommend its adoption by the House of Delegates

Seconded and carried

The Speaker Is there any other reference committee ready to report?

## SPEAKER'S ADDRESS

Dr Leitner, Reference Committee on Speaker's Address

We approve of each and every recommendation made by our Speaker, with the single exception of the one referring to the bestowal of the honorary title of General Supervisor of the Medical Society of the State of New York, upon Miss Lily D Baldwin, and our committee respectfully recommends to the council in its stead the bestowal of an honorarium of Five hundred dollars as an appreciation of the splendid and efficient work done by her for the Medical Society of the State of New York during the past twenty-five years.

It was moved and seconded that the report be adopted. Carried unanimously

## CONTROL OVER COUNTY SOCIETIES (see page 808)

Dr Campbell, Chairman Reference Committee on New Business A

'Resolved that when any action has been taken by the House of Delegates of the Medical Society of the State of New York in session or by a referendum vote by the component County Societies, the majority vote so recorded shall determine the attitude of the County Societies, and that any public action or appearance of the individual County Society against the recorded opinion of the State Society's majority vote shall be a breach of Medical Ethics

This resolution is not meant to limit or prevent the expression of anyone's personal opinions or views"

Since it is highly advisable that the Society shall appear before the public and the State Legislature as holding an undivided opinion on matters pertaining to the profession's welfare, your committee recommends the adoption of this resolution

Seconded.

Dr Kevin, Kings I move that we lay this on the table. Seconded

Upon a rising vote the motion was declared lost

Dr Kevin I arise to a point of order as to whether the resolution is not inconsistent with the constitution and by-laws of the State Society

The Speaker The point of order is not well taken

Dr Frank D Jennings, Kings I rise to a point of information, Mr Speaker May I assume a hypothetical case?

The Speaker Provided it has direct relation to the subject under discussion

Dr Jennings It will, sir, that a given piece of legislation is before the State Legislature, and that my County Society delegates me to talk at a public forum in Brooklyn in opposition to the measure, that the House of Delegates has acted favorably upon it, would I be guilty of a breach of ethics?

The Speaker I am perfectly willing that the Delegate from Kings County should discuss a hypothetical question in relation to the question before the House, but he should not demand a hasty opinion of the Speaker as to the correctness of what he states hypothetically or if it would be a breach of ethics This question of ethics requires considerable thought Even the learned legal counsel at times takes things under consideration before rendering a decision

Dr Jennings In view of that, Mr Speaker and in view of the rather close decision, I move that the question be referred back to the committee

Seconded, and carried

our Constitution and By-Laws to carry into effect the above recommendations."

It is necessary if we want to adopt this form of government that the Legislature of the State of New York pass an enabling act, and this recommendation instructs Mr George Whiteside, our Counsel to prepare such an enabling act so that we shall be able to adopt these proposed changes in our constitution at our next annual session of the House of Delegates. I move the adoption of the resolution

Seconded.

Dr Ludlum, Kings It seems to me that this is such an important and grave matter that it should receive very careful consideration. If this enabling act is passed the presumption is that the rest of the matter is to prevail. I am in no position of opposition or concord with the act at the present time, I am simply emphasizing its importance. I presume it is in order for any one or any group of us to put a recommendation for a change of the Constitution or By-laws on the record so that it can be acted upon next year. It seems to me that inasmuch as we have a committee on Revision of Constitution and By-laws that the best immediate action to take would be to refer the whole matter, including the recommendation, to the Committee on Revision of Constitution and By-laws, for their consideration.

Dr Dougherty I am heartily in favor of all that has been read on the subject by Dr Kopetzky, and I would like to express my opinion that their work in drawing up this drafted amendment is highly commendable, but there is just one thing we have to think of, I consulted with Dr Harris, our Speaker some time ago regarding this with the idea of drawing up such an amendment, and I was informed that Mr Whiteside was working on the matter, and that it could not be received until he had decided whether we could consider even the reception of such amendments before the enabling act. I would like to ask the Speaker if Mr Whiteside has expressed his opinion as to that?

The Vice Speaker Is Mr Whiteside in the room?

Mr Oliver May I answer for Mr Whiteside? Mr Whiteside has expressed the opinion that there could be received at this meeting of the House of Delegates the proposed amendment to be acted upon at the meeting of 1926, if and when the Legislature authorize by an enabling act a change in the Constitution and By-Laws of the Society.

Mr Dougherty Then should not the words be inserted in it?

Dr Ward B Hoag, New York This says that George W Whiteside shall pave the way for the approval of this. Suppose something happens to Mr George W Whiteside, where will that leave the proposed changes?

The Vice Speaker Mr Whiteside's office will take care of it.

Dr Dougherty I move that the debate on this question be closed, as all the speakers have been out of order.

The Vice Speaker Are you ready for the question?

Dr Lasher I rise to a point of order. Is this discussion is out of order, the vote is out of order.

The Vice Speaker Those in favor of the report of the Committee will say aye, opposed, no carried.

Dr Lasher I appeal the decision of the Chair on the point of order by me.

The Vice Speaker I rule against it. It is too late to appeal after the vote has been taken.

The Speaker takes the chair.

#### COMMITTEE ON SCIENTIFIC WORK

Dr Chalmers Your Reference Committee on Scientific Work has the honor to report that it desires to particularly commend the scheme of the scientific program for this year's convention whereby Thursday, May 14th,

is devoted to a complete consideration of tuberculosis in all its aspects and believes this practice furnishes a promising precedent for future programs. The program in general sets a high standard of excellence.

The reference Committee unanimously voted to endorse the recommendation that each section elect its secretary for three years and voted further to endorse the recommendation that the actual expenses of program guests from out of the State be paid by the Society together with the expenses of any necessary laboratory assistant not in practice.

#### POST-GRADUATE MEDICAL INSTRUCTION

The Reference Committee desire to commend in the highest terms the report of the Committee on Post Graduate Medical Instruction and endorse the recommendation contained therein that "a special committee be appointed with power to put into immediate effect a plan of graduate medical extension instruction which will meet the greatest need to-day."

The reference Committee further suggests that it shall be the duty of this special committee to coordinate the existing medical schools and hospital staffs according to their geographical zone to the end that in and around each may be created a center for post-graduate medical education, with which adjacent country societies shall cooperate in every way possible.

I move its adoption.

Seconded and carried.

#### REPORT OF COUNCIL AND COUNCILLORS

Dr John E Jennings Your Committee on the Report of Council and Councillors recommends the acceptance of the report of the Council but calls attention to the neglect of Council to comply with the spirit of the recommendation of the House of Delegates in adopting the report and recommendation of Reference Committee C at the annual meeting of the House of Delegates held in Rochester in 1924 namely, that such amendments to the Public Health Law as are necessary be formulated by the Council and by them referred for approval by referendum sent by mail to the House of Delegates.

The action of the Council on February 18, 1925, approving measures already before the Legislature and ordering a referendum of the House of Delegates on its approval is not deemed a full compliance with the recommendations of the House of Delegates.

The Committee recommends the adoption of the reports of the Councillors of the third, fifth, sixth, seventh and eighth district branches, but calls attention to the neglect of the Councillors of the first, second and fourth district branches to submit reports."

I recommend its adoption.

Seconded.

Dr Kopetzky I do not think this House of Delegates understands that the adopting of that Committee's report carries with it a censure. I cannot conceive that the members of the Council will sit here without a word and hear the gentlemen censured without getting up and saying a word for themselves. I think it is no more than right that some member of the Council get up and explain his action, because I should hesitate to vote for censure of men who have devoted so much time to the interests of this Society, through a lack of an understanding of their action. May I ask that some member of the Council explain his action in the matter?

The Speaker Dr Kopetzky has asked some member of the Council to speak in explanation of that part of the report which he considers censures the Council.

Dr Kopetzky A point of information. Did the Council exceed its authority under the Constitution and By-Laws or did they comply with the Constitution and By-Laws in ordering this referendum?

The Speaker I should answer that they did not exceed their authority.

## PRESIDENT ELECT

Dr Kopetzky Second, the Committee approves and recommends the adoption of changes in the constitution and by-laws to provide for the office of "a President-elect" and submits the following amendments to the By-laws to cover the recommendations

That the Constitution be amended as follows

Article 5 Line 1, after the word 'President', insert the word 'President-elect'

## BOARD OF TRUSTEES

Dr Kopetzky Your Committee feels that the President's recommendation that the Society provide itself with a Board of Trustees whose duties it will be to study the needs and guide the control of the expenditures of the Society is indeed not only a well thought out recommendation, but a necessity if this Society is to function efficiently and without a waste of its funds, and we heartily approve this recommendation and in pursuance therewith we propose the following amendments to the Constitution and By-laws

## CONSTITUTION

Article V—Line 5, before the word "and" insert the words "five trustees"

Line 8, after the sentence ending with the word "years" insert the sentence "One trustee shall be elected annually to serve for a period of five years"

Article VIII, Line 9, strike out the word "Council" insert the words, "Board of Trustees"

Line 13, strike out the word "Council" and insert the words, "Board of Trustees"

## BY-LAWS

Sec 6, line 4, after the semi-colon (,) insert the words "(c) the Trustees", strike out the letter (c) and insert the letter (d)

Line 5 strike out the letter (d) and insert the letter (e)

Sec. 12, after line 12, insert a new line 13 to read "Report of the Trustees"

In the eight lines following change the numbers 8 to 15, inclusive, to read 9 to 16 inclusive

Sec 13 after the word "Officers" insert the word "Trustees"

Line 9, before the word "Chairman" insert the word "Trustees"

Sec 14, line 3, before the word 'censors' insert the word "Trustees"

After Sec 19, insert the following new sections

Section 20 At the first meeting of the Board of Trustees following the annual meeting of the House of Delegates, it shall organize and elect the Chairman The Board of Trustees shall hold regular meetings at times and places that shall be fixed by the Chairman, and any three members of the Board of Trustees may require the Chairman thereof to call a meeting for such time and place as shall be designated by them in writing of which the members of the Board shall have at least 2 days' notice

Section 21 The Board of Trustees shall have charge of all property and manage the financial affairs of the Society The budget prepared by the executive committee shall be submitted to the Board for its approval and all resolutions or recommendations of the House of Delegates or Council pertaining to the expenditures of money must be approved by the Board of Trustees before the same shall become effective

Section 22 All moneys of the Society received by the Board of Trustees, Council or any member or agent thereof shall be paid to the Treasurer of the Society The Board of Trustees shall approve the bond of the Treasurer as to amount, form and surety it shall employ a public accountant to audit the accounts of the Treasurer and Secretary and other agents of the Society and present a statement of the same in its annual report to the House of Delegates The Board of Trustees shall

make a report to the House of Delegates of its transactions for the year and of the amount of money belonging to the Society under its control

Section 23 Three (3) Members of the Board of Trustees shall constitute a quorum

Section 24 The following shall be the order of business at meetings of the Board of Trustees

1 Calling the meeting to order

2 Roll call

3 Reading of minutes

4 Communications

5 Reports

6 Unfinished business

7 New business

Section 25 In case of any vacancy on the Board of Trustees through death, resignation, disqualification, or other cause, the President shall appoint a successor to fill such vacancy until the next meeting of the House of Delegates

Section 26 At the annual session of the Society held in the year 1926, five (5) Trustees shall be elected by the House of Delegates They shall divide themselves according to their tenure of office, to wit, one to serve for five (5) years, one to serve for four (4) years one to serve for three (3) years, one to serve for two (2) years, and one to serve for one (1) year Thereafter, one shall be elected to serve for five years at each annual meeting

Sec. 20, line 1, change the number 20 to "27"

Sec 21, line 1 change the number 21 to "28"

Sec 22, line 1, change the number 22 to "29"

Sec 23 line 1 change the number 23 to "30"

Sec. 23, line 2 strike out the word "shall", line 3, strike out the entire line, line 4, strike out the words *affairs of the society*

Sec. 24, line 1, change the number 24 to "31"

Sec. 25, strike out the entire section

Sec 26, line 1, change the number 26 to "32"

In all succeeding sections change the number of the section

Sec 28, last line, strike out the word "council" and insert the words "Board of Trustees"

Sec 33, line 3, after the word "of" insert the words "The Board of Trustees and of"

After Section 33, insert a new section to be known as Section 40 which shall read

"Sec 40 The President-Elect shall assist the President in the performance of his duties"

Sec 37, line 3, after the word "Council" insert the words, "the Board of Trustees"

Line 35, strike out the word "Council" and insert the words "Board of Trustees"

Sec. 39 lines 4 and 5, strike out the words "Council or the Executive Committee," and insert the words "Board of Trustees"

Line 14, strike out the word "Council" and insert the words "Board of Trustees"

Last line, strike out the word "Council" and insert the words "Board of Trustees"

Sec 42 line 9, after the word "Council," insert the words, "of the Board of Trustees"

Lines 13 and 14, strike out the words *Executive Committee* and insert the words "Board of Trustees"

Line 23 strike out the words *Executive Committee* and insert the words "Board of Trustees"

Line 30 strike out the words *Executive Committee*, and insert the words "Board of Trustees"

Line 34, strike out the words *Council or Executive Committee* and insert the words "Board of Trustees"

Sec. 66 line 4 after the word "Council," insert the words "Board of Trustees"

Your Committee recommends the adoption of the following resolution

## ENABLING ACT

Be it Resolved, that Mr George Whiteside the Council of the Society is hereby instructed to draft a bill for presentation to the Legislature to enable us to amend



Vol 25, No 17  
June, 1925

E. Willard, Catskill, W. R. Sitler, Suffern, James F. Morgan, Brooklyn, G. F. Blauvelt, Nyack, Walter B. Lindsay, Huntington  
Upon motion duly seconded the meeting adjourned to reconvene at eight o'clock in the evening

## EVENING SESSION, MONDAY, MAY 11, 1925

The meeting was called to order by the Speaker at 8:35 P M

### PRIZE ESSAYS

The Speaker We have the report of the Committee on Prize Essays. It is a very short report, there being no essay worthy of the prize, and I ask general consent to suspend Sec. 90 of the By-Laws, in order that the report may be considered now. If there be no objection I shall consider it suspended by general consent, and so ordered.

"The Committee on Prize Essays begs leave to report that no prize was awarded this year. Only one essay was presented. That was a well worked out collection of statistics on a certain subject, but the deductions from them did not seem to the Committee, at least, to be entirely warrantable or worthy of a prize.

Respectfully submitted,

LUCIEN HOWE,  
FREDERIC C. CURTIS, "  
THOMAS H. CURTIN "

The Speaker The report will be received and placed on file.

### LEGAL COUNSEL

'Your Committee of Reference on the Report of Counsel for the period from March 1st, 1924 to April 1st, 1925, has the honor to submit the following report

Your Committee feels that the congratulations and thanks of this body should be tendered to the Counsel upon his success in disposing of one hundred and twenty-nine cases without loss of a single case.

The Counsel's educational propaganda as evidenced in his editorial comments in the Society's Journal as well as his constant interest and vigilance in protecting the laity from impositions of charlatans and irregular practitioners is highly commendable and deserves the official recognition of this body. The Counsel's associate, Mr. Robert Oliver, has rendered excellent service to the State Society in his unswerving fidelity to his chief and his presentation of matters of valuable legal information at meetings of various medical societies.

Your Committee seconds the Counsel's expression of appreciation of Mr. Harry F. Wanvig, the Authorized Representative of the Society, whose time is exclusively given to the administration of the details of the Group Insurance Plan of the Society.

Your Committee strongly endorses the Counsel's advice with reference to the rights and privileges of uninsured members. It recommends without reservation the prompt consideration and affirmative action of this body on the resolutions as outlined by Counsel in the closing paragraphs of his report. Your Committee further recommends that if adopted, a copy of these resolutions be placed in the hands of each member of the State Society.

Your Committee heartily endorses his final recommendations relative to investigation by local committees and report to the Counsel through the presidents of the and county societies the underlying causes of bringing malpractice suits against physicians. Your Committee further recommends that steps be taken to discourage bringing of such groundless suits or detrimental publicity concerning same before judgment has been entered, and, further, that any physician who stimulates a groundless action for malpractice against another physician whereby unjust injury to the accused's professional

standing and reputation may result—whether such action be actuated by unworthy rivalry or jealousy or may be the result of carelessness or thoughtless criticism—should be condemned for unethical and unfair practice and should be subjected to adequate discipline for such offense.

Moved and seconded, that the report be unanimously adopted. Carried.  
Dr Kosmak, New York

### COMMITTEE ON LEGISLATION

Your Reference Committee appointed to consider the report of the Committee on Legislation begs leave to submit the following for your consideration.

We desire to commend the Committee on Legislation of the State Society for its continued devotion to the duties imposed upon it, and especially commend its Chairman—Dr. James N. VanderVeer for his loyalty and untiring efforts for the welfare of the profession of the State.

We also recommend that appropriate expression of appreciation be forwarded by the Secretary of the Society to Governor Alfred E. Smith for his constant watchfulness and effort throughout the legislative and as well for his emergency message on the last day of the session urging that they report and pass the Karle-Dunmore Bill for the better protection of the people of this State. We also suggest a similar expression to be communicated to the other members of the Legislature mentioned in the report as deserving of similar recognition."

I move the adoption of this portion of the report

Seconded and carried.

Dr Kosmak We did not incorporate in our report the recommendations, and I think if we follow them in the printed circular that is sufficient.

### LEGISLATIVE BUREAU

Recommendation number one is approved, that the Legislative Bureau be continued, and a sufficient appropriation, under a budget system to be offered by the new chairman of the Committee on Legislation, be allowed.

I move its adoption

Seconded and carried.

### CONFERENCES COUNTY SOCIETY CHAIRMEN

Dr Kosmak Second, that provision be made for one or more conferences of county legislative chairmen, as in the past.

That recommendation is approved.

Seconded and carried.

### CO-OPERATION WITH SPECIAL SOCIETIES

Dr Kosmak Third, that some provision be made whereby your Committee on Legislation may cooperate with physicians who have grouped themselves into special societies, usually with community interest, some of whose members are not members of the State Society in legislative matters. I believe this will be spoken of in another report, but your committee on Legislation would recommend that the proper changes be made in our constitution and by-laws for some type of legislative representation of such societies is referred to the Council for action.

Seconded.

Dr Rooney I move as a substitute, that the question of authorization of the Committee on Legislation in securing the cooperation of various groups of physicians who are not affiliated with the Medical Society of the State Officially, be referred to the Council for their decision.

Seconded.

The Speaker All those who are in favor of the substitute offered by Dr Rooney will signify by saying aye.

Motion carried

Dr Kopetzky Did the Council fail to carry out any instructions of the House of Delegates?

The Speaker Not as far as I know if any of the instructions included an expenditure of money they were not in agreement with the Constitution and By-Laws, therefore not mandatory on the Council

Dr Rooney Mr Chairman, in order that we may hear from legal Counsel, I would move that we postpone discussion until the evening recess

Seconded, and carried

#### EDUCATION (see page 814)

Dr Critchlow, Reference Committee on New Business A, reports on the resolution presented by Dr Wightman

"Resolved, that when any action has been taken by the House of Delegates of the Medical Society of the State of New York in session or by a referendum vote by the component County Societies, the majority vote so recorded shall determine the attitude of the County Societies, and that any public action or appearance of the individual County Society against the recorded opinion of the State Society's majority vote shall be a breach of Medical Ethics

This resolution is not meant to limit or prevent the expression of anyone's personal opinions or views"

Your Committee is persuaded that the objects sought to be attained in this resolution are for the welfare of the Society as a whole, particularly where the legislative interests of the Society are concerned

We believe that the best interests of the Society will be conserved if all differences of opinion within the Society be allowed the freest discussion We believe also, however, that the legislative Committee should not be compelled to explain such difference of opinion to the State Legislature, thus giving the impression of a divided Society

We would earnestly appeal to all component county societies to loyally support all action that any be taken in any matter as determined by a majority vote of the House of Delegates

We would amend the resolution to read as follows

"Resolved that when any action has been taken by the House of Delegates of the Medical Society of the State of New York in session or by a referendum vote by the component county societies, the majority decision so recorded shall be morally binding on all county societies in their activities relating to state legislative matters"

Move the adoption and seconded.

Dr Wightman Might I say, Mr Speaker, that I accept that amendment in a spirit of co-operation

The Speaker It is moved and seconded that the amendment which is accepted by the mover and now becomes a part of his original resolution be adopted.

Motion carried.

#### COMMITTEE ON PUBLIC HEALTH AND MEDICAL EDUCATION (see page 814)

Dr Ross, Chairman of Reference Committee on Public Health and Medical Education

The Committee on Scientific Work stole the thunder of this Committee's work. We will read it, and if they conflict you can reconcile them

The Report of the Committee on Public Health and Medical Education consists of suggestions for ten activities which might be considered by the State Medical Society The Reference Committee endorses all of these suggestions but especially emphasizes two of the subjects touched upon in the report Suggestions one and ten relate to periodic health examinations Your Committee endorses the movement and recommends that it be promoted in the pages of the Journal and by county societies

Suggestions four, six and seven relate to graduate medical education The Reference Committee recommends that the promotion of graduate medical educa-

tion be one of the major activities of the State Medical Society during the coming year The need and the desire for graduate medical education exists and it only awaits practical organization of method. There is abundant evidence of the truth of this statement in the result of evidence made in several States and Counties, notably Kings

In these times of rapid change of knowledge and practice there is need for some method of providing a steady stream of medical information to all sections away from medical centers as well as to make available to city practitioners the results of medical progress This work belongs to organized medicine.

Keeping every physician in the State fully informed as to advancing medical knowledge would be the most potent factor in the advancement of public health. The Reference Committee recommends that the House of Delegates authorize the Council to request the House of Delegates of the American Medical Association to cooperate with the Medical Society of the State of New York to the end that all available material for graduate medical instruction including teachers, charts, lantern slides, moving pictures, etc., be made available to the appropriate committee of the Medical Society of the State of New York for carrying out this plan and that the Council be authorized to appropriate as much money as they may deem expedient for the work of graduate medical instruction"

The Speaker It is moved and seconded that the report be adopted

Dr Phillips I feel that this House of Delegates should give a little more serious consideration to the report of the Committee in Public Health and Medical Education. Perhaps some of you are not aware that for several years the Council on Medical Education of the American Medical Association has been gradually developing a system of post graduate instruction and to make it available not only for states, but for counties, so that gradually there is being developed a system by which any state may apply to the American Medical Association and get the material, get the slides, get a great deal of help that would save enormous financial expense by the state or by the county, and in that way get before the smaller bodies from the constituent state and county societies the opportunity for medical education, and it is really post graduate instruction I would like if it could be done, to have this House of Delegates, in the line with this report, get it into some form so that you could go before the Council on Medical Education of the American Medical Association and make formal application that they enter into the work in conjunction with this state society in order that we might carry out a state wide system of work on post graduate medical education

The Speaker You could move to refer the report back to the Committee and have them incorporate some of the suggestions stated

Dr Phillips With this object in view I move that the matter be referred back to the Committee.

Seconded and carried

The Speaker It is so referred

#### RETIRED MEMBERSHIP

We have a number of applications for retired membership, and if there be no objection we will suspend section 90 of the By-laws, and consider them now It is so ordered.

The Secretary read the following applications for retired membership, and, upon motion duly made and seconded, each in turn was approved by the unanimous vote of the House

Miriam Gardner, Smyrna Arthur Middleton Jacobus, New York City, David F King, New York City, Walter E Lauderdale, Geneseo Archibald Lybolt, Bogot, N J, Constantine J McGuire, New York City, George W Miles, Oneida, Samuel Sherwell, Brooklyn, Charles

Vol 25 No 17  
June, 1925

The recommendation of your committee is that this matter be referred to the Council  
Seconded and carried  
Dr Kosmak Twelve

#### ATTITUDE ON BILLS

'12 That this House of Delegates discuss the old and familiar bills as to Birth Control, Anti-vivisection Child Experimentation, amendments to the Medical Practice Act, and place on the records of the House of Delegates what action shall be taken by the Committee on Legislation during the coming year so far as can be determined in the light of past legislation"

Dr Kosmak Number twelve is covered by reference to number ten, and approved by your Committee

The Speaker If there be no objection, the recommendation of the Chairman of the Committee will be adopted. Hearing none, it is adopted unanimously

Dr Kosmak Thirteen

#### MEDICAL ADVISOR BILL

"13 That this House of Delegates go on record as favoring a bill similar to Assemblyman Charles P. Miller's bill, A. Int. 1361, and direct your Committee on Legislation to confer with the County Legislative Chairman and legislators urging the passage of the same or some similar measure."

Number 13 is approved, provided that the nominating power is conferred upon the Council if the Legislation becomes effective

The subject matter of this recommendation is based upon the following paragraph in the report of the Committee

"Assemblyman Charles P. Miller of Genesee County introduced a bill amending the Workmen's Compensation law by providing for the appointment of a physician as Medical Advisor to be chosen from a list submitted by the Medical Society of the State of New York. This bill to a large degree would solve the crux of the conflict which has existed in the labor laws relative to medical attendance, judgment, supervision, advice to the industrial board, examination of fee bills examining physicians, employment of specialists, and the like."

The recommendation of your Reference Committee is that this recommendation be approved, provided that the nominating power is conferred upon the Council if the legislation becomes effective

Dr Frank Jennings I would like to inquire, through you, sir, of Dr Vander Veer, if I may, if that bill is the bill which provided that the medical advisor selected by the State Medical Society is to appoint his subordinates on salary? If so, the bill hasn't a Chinaman's chance. The bill is fallacious, if you will permit me to say so, in that it would permit a subordinate in a department to appoint subordinates under him, taking the appointing power away from the head of the department.

The Speaker Any further discussion? All in favor say aye, opposed no It is lost

Dr Kosmak Fourteen

#### NARCOTIC BILL

"14 That this House of Delegates approve or disapprove of the wording and legislative thought contained in the Kennedy-Wenfeld bill concerning habit-forming drugs"

Your committee approves this recommendation in accordance with the action of the House of Delegates of 1924

Dr Rooney I move as a substitute that the question of the approval or disapproval of any narcotic bill introduced in the Legislature of 1926 shall lie in the hands of the Council of the State Society

Seconded and carried

The Speaker The substitute has been approved, and is now before you as the main motion All those in favor say aye Opposed no Carried.

Dr Critchlow, of Erie I move you sir, a reconsideration of the action that was taken in regard to the previous recommendation of the Legislative committee

Seconded and carried

The Speaker The motion is carried and the question reconsidered is before you Any discussion upon number 13?

Dr Rongy, New York On a point of order I believe the entire motion to reconsider is out of order The report of the committee has not been accepted, and we cannot reconsider any part before the entire report is received

The Speaker The point of order is not well taken

Dr Rooney A point of information Is it possible for the Legislature to save to the Medical Society of the State of New York when one of these positions is open, that they shall not nominate the physician?

The Speaker The Chairman of the Committee will be glad to answer you

Dr Kosmak The nominations were to consist of three, from whom one was to be selected for this office, and the idea of the Reference Committee was that this nominating could be done more effectively by the Council than by any other means

Dr Rooney May I ask if the legal Counsel has been asked about that proposition?

Dr Phillips It strikes me that the nominating power would be the House of Delegates, and this House of Delegates can delegate that nominating power I see no reason why they cannot delegate that nominating power

Dr Rooney It is not a question as to which part of the Medical Society of the State of New York shall do the nominating, it is a question of a bill that delegates to the Medical Society of the State of New York the power of nominating to office a person who is a member of the State Department. It is just as though we were to delegate the power to some one outside of ourselves to nominate to office in the Society, and that seems to be the only point which militates against the bill

The Speaker That seems to be a legal question and I will call upon our legal Counsel to answer the legal questions involved

Mr Whiteside It seems to me the question is rather academic. At first you have to have the power before you discuss as to whether you can exercise it. I would suggest that we try it on and see whether we can do it I see no point in anticipating possible success or possible defeat. I think we should try and see whether or not this power can be exercised by this corporation, which is especially created by an act of legislation which has always been recognized as of a quasi-public character

The Speaker Are you ready for the question? All in favor say aye, opposed no Carried

Dr Kosmak Fifteen

#### CHOICE OF PHYSICIAN

"15 That this House of Delegates record itself as for or against the free choice of physicians by an injured workmen"

Recommendation number fifteen is approved, with the recommendation that the House of Delegates, record itself as "for" the free choice of physician.

Seconded and carried.

Dr Kosmak Sixteen

#### COMMITTEE ON WORKMEN'S COMPENSATION LAW

"16 That the Committee which was appointed to study the Workmen's Compensation Law be continued or a similar committee be appointed, and that they be directed to place in the hands of the Counsel their recommendations for amendments to the Workmen's Compensation Law in relation to the medical features thereof by September 1st, 1925 in order that the Counsel may draft the proper bills for introduction, and sub-

The Speaker The substitute which has just been carried becomes the original motion.

Seconded and carried  
Dr Kosmak Fourth

#### EXECUTIVE EDITOR

That your Executive Editor be directed to come to Albany during the legislative session and spend one or more days in Albany each week at the expense of the Society, thus becoming more familiar with legislative matters and being able the more to edit legislative articles for the benefit of the Journal

Seconded and carried  
Dr Kosmak Five

#### EDUCATION OF THE PUBLIC

'5 As before, we again recommend a broad dissemination of education on public health questions through the public press by means of someone of the adjunct committees of the State Society—thus laying a better foundation for the legislation which may come up, and would respectfully suggest (a) That the Journal of the State Society be sent during the Legislative season to all the legislators, to the newspapers published in this State, to the officers and members of the Executive Committees of the allied professions, State or District Societies of nurses, dentists, school medical inspectors, health officers' associations and the like, and to a selected group of lay societies (b) That conferences be held in the Council of the Society as to certain other selected medical and educative publications which should be sent to these groups

The Committee approves that recommendation

Dr Phillips It is going to involve a question of considerable expenditure of money, and I do not think we have a right to make that recommendation as a body I think it should be referred to the Council, and I move as a substitute that this recommendation be referred to the Council

Motion to refer to the Council

Seconded and carried  
Dr Kosmak Six

#### PHYSICIANS APPEARING WITHOUT CONSULTING COMMITTEE ON LEGISLATION

6 We would again recommend that the same rule be adopted in relation to physicians—members of the State Society—appearing before Committees of the Legislature without first consulting with the Chairman of the Committee on Legislation

This recommendation is approved by the committee

Seconded and carried  
Dr Kosmak Seven

#### MEET LEGISLATORS

7 That the County Societies be urged to meet with their legislators in the fall or at some convenient time in a social way and that it be obligatory on the County Society to so report to the Council or Committee on Legislation since much good has come from the meetings so held by many County Societies but, unfortunately, the reports of such meetings only reach the Legislative Bureau in a roundabout way

The Committee approves of that recommendation

Seconded and carried  
Dr Kosmak Eight

#### PROPOSING LEGISLATION

"8 That legislation which is sought by County Societies and individual members be sent in to the Bureau in the early Fall, so that the Counsel of the Society may draw up in proper form such legislation and submit it to the Council and Committee on Legislation before the opening of the session and that any Legislative suggestion or thought within or by a County Society shall

be in the hands of the Council for approval or disapproval not later than September 1st, 1925

Moved and seconded

That recommendation No 8 be adopted

Dr O'Reilly I would like to offer an amendment to that, Mr Speaker, that these communications from County Societies be in the possession of Council not later than July and that they be printed in the Journal not later than September 1, and that the columns of the Journal be open to a full discussion on the merits and demerits

Dr Kopetzky, New York I move that the amendment presented by Dr O'Reilly be laid on the table

The Speaker If it doesn't include the main question I must declare your motion out of order When a motion is laid on the table every motion adhering to it goes with it. Is there any further discussion? If not we will now vote on the amendment offered by Dr O'Reilly The amendment is lost. We will now vote upon the original motion of the chairman of the committee Carried

Dr Kosmak Nine.

#### ADVISORY COMMITTEE

"9 That the Council of the Society be directed to form some type of Advisory Committee of the profession of this State which shall eventually become an Advisory Council to governmental officers or departments when advice is so sought, since in many instances some physicians in private meetings with legislators hold themselves out to be representatives of many of these bodies and would convey to the individual legislators the thought of their importance of position, thus negating the efforts of the duly accredited officers of the various and individual professional societies This does not work for a harmonious entity in matters of public health legislation but by such a movement a body would be created which can speak with authority in allied matters of public health from all angles pertaining to the people of this State."

Number Nine is approved, but modified as follows That the President annually appoint a committee of five members of the State Society including himself and the Chairman of the Committee on Legislation with the approval and advice of the Council, and that the fact of such appointment be communicated to interested bodies such as the various state governmental officers and departments, and professional and lay organizations interested in medical and public health activities by the Secretary of the Medical Society of the State of New York."

Seconded and carried

Dr Kosmak Ten

#### ATTITUDE ON BILLS

"10 That the position of the State Society in relation to legislation as it may appear in the legislature be the same on such similar matters as has maintained in the past years unless a specific resolution be passed by the House of Delegates, by referendum vote or by the Council, thus changing the position of the Society without placing the burden of the change on the Committee on Legislation"

Seconded and carried.

Dr Kosmak Eleven.

#### STATE INSTITUTIONS

"11 That legislation which has come up in the past session in reference to the State Institute for the Study of Malignant Disease at Buffalo, and the State Hospital for Crippled and Deformed Children at West Haverstraw, be referred by the House of Delegates to the proper committee of the Society for study and suggestions as to action for your next Committee on Legislation The same report to be given to the Council by September 1st 1925, that they may act upon it for the guidance of the Committee on Legislation."

## ADJOURNED SESSION OF THE HOUSE OF DELEGATES, TUESDAY, MAY 12, 1925

The meeting was called to order by the Speaker at 9 30 a.m.

The Speaker We will hear the report of the Chairman of the Committee on Credentials

The Secretary The Committee on Credentials report that the roll is complete

The Speaker The Secretary will call the roll.

### ROLL CALL

The Secretary called the roll and the following delegates responded Nelson K. Fromm, L. Whittington Gorham, Thomas W. Jenkins, Chauncey R. Bowen, J. Lewis Amster, Edward R. Cunniffe, W. Meddaugh Dunnung, Cornelius J. Egan, Edward C. Podvin Norman Roth, Edmund E. Specht, Nathan B. Van Etten, Frank M. Dyer, Joseph J. Kane, William B. Johnston, Raymond C. Almy, Edgar Bieber, George W. Cotts, Reeve B. Howland, Leo F. Schiff, Charles D. Ver Nooy, John A. Card, James B. Sadlier, L. Franklin Anderson, Charles R. Borzilleri, W. Warren Britt Marshall Clinton, George R. Critchlow, James A. Gardner, Julius H. Potter, Sidney F. Blanchet, Sylvester C. Clemans, Clarence J. Whalen, Alton B. Daley, Charles J. Diss, Murray MacG. Gardner, John L. Bauer, William F. Campbell, Claude G. Crane, William H. Field, Charles H. Goodrich, Charles A. Gordon, Edwin A. Griffin, George D. Hamlin, Frank D. Jennings, John E. Jennings, William A. Jewett, Henry Joachim, J. Richard Kevin, William Linder, Walter D. Ludlum, Philip I. Nash, John J. A. O'Reilly, Harry H. Patrie, Charles E. Scofield, William Schroeder, Jr., James Steele, Alec N. Thompson, George H. Gage, Samuel H. Rosenthal, Willard H. Veeder, Floyd S. Winslow, Warren Wooden, David Wilson, Arthur D. Jaques, George A. Newton, Walter H. Conley, Edward C. Brenner, Milton A. Bridges, David E. Hoag, S. Dana Hubbard, Edward M. Cole, Jr., Daniel S. Dougherty, William M. Patterson, Harold Hays, William P. Healy, Ward B. Hoag, Samuel J. Kopetzky, George W. Kosmak, Samuel Lloyd, J. Milton Mabbott, Henry S. Patterson, James Pedersen, Otto H. Leber, Alfred C. Prentice, Abraham J. Rongy, Louis Tulipan, DeWitt Stetten, Terry M. Townsend, Luther M. Jayne, William A. Peart, Robert L. Bartlett, David H. Roberts, Andrew Sloan, Henry B. Doust, Frederick W. Sears, Homer J. Kuckerbocker, Warren B. Andrews, Frank E. Fox, Addison H. Bissell, Carl Boettiger, Thomas C. Chalmers, Henry C. Courten, L. Howard Moss, Joseph S. Thomas, Frank M. Sulzman, D. Vincent Catalano, E. Warren Presley, Charles D. Klune, Stanley W. Sayer, Carl R. Comstock, Dudley R. Kathan, Frederick C. Reed, LeRoy Becker, Allen W. Holmes, Robert M. Elliott, Herbert B. Smith, William J. Tracy, Frank Overton, William H. Ross, Luther C. Payne, Luther Emerick, Morris Maslon, Zenas V. D. Orton, Lucius H. Smith, Edward F. Briggs, Romeo Roberto, George B. Stanwix, Edward W. Weber, George B. Welker.

The following officers and chairmen of standing committees were present Owen E. Jones, George A. Leitner, Luzerne Coville, E. Eliot Harris, George M. Fisher, Andrew MacFarlane, James N. Vander Veer, Frederick H. Flaherty, Edward C. Rushmore, Frank H. Lasher, Arthur J. Bedell, Nelson O. Brooks, Harry R. Trick.

The following ex-presidents were present Arthur W. Booth, George H. Fox, Thomas H. Halsted, Grant C. Madill, Wendell C. Phillips, James T. Rooney, Charles Stover, Grover W. Wende.

### ELECTION OF OFFICERS

The Speaker There being a quorum present, the House is organized for business, and we will proceed to the election of officers. The first nomination is for President. The following officers were nominated and declared unanimously elected.

President, Dr. Nathan B. Van Etten, New York City, Vice-President, Dr. William H. Ross, Brentwood, Second Vice-President, Dr. Frederick H. Flaherty, Syracuse, Speaker, Dr. E. Eliot Harris, New York City, Vice-Speaker, Dr. George M. Fisher, Utica, Secretary, Dr. Daniel S. Dougherty, New York City, Assistant Secretary, Dr. Howard G. Myers, New York City, Treasurer, Dr. Charles Gordon Heyd, New York City, Assistant Treasurer, Dr. James Pedersen, New York City, Chairman of the Committee on Scientific Work, Dr. Andrew MacFarlane, Albany, Chairman of Committee on Public Health and Medical Education, Dr. Charles A. Gordon, Brooklyn, Chairman of Committee on Medical Economics, Dr. William W. Britt, Tonawanda. Upon motion duly seconded and carried the selection of the Chairman of the Committee on Legislation was left to the Council. Upon motion, duly seconded and carried, the selection of the Chairman of the Committee on Arrangements was left to the Council. Committee on Prize Essays, Dr. Lucien Howe, Buffalo, Dr. John E. Jennings, Brooklyn, Dr. Thomas H. Curtin, New York City, Censors. To consist of the President and Secretary and eight District Councillors, as provided by the Constitution.

Five delegates to the American Medical Association, for two years: Dr. Owen E. Jones, Rochester, Dr. Arthur W. Booth, Elmira, Dr. Grover W. Wende, Buffalo, Dr. Grant C. Madill, Ogdensburg, and Dr. William Francis Campbell, Brooklyn.

Five alternates to the American Medical Association for two years: Dr. James N. Vander Veer, Albany, Dr. George A. Leitner, Piermont, Dr. Nelson O. Brooks, Oneida, Dr. L. Howard Moss, Richmond Hill, and Dr. Edward C. Podvin, New York City.

The Speaker We will hear reports of the Reference Committees.

### SECRETARY'S AND TREASURER'S REPORTS

Dr. Pedersen, Chairman of the Reference Committee on the Report of Secretary and the Report of the Treasurer. We have the honor to submit the following recommendations:

As to the Secretary's report: Your Committee recommends that the plan to conserve the Society finances, as outlined in the report, be endorsed without, however, necessarily establishing a so-called "sinking fund" now. The Committee feels that the subject of a sinking fund should be postponed for discussion a year or more.

In consequence of the increased dues, your Committee anticipates a considerable balance at the close of the current year. Therefore, we recommend that a conservative budget be submitted by the Executive as provided by the By-laws, and that the major part of any balance remaining at the close of the year be temporarily invested under the control of the Council.

As to the Treasurer's report: It having been audited and found correct, your Committee recommends its acceptance.

Seconded and carried.

Dr. John E. Jennings, Reference Committee on the Report of Council and Councillors.

### REPORTS OF COUNCIL AND COUNCILLORS

The Committee recommends the acceptance of the report of the Council but calls attention to the neglect of Council to comply with the spirit of the recommendation of the House of Delegates in adopting the report and recommendation of the Reference Committee C at the annual meeting of the House of Delegates held in Rochester in 1924, namely, that such amendments to the Public Health Law as are necessary be formulated by the Council and by them referred for approval by referendum sent by mail to the House of Delegates.

The action of the Council on February 18, 1925, approving measures already before the Legislature and ordering a referendum of the House of Delegates, on

mit them to the Council by the 1st of December, 1925, should the Council pass favorably upon their introduction

Recommendation Sixteen is approved by the Committee.

Seconded.

Dr O'Reilly A point of information Is it recommended that the committee in charge of this matter be continued, or a similar committee be appointed?

The Speaker That is left to the President to make a choice either way All in favor of that motion say Aye, opposed, no Carried

Dr Kosmak Seventeen

#### LEGISLATIVE SUGGESTIONS

"17 That any legislative suggestion or thought within or by a County Society shall be in the hands of the Council for approval or disapproval not later than September 1st, 1925"

Your committee approves that recommendation

Dr O'Reilly A point of information, isn't that the same proposition as number eight?

The Speaker The recommendation number eight was carried Number seventeen is the same as number eight and no action is necessary

Dr Kosmak Eighteen

#### DIRECTING EXECUTIVE OFFICER

"18. That the House of Delegates direct that the services of the Executive Officer shall be wholly under the direction of the Committee on Legislation from the 1st day of December until one month after the closing of the legislative session"

Dr MacFarlane I move as an amendment to that paragraph "The House of Delegates directs that the services of the Executive Officer shall be largely under the direction of the Committee on Legislation," not entirely so

Seconded

Dr Phillips I move that eighteen be referred to the Council, with power

Seconded, and, upon a rising vote, carried

Dr Kosmak Nineteen

#### PRESS BUREAU

"19 That some means be devised whereby articles on medical topics may be syndicated to newspapers through the editorial office of the Journal, or a Press Bureau to be established within one of the standing committees of the Society, from whence can be sent to newspapers, lay organizations, churches, schools, and the like, authentic and interesting articles concerning the public health and the duty of the individual in relation to the health of his neighbor This is one of the crying needs of the Society at the present time and it might be of advantage to the Society were some journalist engaged upon half or full time to help the committee upon whom such work would fall

Your Committee approves this recommendation and requests that it be referred to the Council for further action

Seconded and carried.

Dr Kosmak I move that the report as amended be adopted as a whole Seconded

#### ACTION ON THE REPORT AS A WHOLE

Dr Frank Jennings Action on question 12, as I understand it, was a blanket action on the basis that in having passed number 10 we passed 12 Is that right? I voted in the affirmative on number 10 I would like to move for the reconsideration of number 10

Seconded

Motion to reconsider the adoption of number 10 is lost.

Dr Ludlum, Brooklyn As I understand it, section 12 was passed by unanimous consent by declaration of the Speaker That is my understanding Therefore, we can proceed to the reconsideration of number 12, if

we so desire, and I therefore, subject to correction, as to Parliamentary procedure, move that we reconsider number 12, which we unanimously passed by consent.

The Speaker Your motion to reconsider is in order

Dr Ludlum I so move.

Seconded

Motion to reconsider the adoption of number 12 is lost.

Dr Ludlum We have not been enlightened as to our exact position on this situation I suppose we are opposed to Birth Control, anti-vivisection, and Child Experimentation by the action so far taken, but can take action when other reports of this committee are brought in Is that where we stand? The House of Delegates stands opposed to these first three and in favor of the Karle-Dunmore bill?

Dr Kosmak I think it was the idea that we would endorse the recommendation of the Chairman of the Committee on Legislation in reference to the changes made by these measures by any other means than those which are referred to, that is to say by the House of Delegates or by referendum vote, or by the Council changing the position of the Society and not placing the burden of such changes on the shoulders of the Chairmen of the Legislative Committee.

In recommendation 12, the action of the House of Delegates on these three bills is acknowledged, I believe The action on the question of the amendments to the Medical Practice Act I believe has been concluded by the referendum made by the Society, and therefore we accepted that interpretation Now the action of the Society was against these other three bills and it was in favor of amendments to the Medical Practice Act

Dr Ludlum I still do not think we are taking proper action on 12 The recommendation is that this House of Delegates discuss The Speaker of the House declared that this matter had been disposed of by number 10 How a discussion can be disposed of in that way is hard to understand, that is the discussion was closed by not being entered into

Dr O'Reilly A point of information I cannot vote upon this in view of the statement of the Speaker that number 10 covers number 12, and that number 12 required no vote We are now voting upon this report as a whole, making number 10 inclusive of number 12

Dr Ludlum Is it now in order to appeal from the decision of the Speaker, made an hour ago, that 12 was covered by 10?

The Speaker An appeal from the decision of the chair must be made before any debate or new business intervenes The announcement of a vote is not a decision of the Chair, therefore not subject to appeal The speaker's decision was that the House of Delegates unanimously carried the adoption of No. 12 as recommended by the Reference Committee. Then separate motions were made to reconsider No. 10 and No. 12 and both motions to reconsider were lost The only way you can further reconsider No. 10 and No. 12 is by unanimous consent.

Dr Kosmak Moved the adoption of the report as a whole.

Seconded and carried

#### MEDICAL PRACTICE BILL (see page 803)

Dr Kosmak With reference to the resolutions introduced by Dr Chalmers, of Queens, we desire to express our disapproval, as these are contrary to a referendum vote taken during the Legislative session of 1925

Seconded

The Speaker It is moved and seconded that the recommendation of the Committee be adopted

Are you ready for the question? All in favor of adopting the report of the Committee will signify by saying aye. Opposed, no The Chair is in doubt.

Upon a rising vote the motion was carried.

Upon motion, duly seconded, the meeting adjourned to Tuesday morning, May 12, at 9 30 in the forenoon

cal education The Reference Committee recommends that the promotion of graduate medical education be one of the major activities of the State Medical Society during the coming year The need and the desire for graduate medical education exists and it only awaits practical organization of method There is abundant evidence of the truth of this statement in the result of efforts made in several States and Counties, notably Kings

In these times of rapid change of knowledge and practice there is need for some method of providing a steady stream of medical information to all sections away from medical centers as well as to make available to city practitioners the results of medical progress This work belongs to organized medicine.

Keeping every physician in the State fully informed as to advancing medical knowledge would be the most potent factor in the advancement of public health The Reference Committee recommends that the House of Delegates authorize the Council to request the House of Delegates of the American Medical Association to cooperate with the Medical Society of the State of New York to the end that all available material for graduate medical instruction including teachers, charts, lantern slides, moving pictures, etc, be made available to the appropriate committee of the Medical Society of the State of New York for carrying out this plan and that the Council be authorized to appropriate as much money as it may deem expedient for the work of graduate medical instruction

I move its adoption

Seconded and carried

Dr Wightman I would like to introduce two amendments.

#### AMENDMENTS TO CONSTITUTION

Amend section 20 of the By-laws, second line, by striking out the word "Society," and inserting the words "House of Delegates"

Amend section 28 by striking out on line 2, the words, after the word Council," and before the word 'shall,' on the third line.

The Speaker They will be placed on file.

#### WHEN TERM OF DELEGATES BEGIN

Dr Wightman Another matter I would like to bring to your attention is relative to the election of delegates, and I would like to offer this as a resolution The term of a delegate elected by a component county medical society shall begin at the first annual meeting of the House of Delegates subsequent to his election.

Dr Kevin I move you as a substitute to the motion, that Dr Wightman be appointed a committee of one to make recommendations for the solution of this question to the next House of Delegates

Seconded and carried.

The Speaker Dr Wightman is so delegated

The Speaker We will hear from the Chairman of the Reference Committee on Medical Economics

#### COMMITTEE ON MEDICAL ECONOMICS

Dr Britt Your Reference Committee on Medical Economics begs to report as follows Owing to the illness of Dr Henry Lyle Winter, his report was not received in time for publication in the printed reports Your Reference Committee wishes to commend Dr

Winter for the careful and extensive report submitted and recommend that this House of Delegates extend to Dr Winter a vote of thanks for his faithful service to this Society during his long term of office

Seconded and carried

Dr Britt We would like to submit the report of Dr Winter and read it to the House of Delegates

Dr Chalmers I move the report be printed in the next issue of the Journal

Seconded

Dr Mabbott May I ask the Chairman whether there is anything important in it, in his opinion, which ought to be read to us now, and whether he could select any small portion of it that is important

Dr Britt It is submitted under the following headings

- 1 The Work of the New York State Council of Rural Workers
- 2 Nursing Problems
- 3 Health Insurance.
- 4 Workmen's Compensation
- 5 The Medical Practice Act.
- 6 Health Centers, with special reference to the plan adopted by the Medical Society of the State of California.
- 7 Pay Clinics

During the current year the increased activities of the advocates of Birth Control have attracted notice and your Committee has had the subject under consideration

Dr Ludlum It seems to be impossible to consider an attractive report like this without having the opportunity to consider it in advance Therefore, I would move that this report be referred to the Council with power

Seconded and carried

The Speaker Has any member introduced a resolution that has not been reported back by a Reference Committee?

The Vice-Speaker took the chair

#### VOTE OF THANKS TO COMMITTEE ON ARRANGEMENTS

Dr Bedell I move you, sir, that this House go on record as thanking the local arrangements committee for the entertainment that they have provided for us, and that that expression be transmitted to Dr Flaherty as Chairman of the Committee.

Seconded and unanimously carried by a rising vote

#### COMMITTEE TO DRAFT MEDICAL PRACTICE ACT (see page 803)

Dr Chalmers In order that we may all get together and have a Medical Practice Act next year which we can all support, I wish to offer the motion, that the President shall appoint a Committee of seven with power to draft a Medical Practice Act which shall be the official bill of this Society, and that the same be published in the September issue of the Journal.

Seconded

Upon motion, duly seconded and carried, the rule that all resolutions go to a Reference Committee was suspended, whereupon the motion of Dr Chalmers was carried

Upon motion, duly seconded and carried, the meeting adjourned.

E. ELIOT HARRIS *Speaker,*  
EDWARD LIVINGSTON HUNT, *Secretary*

its approval is not deemed a full compliance with the recommendations of the House of Delegates

The Committee recommends the adoption of the reports of the Councillors of the third, fifth, sixth, seventh and eighth district branches, but calls attention to the neglect of the Councillors of the first, second and fourth district branches to submit reports

I move its adoption

Seconded

The Speaker The legal counsel was requested to answer the question in regard to the implied censure of the Council

Mr Whiteside What are the questions?

Dr Kopetzky I ask, through the Speaker, that the Counsel of the Society inform us of any neglect of the Council to carry out the mandate of the House of Delegates, so that I may vote intelligently

Mr Whiteside The inquiry is directed toward the making of a defense against a charge of neglect, apparently. It appears there is a charge of certain neglect against the Council. Before entering into a discussion of the merits, as to whether or not there was any neglect, I would like to consider whether the Council should be placed in a position where it even ought to discuss the question. The Council of the Society is the executive department of the Society, clothed with all executive powers. It occupies the same position in the government of this Society that the executive of the State occupies in the government of the State. This House of Delegates is a legislative branch of the Medical Society of the State of New York. The Council is its executive branch. They are independent one of the other, except as far as the power of the House of Delegates reaches out to legislate upon matters concerning the affairs of the Society.

It is no function, if I may say so, of the House of Delegates to pass votes of censure upon any executive officer, and for the same reason it is my opinion that the House of Delegates has no power to criticize any executive officer. They may have a right under the By-laws or the Constitution to file charges against any officer, or any particular body in the Society, and to try those charges on the merits, sitting as a court to hear the evidence and to determine the facts thereon, but simply in the form of a resolution or in the form of a report, I am of the opinion that this House has no power to pass judgment in the nature of criticism, or to make a charge of this character, either directly or by innuendo, reflecting upon Council of the Society.

If the first point is well taken, it may be unnecessary to proceed to the second, which would be a discussion of the merits.

May I ask what is the decision of the House on this point?

Dr Kopetzky I arise to make a point of order since the gentleman has not the right to do so. I make the point of order that under the argument as presented by counsel, the consideration of a report carrying an implied criticism of an executive of this Society is out of order, and that the consideration of that portion of the report is therefore out of order.

The Speaker As the Speaker happens to be a member of the Council, modesty forbids his deciding the point of order and therefore he submits it to the House. All in favor of that portion of the report reflecting upon the Council shall be stricken out as out of order say aye opposed no.

Motion carried

The Speaker The House has stricken that out of your report Dr Jennings the censure of the Council. Upon motion, duly seconded, the report as deleted, was adopted.

#### COMMITTEE ON NURSES

Dr Andrew Sloan Chairman of Committee on Report of the Special Committee on Nurses

"The Committee on Report of the Special Committee on Nurses has carefully analyzed the printed report of

the Committee on the nurse problem and has reviewed various opinions and records, verbal and written offered by members of the House of Delegates and others.

The Committee recognizes the value of many of the suggestions, has not included any suggested legislative changes, and believes that the subject is so tremendous that no final decision regarding supply and demand, training, legislation, or other attempts at solution should be outlined or devised without careful consideration in conference between the medical and nursing professions.

This Committee approves the report of the Committee on nurse problem as printed and their recommendations.

(a) That a Nurse Committee be appointed by the President to work in conjunction with the Committee on Medical Economics to study the problems of the nurse and report annually or oftener to the Society.

(b) That the same committee be authorized to confer with the State Education Department on matters concerning Nurse Education, and especially on that which concerns the proper balance of theoretical and practical training and instruction.

We feel that the Committee on the Nurse Problem has given the subject very careful and thorough study and has earned the thanks of the House of Delegates.

I move the adoption of Section A

Seconded

Dr Dougherty A point of information. It says to report annually or oftener to the society. That means that the Committee might on an inconsequential matter call a special meeting of the Society.

Dr Sloan It was the understanding of the Committee that they report back to the representative of the House of Delegates, which would be the Council.

The Speaker Make that change.

Upon motion, duly seconded, recommendation A was adopted as amended.

Dr Sloan I move the adoption of section B

Seconded and carried

Dr Sloan I move the adoption of this report as a whole.

Seconded

Dr Critchlow I move an amendment to the motion to adopt this report as a whole, the last portion of the report has been adopted. A and B are the recommendations of this Committee. I move that the Committee's report as a whole be received and filed.

Seconded

The Speaker When a report is read it has been received. It is moved that the report as a whole be filed.

Dr Kopetzky I wish to move to amend the motion that is pending, namely the adoption of the Reference Committee's report as a whole and amend it to read "The Reference Committee's Report be adopted as a whole, with this amendment, that in adopting, due and special consideration be given to the facts as presented to this House of Delegates by Erie County."

Seconded and carried

The Speaker Now you will vote on the adoption of the report as a whole with the amendment added as voted. All in favor say aye. Opposed no. Carried.

#### COMMITTEE ON PUBLIC HEALTH AND MEDICAL EDUCATION (see page 808)

Dr Ross Report of Reference Committee on Public Health and Medical Education

"The Report of the Committee on Public Health and Medical Education consists of suggestions for ten activities which might be considered by the State Medical Society. The Reference Committee endorses all of these suggestions, but especially emphasizes two of the subjects touched upon in the report. Suggestions one and ten relate to periodic health examinations. Your Committee endorses the movement and recommends that it be promoted in the pages of the JOURNAL and by county societies."

Suggestions four six and seven relate to graduate medi-



## IN PROSPECT

Every spring the Medical Society of the State of New York lightly turns to new leadership, thus following time honored tradition, wisely obtained no doubt, but often thrusting serious responsibilities upon untrained and inexperienced men who must inevitably waste valuable time in acquiring understanding of fundamentals.

In giving a courtesy seat at the council table to the Editor of the JOURNAL, my predecessor, Dr Jones, offered the opportunities for observation that he recommends for the man who next year, if the House of Delegates passes the constitutional amendment, shall be the President-elect. Overlapping trusteeships will also help to maintain continuity of knowledge and simplify administration of finances. The American Medical Association here wisely shows us a working model and further carries out the spirit of continuity of service in electing to the Presidency Dr Wendell C Phillips, whose long experience as trustee and as a student of organized medicine has developed an officer without a peer in this country. The Medical Society of the State of New York will undoubtedly continue to enjoy his active service and his wise counsel.

The council is a new one, very largely, but represents enthusiasm based on experience which will surely be valuable to the Society and will stimulate active interest.

We are warranted in expecting developments from a very active Committee on Economics working with several sub-committees, one studying very seriously the nurse question, which seems to be chiefly an economic problem in which the law of supply plays a leading rôle. Active committees are studying workmen's compensation laws and other economic problems, and a general committee will try to discover the needs of our members through consultation with the chairmen of local county committees which are engaged upon related economic questions.

The conference of County Society Secretaries with Presidents of District Branches promises valuable returns from serious discussions of local problems which may be sample problems with solutions applicable to every County Society.

The development of a new medical practice act or a new plan for constructive legislation from a special committee under the chairmanship of Dr John E Jennings of Kings, awakens renewed interest in questions which have led to serious local disagreements, and to renewed hope that unanimous support will be given to whatever legislative program may be decided upon by referendum of the House of Delegates.

The House annually elects officers, passes resolutions and recommendations to them and then awaits, usually very calmly, its annual dissolution. The Members of the House of Delegates should remember that they are themselves officers of the Society until the moment that the Speaker forms the new House at the

next annual meeting. They should be actively interested in their own legislation, and should communicate their individual opinions with great freedom to their elected representatives and so develop a body of opinion which would unquestionably be respected.

With the support of a Governor who is eager for constructive legislation favoring any valuable public health program, organized medicine should present a united front at the next legislative session. The past history of our State reveals no other Governor with such ideals and the future may be equally barren.

The Committee on Scientific work is already at work upon the program for the next annual meeting and basing their efforts upon their recent successful experience, have reason to hope for a meeting which will attract a very large attendance. The chairman of this standing committee is the only chairman carrying on from last year and is fortunate in having acquired a momentum which will carry him over many difficulties.

From the new program of post graduate medical education now being developed by the new chairman of the Committee on Public Health and Medical Education, we expect that most active interest will be excited among our members. Every busy doctor knows that he has limitations, every busy doctor desires with all his heart to keep up to date with the practical as well as the scientific side of medical progress. The active doctor is too busy to stop his daily work and go to school again, as in fact he should, for a few weeks every year. This new committee proposes to evolve a plan to carry this practical material to the doctor in his own county at conveniently located places, and from experience already gained from a completed experiment, feels sure that the State Society will exhibit an accomplishment that will stimulate other state societies to attempt similarly ambitious programs.

The group insurance opportunity now embraced by half of our members deserves our full support. As has often been said, it is incomprehensible that any doctor, no matter how limited his field, should have the temerity to practice his art one moment longer without ample protection. The fact that our legal counsel is regarded as the most eminent specialist in defense of whom we have knowledge, does not justify us in recklessly puffing out our chest so that the blackmailer may have a better target.

An improved JOURNAL is assured by the promise of a stronger editorial staff, by new business methods, and by a growing general interest in a most valuable organ. The next Directory will be strengthened by the addition of the list of the Hospitals of the State and of the Physicians who serve them.

The prospect is a busy one and should arouse a lively enthusiasm.

N B V E

# EDITORIALS

The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer.

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N. Y.  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

Editor-in-Chief—ORRIN SAGE WIGHTMAN, M.D.,

New York

Executive Editor—FRANK OVERTON, M.D.

Patchogue

### COMMITTEE ON PUBLICATION

E. ELIOT HARRIS, M.D., *Chairman*

WILLIAM H. ROSS, M.D.

DANIEL S. DOUGHERTY, M.D.

New York

Brentwood

New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

President—NATHAN B. VAN ETEN, M.D.

New York

First Vice President—WILLIAM H. ROSS, M.D.

Brentwood

Second Vice President—FREDERICK H. FLAHERTY, M.D.

Syracuse

Speaker—E. ELIOT HARRIS, M.D.

New York

Vice Speaker—GEORGE M. FISHER, M.D.

Utica

Secretary—DANIEL S. DOUGHERTY, M.D.

New York

Assistant Secretary—HOWARD GILLESPIE MYERS, M.D.

New York

Treasurer—CHARLES GORDON PEYD, M.D.

New York

Assistant Treasurer—JAMES PEDERSEN, M.D.

New York

### CHAIRMAN, STANDING COMMITTEES

Arrangements—EDWARD R. CUNIFFE, M.D.

New York

Public Health and Medical Education

CHARLES A. GORDON, M.D., Brooklyn

Scientific Work—ANDREW MACFARLANE, M.D.

Albany

Medical Economics—WILLIAM WARREN BRITT, M.D.

Tonawanda

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer) the ex-President and the Councilors of the District Branches

First District—JOHN A. CARD, M.D.

Poughkeepsie

Second District—JOSEPH S. THOMAS, M.D.

Flushing

Third District—CHARLES P. MCCABE, M.D.

Greenville

Fourth District—HORACE M. HICKS, M.D.

Amsterdam

Fifth District—NELSON O. BROOKS, M.D.

Oneida

Sixth District—GEORGE H. FOX, M.D.

Binghamton

Seventh District—WILLIAM I. DEAN, M.D.

Rochester

Eighth District—HARRY R. TRICK, M.D.

Buffalo

### COUNSEL

GEORGE W. WHITESIDE, Esq., 27 William St.  
Telephone, Broad 1744

New York

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St.

New York

### EXECUTIVE OFFICER

JOSEPH S. LAWRENCE, M.D. 51 Chapel Street, Albany

### SECTION OFFICERS

#### Medicine

Chairman—L. WHITTINGTON GORHAM, M.D.

Albany

Secretary—WARDNER D. AYER, M.D.

Syracuse

#### Surgery

Chairman—EDWARD S. VAN DUYN, M.D.

Syracuse

Secretary—GEORGE E. BEILBY, M.D.

Albany

#### Obstetrics and Gynecology

Chairman—ALFRED C. BECK, M.D.

Brooklyn

Secretary—NATHAN P. SEARS, M.D.

Syracuse

#### Pediatrics

Chairman—ROGER H. DENNETT, M.D.

New York

Vice Chairman—ARTHUR W. BENSON, M.D.

Troy

Secretary—JOHN AIKMAN, M.D.

Rochester

#### Eye, Ear, Nose and Throat

Chairman—EUGENE E. HINMAN, M.D.

Albany

Secretary—JAMES W. WHITE, M.D.

New York

#### Public Health, Hygiene and Sanitation

Chairman—ARTHUR D. JAMES, M.D.

Lynbrook

Secretary—LEO F. SCHIFF, M.D.

Plattsburg

#### Neurology and Psychiatry

Chairman—CLARENCE O. CHENEY, M.D.

Utica

Secretary—THOMAS K. DAVIS, M.D.

New York

For a list of the officers of the county medical societies, see April 24th JOURNAL, advertising page v

## DR WENDELL C PHILLIPS, PRESIDENT-ELECT OF THE AMERICAN MEDICAL ASSOCIATION

It is with pleasure that we offer our congratulations to a fellow member and ex-president of our State organization, Dr Wendell C Phillips, who was unanimously elected president-elect of the American Medical Association, the highest medical body, and probably the most influential medical organization in the world.

Dr Phillips is peculiarly fitted to fill this high office. He has given years of unselfish devotion to the ideals and upbuilding of medical progress in the United States. No one ever will be able to compute the time, the thought and the effort which Dr Phillips has given toward promoting the interests of the medical profession. He combines personal charm and tact, together with a dignified bearing, which makes him a most ac-

ceptable presiding officer at any gathering, his tireless effort and patience, and his willingness to adopt anything which promises improvement, have fitted him particularly well to guide the affairs of the American Medical Association. The delegates of New York State are glad to say that they were not only unanimous in his support as a candidate for this office, but that they will likewise be unanimous in helping him in every way to make his administration a great success. New York has been honored in the selection of Dr Phillips and we believe that he will have the unqualified support, so well deserved, of everyone throughout the union who has the welfare of the medical profession at heart.

O S W

# NEWS NOTES

## AMERICAN MEDICAL ASSOCIATION CONVENTION OF 1925

Attending the national convention of the American Medical Association in the capacity of a delegate offers many opportunities for careful study of the live issues at present before the profession

1925 has been a year of progress in medicine throughout the United States

After the convention was well under way, various committees previously appointed made their reports And, inasmuch as these reports contain the essence of progress during the year, a brief summary will be attempted

The committee from the Board of Trustees, in speaking of the A M A JOURNAL, stated that during the year 4,410,220 copies had been printed, which was an increase of more than 176,000 over the previous 12 months During this period the JOURNAL had received from advertisement \$614,084 00, an amount slightly less than the year previous It was interesting to learn that the Spanish edition showed a deficit of \$12,902 00 which had fortunately been met by the Rockefeller Foundation

Another publication of the A M A which showed healthy signs of growth was *Hygeia*, whose circulation had risen from nineteen to thirty-two thousand It was an interesting fact that in spite of this increase the magazine was still running at a loss—that of the past year being \$42,745 00 In other words, any magazine to be self-sustaining must require a definite interval in which to "find itself" *Hygeia*, however, gives every sign of vigorous growth and within the next few years should be self-supporting

The Committee on Full-Time Officers, through Dr Cramp, stated that the Bureau of Information in Chicago was doing very efficient work They spent a great deal of time in replying to questions from physicians as well as lay societies, giving the necessary information asked for They stated that it would be highly desirable if everybody knew the amount of information in the possession of this Bureau and they were at the service of the medical profession throughout the country In speaking of the investigation of the Abrams Fake, it was pointed out that in 1922 and 1923 this pseudo-method of treatment was on the down grade and that in 1924 it had practically passed They wished to correct the impression that the medical men of Great Britain looked with favor upon Abrams and his methods Considerable newspaper notoriety had been given to this matter—all of which was absolutely untrue.

Dr Woodward, who was the Secretary of Legal Medicine and Legislation, was very glad to state that he had had the full cooperation of the various states in the Union during the past year His efforts had been particularly with the Department of Internal Revenue relative to improving the Narcotic Bill and making it less onerous for physicians He stated that the chiropractors of the Veterans' Bureau numbered six at the present time in training, that there would be no new ones after the 30th of June and all of this ill-advised training would be completed by 1926

In the matter of mal-practice suits the Bureau is not yet willing to make any recommendations Fifteen states had spent \$36,663 00 for medical defense covering 43,000 physicians There had been a marked increase in the number of mal-practice suits against doctors This has been so often emphasized by our own State Counsel, Mr George W Whiteside, that it needs but little comment At no distant date the absolute protection of the physician will require that every doctor be insured through properly incorporated insurance companies, and this task of mal-practice defense will not be the work of any State Society In the old days when the claim for damages was small and recoveries were infrequent, mal-practice suits had not attained proportions they have reached at the present time The whole question is in a state of development The public have unfortunately been taught that large judgments can be secured from physicians and hence old methods are no longer applicable to present needs

The Bureau at Chicago is constantly fighting to secure the repeal of the Federal narcotic tax on physicians of \$3 00 so that the medical fraternity may be spared this injustice It never has been the amount involved, but rather the principle This question, however, is so big that it cannot be solved in a short time

Under Health and Public Instruction, Dr Dodson again emphasized the wonderful work *Hygeia* was doing, drawing attention to the fact that they had a clipping bureau in connection with this magazine which could be used to advantage by many other Journals It might be well for these interested in these terse comments to get in touch with Dr Dodson's Bureau The Department had a Speakers' Hand-book for publicity work in press They had found it advisable in medical matters to use the radio, two stations being used in Chicago and eight in other cities throughout the country He stated that

## THE TUBERCULOSIS SESSION

The last day of the meeting of the State Society has always been a bugbear and nightmare to the Committee on Scientific Work. There is always so much semblance to a funeral, without the joy of a wake, that each year it has been seriously considered whether or not these last day sessions should be discontinued or the agony prolonged for another year.

At this year's meeting an innovation was put into effect. Instead of the presentation of papers it was decided to give over the entire day to the complete consideration of one single disease in all its protean and diffuse manifestations.

Tuberculosis was selected as the disease which would naturally appeal to every physician, no matter what his intensive or extensive field of medical work might be.

The underlying feeling was that the presentation of a disease from every aspect not only demonstrated the unity of disease but also was a demonstration of the entire field of medicine. Osler wisely stated—know syphilis and all disease is known. Know tuberculosis and all disease is an open book, is equally true.

The unexpected and great success of this last day's meeting with almost 200 new registrants and about 600 visitors reveals a new and helpful phase of work for future meetings. The complete presentation in a similar way of syphilis and cancer during a whole day's session would be such an attractive program that it would draw hundreds and even thousands of physicians who never attend or take interest in the meeting of the State Society. The sessions, instead of being wasted, as in previous years when ten to fifteen tired physicians, constantly consulted time tables and then watches, were crowded with 600 alert visitors who were keenly anxious to absorb

everything which might be helpful in their battle against this ever present disease. The morning session consisted of a demonstration of pathological and bacteriological specimens of human and bovine tuberculosis, exhibition of X-ray findings in infancy, childhood and adult life, together with the interpretation and significance of chest radiograms. Probably the most popular section was the presentation of the moving pictures of pulmonary tuberculosis and demonstration charts by Dr. L. Gregory Cole of New York City. Physical signs were demonstrated by the stethophone and the value of heliotherapy and the mercury lamp illustrated by the presence of a group of lively, happy youngsters who were clothed only in loin cloths and continuous smiles, a possible prophecy of the flapper of the future.

The morning session was closed by short, practical, illustrated talks by specialists which held a vast audience until the last word was spoken.

The afternoon session was given over to concise, snappy addresses without discussion, by authorities in the field of tuberculosis. That these addresses were thoroughly appreciated is evidenced by the fact that the auditorium was overcrowded up to the last word. It would take an entire number of the JOURNAL to properly describe these sessions. There was a feeling of intentness and tenseness in the air which made everyone feel that they were taking part in the most complete demonstration of this subject ever presented.

Every physician present felt abundantly repaid for remaining an additional day, while those who were unable to be present missed an opportunity of having solved for them the many problems of tuberculosis.

ANDREW MACFARLANE.

## INTEREST IN MEETINGS OF COUNTY MEDICAL SOCIETIES

We have frequently heard discussions on the subject of how to make the meetings of county medical societies interesting and attractive, and how to increase their attendance. Suggestions have been made that meetings be held more frequently and that more committees be appointed. We have sought for a practical scheme which will apply to every county society—one which will require little machinery, and which has been demonstrated to work.

The plan which we suggest is that of clinical programs for the meetings.

How will a clinical program be carried out? In the first place a teacher will be needed. The State Society is now providing the means by which one will be available for any group anywhere in the State.

In the second place, the members of the society

or group will provide six patients for study and diagnosis. The object is to teach the doctors, although of course the patients will get the benefit of free advice.

What is likely to be the course of events in a society in which one clinical program is introduced? Where the experiment has been tried and the members attend one clinical meeting, they ask for another to be held within a month, then the next step is a series of teaching clinics, or a system of graduate education in that county, and by that time the problem of interest in the meetings of the society is solved.

We offer this plan for increasing the interest in county societies as the most natural and most practical one which we have heard suggested.

F. O.

# NEWS NOTES

## AMERICAN MEDICAL ASSOCIATION CONVENTION OF 1925

Attending the national convention of the American Medical Association in the capacity of a delegate offers many opportunities for careful study of the live issues at present before the profession

1925 has been a year of progress in medicine throughout the United States

After the convention was well under way, various committees previously appointed made their reports. And, inasmuch as these reports contain the essence of progress during the year, a brief summary will be attempted

The committee from the Board of Trustees, in speaking of the A M A JOURNAL, stated that during the year 4,410,220 copies had been printed, which was an increase of more than 176,000 over the previous 12 months. During this period the JOURNAL had received from advertisement \$614,084.00, an amount slightly less than the year previous. It was interesting to learn that the Spanish edition showed a deficit of \$12,902.00 which had fortunately been met by the Rockefeller Foundation

Another publication of the A M A which showed healthy signs of growth was *Hygeia*, whose circulation had risen from nineteen to thirty-two thousand. It was an interesting fact that in spite of this increase the magazine was still running at a loss—that of the past year being \$42,745.00. In other words, any magazine to be self-sustaining must require a definite interval in which to “find itself.” *Hygeia*, however, gives every sign of vigorous growth and within the next few years should be self-supporting

The Committee on Full-Time Officers, through Dr Cramp, stated that the Bureau of Information in Chicago was doing very efficient work. They spent a great deal of time in replying to questions from physicians as well as lay societies, giving the necessary information asked for. They stated that it would be highly desirable if everybody knew the amount of information in the possession of this Bureau and they were at the service of the medical profession throughout the country. In speaking of the investigation of the Abrams Fake, it was pointed out that in 1922 and 1923 this pseudo-method of treatment was on the down grade and that in 1924 it had practically passed. They wished to correct the impression that the medical men of Great Britain looked with favor upon Abrams and his methods. Considerable newspaper notoriety had been given to this matter—all of which was absolutely untrue

Dr Woodward, who was the Secretary of Legal Medicine and Legislation, was very glad to state that he had had the full cooperation of the various states in the Union during the past year. His efforts had been particularly with the Department of Internal Revenue relative to improving the Narcotic Bill and making it less onerous for physicians. He stated that the chiropractors of the Veterans' Bureau numbered six at the present time in training, that there would be no new ones after the 30th of June and all of this ill-advised training would be completed by 1926

In the matter of mal-practice suits the Bureau is not yet willing to make any recommendations. Fifteen states had spent \$36,663.00 for medical defense covering 43,000 physicians. There had been a marked increase in the number of mal-practice suits against doctors. This has been so often emphasized by our own State Counsel, Mr George W Whiteside, that it needs but little comment. At no distant date the absolute protection of the physician will require that every doctor be insured through properly incorporated insurance companies, and this task of mal-practice defense will not be the work of any State Society. In the old days when the claim for damages was small and recoveries were infrequent, mal-practice suits had not attained proportions they have reached at the present time. The whole question is in a state of development. The public have unfortunately been taught that large judgments can be secured from physicians and hence old methods are no longer applicable to present needs.

The Bureau at Chicago is constantly fighting to secure the repeal of the Federal narcotic tax on physicians of \$3.00 so that the medical fraternity may be spared this injustice. It never has been the amount involved, but rather the principle. This question, however, is so big that it cannot be solved in a short time.

Under Health and Public Instruction, Dr Dodson again emphasized the wonderful work *Hygeia* was doing, drawing attention to the fact that they had a clipping bureau in connection with this magazine which could be used to advantage by many other Journals. It might be well for these interested in these terse comments to get in touch with Dr Dodson's Bureau. The Department had a Speakers' Hand-book for publicity work in press. They had found it advisable in medical matters to use the radio, two stations being used in Chicago and eight in other cities throughout the country. He stated that

## THE TUBERCULOSIS SESSION

The last day of the meeting of the State Society has always been a bugbear and nightmare to the Committee on Scientific Work. There is always so much semblance to a funeral, without the joy of a wake, that each year it has been seriously considered whether or not these last day sessions should be discontinued or the agony prolonged for another year.

At this year's meeting an innovation was put into effect. Instead of the presentation of papers it was decided to give over the entire day to the complete consideration of one single disease in all its protean and diffuse manifestations.

Tuberculosis was selected as the disease which would naturally appeal to every physician, no matter what his intensive or extensive field of medical work might be.

The underlying feeling was that the presentation of a disease from every aspect not only demonstrated the unity of disease but also was a demonstration of the entire field of medicine. Osler wisely stated—know syphilis and all disease is known. Know tuberculosis and all disease is an open book, is equally true.

The unexpected and great success of this last day's meeting with almost 200 new registrants and about 600 visitors reveals a new and helpful phase of work for future meetings. The complete presentation in a similar way of syphilis and cancer during a whole day's session would be such an attractive program that it would draw hundreds and even thousands of physicians who never attend or take interest in the meeting of the State Society. The sessions, instead of being wasted, as in previous years when ten to fifteen tired physicians, constantly consulted time tables and then watches, were crowded with 600 alert visitors who were keenly anxious to absorb

everything which might be helpful in their battle against this ever present disease. The morning session consisted of a demonstration of pathological and bacteriological specimens of human and bovine tuberculosis, exhibition of X-ray findings in infancy, childhood and adult life, together with the interpretation and significance of chest radiograms. Probably the most popular section was the presentation of the moving pictures of pulmonary tuberculosis and demonstration charts by Dr L. Gregory Cole of New York City. Physical signs were demonstrated by the stethophone and the value of heliotherapy and the mercury lamp illustrated by the presence of a group of lively, happy youngsters who were clothed only in loin cloths and continuous smiles, a possible prophecy of the flapper of the future.

The morning session was closed by short, practical, illustrated talks by specialists which held a vast audience until the last word was spoken.

The afternoon session was given over to concise, snappy addresses without discussion, by authorities in the field of tuberculosis. That these addresses were thoroughly appreciated is evidenced by the fact that the auditorium was overcrowded up to the last word. It would take an entire number of the JOURNAL to properly describe these sessions. There was a feeling of intentness and tenseness in the air which made everyone feel that they were taking part in the most complete demonstration of this subject ever presented.

Every physician present felt abundantly repaid for remaining an additional day, while those who were unable to be present missed an opportunity of having solved for them the many problems of tuberculosis.

ANDREW MACFARLANE.

## INTEREST IN MEETINGS OF COUNTY MEDICAL SOCIETIES

We have frequently heard discussions on the subject of how to make the meetings of county medical societies interesting and attractive, and how to increase their attendance. Suggestions have been made that meetings be held more frequently and that more committees be appointed. We have sought for a practical scheme which will apply to every county society—one which will require little machinery, and which has been demonstrated to work.

The plan which we suggest is that of clinical programs for the meetings.

How will a clinical program be carried out? In the first place a teacher will be needed. The State Society is now providing the means by which one will be available for any group anywhere in the State.

In the second place, the members of the society

or group will provide six patients for study and diagnosis. The object is to teach the doctors, although of course the patients will get the benefit of free advice.

What is likely to be the course of events in a society in which one clinical program is introduced? Where the experiment has been tried and the members attend one clinical meeting, they ask for another to be held within a month, then the next step is a series of teaching clinics, or a system of graduate education in that county, and by that time the problem of interest in the meetings of the society is solved.

We offer this plan for increasing the interest in county societies as the most natural and most practical one which we have heard suggested.

F O

# NEWS NOTES

## AMERICAN MEDICAL ASSOCIATION CONVENTION OF 1925

Attending the national convention of the American Medical Association in the capacity of a delegate offers many opportunities for careful study of the live issues at present before the profession.

1925 has been a year of progress in medicine throughout the United States

After the convention was well under way, various committees previously appointed made their reports. And, inasmuch as these reports contain the essence of progress during the year, a brief summary will be attempted

The committee from the Board of Trustees, in speaking of the A M A JOURNAL, stated that during the year 4,410,220 copies had been printed, which was an increase of more than 176,000 over the previous 12 months. During this period the JOURNAL had received from advertisement \$614,084 00, an amount slightly less than the year previous. It was interesting to learn that the Spanish edition showed a deficit of \$12,902 00 which had fortunately been met by the Rockefeller Foundation

Another publication of the A M A which showed healthy signs of growth was *Hygeia*, whose circulation had risen from nineteen to thirty-two thousand. It was an interesting fact that in spite of this increase the magazine was still running at a loss—that of the past year being \$42,745 00. In other words, any magazine to be self-sustaining must require a definite interval in which to “find itself.” *Hygeia*, however, gives every sign of vigorous growth and within the next few years should be self-supporting

The Committee on Full-Time Officers, through Dr Cramp, stated that the Bureau of Information in Chicago was doing very efficient work. They spent a great deal of time in replying to questions from physicians as well as lay societies, giving the necessary information asked for. They stated that it would be highly desirable if everybody knew the amount of information in the possession of this Bureau and they were at the service of the medical profession throughout the country. In speaking of the investigation of the Abrams Fake, it was pointed out that in 1922 and 1923 this pseudo-method of treatment was on the down grade and that in 1924 it had practically passed. They wished to correct the impression that the medical men of Great Britain looked with favor upon Abrams and his methods. Considerable newspaper notoriety had been given to this matter—all of which was absolutely untrue

Dr Woodward, who was the Secretary of Legal Medicine and Legislation, was very glad to state that he had had the full cooperation of the various states in the Union during the past year. His efforts had been particularly with the Department of Internal Revenue relative to improving the Narcotic Bill and making it less onerous for physicians. He stated that the chiropractors of the Veterans' Bureau numbered six at the present time in training, that there would be no new ones after the 30th of June and all of this ill-advised training would be completed by 1926

In the matter of mal-practice suits the Bureau is not yet willing to make any recommendations. Fifteen states had spent \$36,663 00 for medical defense covering 43,000 physicians. There had been a marked increase in the number of mal-practice suits against doctors. This has been so often emphasized by our own State Counsel, Mr George W Whiteside, that it needs but little comment. At no distant date the absolute protection of the physician will require that every doctor be insured through properly incorporated insurance companies, and this task of mal-practice defense will not be the work of any State Society. In the old days when the claim for damages was small and recoveries were infrequent, mal-practice suits had not attained proportions they have reached at the present time. The whole question is in a state of development. The public have unfortunately been taught that large judgments can be secured from physicians and hence old methods are no longer applicable to present needs

The Bureau at Chicago is constantly fighting to secure the repeal of the Federal narcotic tax on physicians of \$3 00 so that the medical fraternity may be spared this injustice. It never has been the amount involved, but rather the principle. This question, however, is so big that it cannot be solved in a short time

Under Health and Public Instruction, Dr Hodson again emphasized the wonderful work *Hygeia* was doing, drawing attention to the fact that they had a clipping bureau in connection with this magazine which could be used to advantage by many other Journals. It might be well for these interested in these terse comments to get in touch with Dr Dodson's Bureau. The Department had a Speakers' Hand-book for publicity work in press. They had found it advisable in medical matters to use the radio, two stations being used in Chicago and eight in other cities throughout the country. He stated that

1200 newspapers were using the clipping service of *Hygeia*, covering a circulation of twenty-two million people. He wanted to impress upon the delegates the fact that a great change was coming over the community relative to health education. They were beginning to believe that health comes first and was most important, and that the movement for periodical health examination was growing and he was glad to state that their Manual on this subject should be out within a few weeks.

The meeting was most fortunate in having as its guest Mr. Hall, who is President of the British Medical Association. Mr. Hall stated some of the difficulties of his particular task at home. He dwelt especially upon health insurance and stated that under the Lloyd George administration the physicians of Great Britain were poorly organized, that Mr. George made them a proposition relative to health insurance examinations, fixing the amount that the state would pay. He further stated that unless the physicians as a whole would accede to this demand, he had already secured consent from a sufficient number of physicians to carry out the plan. Mr. Hall stated that recently when the Government made up its mind to diminish the fees allowed physicians, various civic bodies arbitrarily suggested to the government a very low rate for this service. This was considerably below what the medical fraternity felt they could work for. As the controversy developed, a referendum was sent to the medical fraternity, which was now thoroughly organized, and 96 per cent responded refusing to work under the terms offered by the civic body. This brought about a very prompt reconsideration of the subject with the result that the doctors' demand was promptly met. Mr. Hall pointed out the need of unity in medical action—not as a union in the trade sense of the word—but in the sameness of ideals so as to bring about fairness and justice to all. He said that anything could be accomplished by the medical profession if they stood united. Coming from a foreigner after our own varied experience, this was most assuredly helpful.

Dr. Haggard, the new President of the American Medical Association, briefly outlined the duties of the hour. He thought that our present medical education was somewhat too technical. The time for developing a physician should be shorter. One suggestion was that instead of long summer vacations there should be four sessions so as to carry out a completed year. He felt that where such institutions issued diplomas to their graduates, and this particularly applied

to State Institutions, this in itself should be a sufficient preliminary for the various medical examining boards of the State. Dr. Haggard felt the need of a minimum education requirement in all medical matters. He felt that there should be a fundamental training in preparation and that after that people could use any particular method of practice they wished.

Relative to legislation, the sentiment of the physicians seemed to be that professional lobbying on the part of the Medical Fraternity was a bad thing, that the way to affect law making bodies was to go to the representatives before election and before they had gone to the various legislative chambers, to personally express the opinions of the medical profession and not to join the professional lobbying class. Dr. Haggard likewise stated that he hoped to make Periodical Health Examinations the keynote of his administration, and that in the very near future he would call a conference of those who had already done this work so as to secure the best information which might be of help in perfecting a policy applicable to the various states in the Union.

Things which will interest the profession at large were the creation of a Section on Radiology and the omission of the Section on Stomatology. It was also voted to increase the House of Delegates from 150 to 175, and reapportion the representatives on a basis of 1 to 750 members.

The nursing problem was in a condition of flux, the convention recognized the transformation which was taking place, and a committee was appointed to study this whole matter and report at the next meeting.

The recommendation relative to the unrestricted prescribing of alcohol by physicians was unanimously carried. This is no wise involved the legal observation of the Volstead amendment and had no bearing upon alcohol other than in a medical sense.

On the whole the meeting was most successful. One could not attend such a gathering without being impressed with the seriousness of medical thought in America. Mr. Hall, whom we have already quoted, stated it was a great pleasure to come to America and secure so great an inspiration. He had no idea that our activities were so intense and varied, and he felt that his coming would enable him to carry back to the British Isles much that was worth while. It was voted to hold the 1926 meeting of the American Medical Association in Dallas, Texas.

O S W



## AMERICAN MEDICAL ASSOCIATION

We are highly pleased with the meeting of the American Medical Association, which was held in Atlantic City, New Jersey, during five days beginning Monday, May twenty-fifth. We went for the specific purpose of observing the many features of the meeting as we happened to run across them. We registered on Monday noon and then started out rather aimlessly to see what we could see. We confess that our method was not scientific, and that we should have studied the programs beforehand, and should have made out a schedule assigning every fifteen minutes of every day to a specific observation. We did not do it because no one else did it. As we wandered up and down the aisles of the registration and exhibit rooms, we met every doctor that we had hoped to meet, and every one of them was doing exactly the same thing that we were doing. If we stopped to talk with a friend, other acquaintances would join us until we blocked the aisle, and then we would separate, each headed for some exhibit, or friend, or meeting that had been mentioned. This method of seeing the A.M.A. was highly satisfactory and enjoyable, and we recommend it as the most efficient way to take in its features. After all, the physicians that one meets constitute the essence of the meeting of the A.M.A., or of any other organization.

When we registered, we received a big guide book and circulars of information—which we promptly lost,—as did five hundred other doctors on the first day of the session, according to the over-worked girl at the Information Bureau. A carrying bag with shoulder straps for the benefit of absent minded doctors was the only needful thing that was omitted by the Committee of Arrangements.

The central attraction of the meeting was the Exhibits Building. Here we went at every spare moment, here we found our old friends and made new ones, and here we saw practically everything that a doctor would use in his practice. The exhibits were of two kinds,—the commercial and the scientific. The commercial exhibits contained medical books, and surgical instruments, and X-ray apparatus, and foods, and drinks, and magic lanterns, and microscopes, and medicines, and gowns, and diplomatic demonstrators, and accommodating nurses and clerks,—everything except automobiles. We were told there were 149 commercial booths in the exhibits, and we know the aisles were packed during the entire day.

The scientific part of the exhibit was in the far end of the building, and the exhibitors were medical schools, medical societies, departments of health, and lay organizations for the promotion of health. The aisles were not so crowded as those of the commercial exhibits, and the visitors were possibly more sedate and dignified than

those who patronized the soft-drink booths, but yet we felt that the scientific exhibition was the most important feature of the whole A.M.A. meeting. The exhibits were not designed to impart instruction, as the wife of one of the doctors found when she saw a demonstration of freshly autopsied lungs and thereby lost her appetite for dinner. But the exhibits gave the physicians an idea where they could find information on any subject. The Medical Society of the County of Kings, N.Y., for example, had a modest booth illustrating the graduate education work of the Society. We met a Pennsylvania doctor there to whom the demonstrator was showing the Monthly Bulletin of the Kings County Society as a novel feature of the Society's work, and he responded by producing a copy of the Monthly Bulletin of the Lycoming County Medical Society which has only 110 members and has issued a monthly publication regularly for over five years. This is a sample of the give and take which was constantly going on in the exhibit room. In order to get the most out of the exhibits, a doctor needed to have plenty of time, and a pocket note book with which to catch the information which was freely offered to him. It beat a radio concert.

We were interested in the educational motion picture films, especially those that were produced at home in New York. Dr. Lewis Gregory Cole's film that was shown on Tuberculosis Day at the Syracuse meeting of the Medical Society of the State of New York, was also shown at Atlantic City, and we were also permitted to see a private demonstration of a companion film on gastric peristalsis. These films are to be considered in the same class as the illustrations of a book or an article in a medical journal, and we are entirely ethical in informing our readers that they may rent the films through the American Medical Films, Inc., 350 Madison Avenue, New York. Medical Societies and health organizations will find the films valuable for serious demonstrations. They will fit well into the education plans of the Medical Society of the State of New York.

The wealth of lectures and demonstrations was incredibly extensive. A large theatre over the registration and exhibition hall was in constant operation all day long on every one of the five days of the meetings. The program consisted of either moving picture demonstrations or of medical lectures illustrated with lantern slides. The subjects that were presented were of practical, every-day interest to every family physician. The amount of material presented in this room would have been considered sufficient for almost any state society meeting, but in addition scientific programs were being presented at the same time.

in each of the sixteen scientific sections of the Association. The presentation of papers read before the sections will be a major feature of the A M A Journal during the coming year.

We had planned to report proceedings of the House of Delegates, but when we reached the meeting room, the House was in executive session over a dispute between the physicians and a lay health organization. The House acted wisely in guarding against leaks of confidential information.

We are glad that we had the opportunity to attend the meeting with which the 76th Annual Session was opened. We were interested in the historical remarks made by Dr L F Donohue, President of the Medical Society of New Jersey, when he said that the number of people who come to Atlantic City for their health is greater than those seeking health in any other city in the United States. He also said that the Medical Society of New Jersey was the oldest medical society in the United States, having been founded 159 years ago. It was one of the sixteen state societies whose representatives founded the American Medical Association on March 5, 1846.

The principal feature of the evening's program

was an address by the incoming President, Dr William D Haggard, of Nashville, Tennessee, on the subject, "The Romance of Medicine." Dr Haggard spoke eloquently of the conquest of smallpox, yellow fever, typhoid,—deadly diseases that were formerly prevalent, and mentioned the heroes who, like Dr Lazear, gave their lives in research into the causes of the diseases, and in the development of the means of prevention and cure. He then developed the need of the adoption of the practice of periodic health examinations, and ended by eulogizing the family physician on whom there rests the responsibility of supervising the health of the great mass of people.

Dr Haggard's address is published in the May 30 issue of the A M A, and we advise our readers to read it.

Dr Haggard had spoken in the House of Delegates, and had advocated the adoption of an extensive system of graduate education for general practitioners along the lines that are being suggested by the Medical Society of the State of New York. It is probable that the State and the National organizations will cooperate in developing comprehensive plans for graduate education.

F O

### SCHOOL MEDICAL INSPECTORS

It is the custom of the Association of Medical School Inspectors of New York State to hold an informal dinner and conference on some evening during the meeting of the Medical Society of the State of New York. The conference this year was held in the Hotel Onondaga on May 13th, and was attended by forty physicians. The report of the meeting is packed full of good suggestions and ideas, and we are glad to give publicity to an abstract of it. We will give our impressions rather than a literal transcript of the meeting.

We are impressed with the fact that the examination of school children is the periodic health examination of the ten-year group of from five to fifteen, and that it constitutes the practice of modern pediatrics as applied to older children. It is the application of facts of general medicine to children of a certain age group, and the more general medicine, or pediatrics, the examiner knows the better will be the examination that he will make.

How much of an examination should an inspector make? Dr Haven Emerson said that it would require five dollars' worth of medical service to make an adequate examination of a school child. Dr Emerson says that five dollars is a minimum price at what a physician can make an adequate health examination of an adult, and that

the actual cost has been three dollars when an extensive series of examinations has been made by an economical institution. Of course, the standard form of health examinations is attained in very few schools.

Five cents a minute is a standard value of doctor's services in examining school children. A common rate of pay is one dollar per pupil, or if twenty minutes is given to each pupil,—more than the average time,—the price is five cents per minute. The standard suggested by Dr Emerson is two hours for each examination and charge of five dollars. The schools get just about the kind of examinations they pay for. Some want only a ten cent examination, just to comply with the law.

Dr Emerson called attention to a very obvious yardstick that could be used for measuring the effectiveness of health work in a school,—and that is the "non-effective rate", or the percentage of pupils who are absent on account of their health. This varies from one and one-half to thirteen and even more per cent. This is the same standard that is applied to workmen in factories. Few schools teachers know what percentage of absentees is due to ill health, for parents give that in place of other reasons for absence.

The examination of pupils who are mentally defective or retarded was discussed by Warren W Cox, Ph D, Chief of the Educational Measurements Bureau of the State Department of Education, and the psychiatric examination for nervous and abnormal mental states was presented by Dr C O Cheney, Assistant Superintendent of the Utica State Hospital. Doctors generally need to remember that the services of examiners in these two State Departments are available for their private cases, and that clinics in both branches may be arranged through correspondence with the Departments.

Dr Frederick Martin of Ithaca, N Y, said

that about five per cent of school children needed treatment for speech defects, and that their treatment was set forth in an article which could be obtained by application to the State Department of Education. He advocated palatal exercises for lax pillars after tonsilectomy. The exercise consists in standing before a mirror and watching the pillars contract and relax while saying "ah". This syllable is to be uttered one thousand times daily until the pillars, when at rest, assume a normal high-arched position. We fear that few children will use the exercise if it has to be done one thousand times every day.

F O

### ANNUAL MEETING OF THE NEW YORK STATE ASSOCIATION OF PUBLIC HEALTH LABORATORIES

At the ninth annual meeting of the New York State Association of Public Health Laboratories held in Syracuse on May 12th, Dr V C Jacobson of Albany was elected President of the Association. Others elected were Dr M Maslon, Glens Falls, Vice-President, Miss M B Kirkbride, Albany, Secretary-Treasurer, and Dr F E Sondern of New York, member of the Council. Dr Warren B Stone is also a member of the Council. The business meeting was followed by a scientific session at which several papers of general interest were presented.

The importance of commencing specific therapeutic treatment at the earliest possible moment in the case of syphilitic individuals was urged by Professor Wilhelm Kolle, Director of the State Serum Institute at Frankfurt-on-Main, who, as guest of the Association, delivered the principal address. While sterilization is successful in a high percentage of cases treated shortly after infection has occurred, the period during which an abortive healing is possible has been shown by animal experiments and clinical observation to be very limited, in human beings not more than four to eight weeks. After this period sterilization of the infected body is usually not possible. Prompt and vigorous treatment with the most effective remedy is therefore of the utmost importance in syphilis. The intramuscular use of mercury and especially of bismuth in conjunction with salvarsan treatment is recommended because of their power of arresting the progress of the infection while the precipitate formed is undergoing very gradual absorption in the tissues.

When using the Weil-Felix reaction as an aid in the diagnosis of typhus fever, Dr Gilbert and Miss Coleman of the State Laboratory in Albany emphasized the necessity of performing the test with the patients' serum unheated and heated to 56° C for an hour. Relatively thermostable ag-

glutinins for B Proteus X-19 were present in serum from a doubtful case with symptoms slightly suggestive of typhus fever or Brill's disease, while heating destroyed the agglutinins in two specimens of serum from typical cases of typhus fever.

The rapid development of the Montgomery County Laboratory with the Julius Wassermann Memorial, under State Aid, was described by Dr J A Dickson, the Director. The greatly increased service now rendered by the laboratory to the physicians in the county is directly due to the influence of State aid. The staff consists of six persons. The entire county laboratory work, including public health and private work and the laboratory work in the different hospitals, is carried on under one head. No charges whatever are made and the services of the laboratory staff are available at all times.

Dr Stanhope Bayne-Jones of the University of Rochester reviewed the studies of D'Herelle and others of the nature, action, and use of bacteriophage. The two theories, one that it is a living parasite of bacteria, and the other that it is a lytic ferment produced by the bacteria, were discussed as was also the importance of bacteriophage in the biologic study of bacteria and its possible significance for the study of the ultra-viruses and practical value in the treatment of certain infections.

Dr Baumgartner of Clifton Springs described the clinical and laboratory findings in seven cases of tropical sprue. It has been suggested that the disease, which is characterized by frequent large frothy stools, loss of weight and anemia, may be due to a gastro-intestinal infection with a yeast-like organism, *monilia psilosis*. This organism was cultivated from the stools of all the cases studied. It, or a similar organism, was found,

however, in a few other diarrheal anemic cases not diagnosed as sprue

A statistical review of the types of pneumococci isolated from one hundred forty-eight specimens of sputum by the Syracuse Municipal Laboratory indicated, according to Professor Jones of Syracuse, that there may be very marked variations in the relative frequency of the various types of pneumococci isolated from sputa, according to the class of patients selected, their age, geographical distribution and perhaps other factors

Dr Alvin G Foord of Buffalo reported a fatal case of botulism in a woman who died five days after eating spoiled home canned string beans prepared by the "cold pack" method six months previously, and kept meanwhile in a kitchen cupboard at room temperature. The symptoms and autopsy findings were typical *B Botulinus*,

Type B, was isolated from the beans and from the intestinal contents of the patient at autopsy. An extract of the beans and toxin produced in cultures were extremely toxic for guinea-pigs and rabbits, while chickens proved highly refractile. Complete protection was afforded by Type B antitoxin

Results of a study of variations in the alkaline tide in urine and parallel variations in gastric acidity were discussed by Dr Roger S Hubbard of Clifton Springs. In about 80% of the cases studied the results corresponded. They indicate that the tide is probably due to the secretion of hydrochloric acid by the stomach and that the presence or absence of significant amounts in the gastric juice can be shown with a fair degree of accuracy without resorting to gastric analyses

M B K.

---

### ANNUAL CONFERENCE OF NEW YORK STATE HEALTH OFFICERS AND PUBLIC HEALTH NURSES

The Annual Conference of Health Officers and Public Health Nurses of the State will be held at Saratoga Springs June 23d to 25th inclusive

The morning session on the first day, which will be a joint session for health officers and nurses, will be addressed by Governor Smith, Dr N B Van Etten, President of the N Y State Medical Society, Dr J W S McCullogh, Chief Officer of Health, Ontario Provincial Department of Health, and Dr Matthias Nicoll, Jr, State Commissioner of Health

During the remainder of the Conference separate sessions for health officers and nurses will be held. Among the speakers will be Dr William H Park, Director of the Bureau of Laboratories, N Y City Health Department, who will

discuss the question of active immunization and serum treatment of scarlet fever, Dr Henry F Vaughan, President of the American Public Health Association, whose subject is Climatological Conditions and their effect on Health, and Dr John O Polak, Professor of Obstetrics and Gynecology, Long Island College Hospital, who will speak on The Practical Value of Prenatal Care

On the evening of Wednesday, June 24th, the N Y State Sanitary Officers' Association and the N Y State for Public Health Nursing will hold their annual dinner. Professor Robert W Moore of Colgate University will be the speaker of the evening

---

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

OL 25, No 18

NEW YORK, N Y

JULY, 1925

## RECENT ADVANCEMENTS IN CHOLECYSTOGRAPHY \*

By WILLIAM H STEWART, M D, MAX EINHORN, M D, AND ERIC J RYAN, M D

NEW YORK CITY

THE February, 1924, issue of the Journal of the American Medical Association contained an article entitled "A Preliminary Report on the Roentgenographic Examination of the Gall Bladder, A New Method Utilizing the Intravenous Injection of Tetrabrom Phenolphthalein Sodium Salt," by Drs E A Graham, W H Cole and G H Copher, of St Louis. While investigating tests to ascertain the function of the liver, the discovery was made that when certain drugs were administered intravenously the bile became opaque to the X-ray, causing the outline of the gall bladder to be clearly defined. Different dyes were used experimentally, the outcome being that the Tetrabrom Phenolphthalein Sodium Salt was found to be the most practical for routine use.

This discovery was received with enthusiasm by all the roentgenologists throughout the world. Up to this time the roentgen diagnosis of gall bladder lesions had not been satisfactory. In a fair percentage of cases, if special attention was paid to the technique, gall stones, pathological gall bladders and adhesions were recognized, but a considerable proportion remained that could not be detected.

With this new method we are now able to not only discover the pathology present, but in addition, to give some definite data as to the size, shape, location and emptying power of the gall bladder and of no small importance is the ability to study the function of the liver, recognizing delay.

The greatest achievement is the fact that gall stones which are non-opaque to the X-Ray, when surrounded by this opaque bile are outlined by negative shadows which can be readily recognized. In some cases the surface of the non-opaque stones absorb a sufficient amount of the dye impregnated bile to become visible in the roentgenograms.

It was early recognized that if, with no fault in the technique, the gall bladder shadow did not appear at any time during the frequent necessary X-Ray examinations after the injection, it was due to one of the following reasons:

### *A In cases without obstructive jaundice*

1 Obstruction of the cystic duct due either to stone or stricture. This includes cases of hydrops or empyema of the gall bladder.

2 Obliteration of the lumen of the gall bladder due to shrinkage, tumor growth or packing with calculi.

3 Thickening of the wall of the gall bladder with insufficient lumen and bile content, to cast a shadow.

4 Unusual thickening of the contents of the gall bladder (bile mud) so that it cannot mix with the recently excreted bile from the liver containing the test medium.

5 Defective liver function with imperfect excretion of the opaque bile.

*Theoretically in all other cases without obstructive jaundice the gall bladder should be visualized.*

### *B In cases with obstructive jaundice*

1 Shrunken, contracted and empty gall bladder found, according to Courvoisier's law, in the chronic intermittent form of obstruction produced by a calculus in the common bile duct.

2 Obstructions above the junction of the cystic duct with the common duct with no bile filling of gall bladder, as for example in carcinoma of the hepatic duct or carcinoma of the hylus of the liver.

3 Excessive distention of the gall bladder with bile, in common bile duct obstruction due, for example, to chronic pancreatitis, carcinoma of the head of the pancreas or carcinoma of the papilla of Vater, so that the

\* Read at the annual meeting of the Medical Society of the State of New York at Syracuse May 12 1925

admixture of the test medium is too dilute to cast a shadow

4 Arrested liver function in cases of very protracted and intense chronic obstructive jaundice due to any cases where, by continued back pressure in the biliary system, not even the normal bile is excreted into the bile ducts or gall bladder and so-called "white bile" is found at operation

Therefore, in cases with obstructive jaundice the gall bladder would most likely be visualized when the jaundice is due to a chronic progressive obstruction at or near the papilla of Vater produced by a chronic pancreatitis, carcinoma of the head of the pancreas or carcinoma of the papilla, or when it is due to the more acute form of calculous obstruction, provided the distention of the gall bladder has not been too extreme

The shadow of the normal gall bladder following the intravenous injection of Tetrabron should appear at the fourth hour, show diminished size and increased intensity at the eighth hour, become more intense in detail and less in size at the twenty-fourth hour and disappear thirty-six hours after the injection. Any variation in this sequence is strongly suspicious of pathology

Largely due to these positive findings the use of the test became general

Soon, however, objections were advanced against the method, the most serious being the severe toxic symptoms which developed in many cases almost immediately after the intravenous injection. These consisted of flushing of the face, dizziness, headache, vomiting, faintness and collapse. In some patients the condition seemed critical, nevertheless they revived quickly. Some stated they felt as well after as before the injection, others suffered from severe headache and nausea for twenty-four hours. So far as we have been able to ascertain, no deaths have been reported

Efforts were immediately made to overcome these toxic symptoms. The usual dose of 55 grams of the Tetrabrom was administered intravenously in two doses instead of one, fifteen minims of 1-1000 solution of adrenalin were given just before the first dose, and if there was much flushing of the face, five minims more were given before the second injection. The technique was also much improved, only freshly distilled water being used and the injection given slowly in the recumbent position by the gravity method instead of by a syringe. The preparation of the patient was improved upon, food being withheld for about twelve hours before the test. More care was exercised in the selection of the cases. Patients with cardiac lesions were not allowed to submit to the procedure, nor were highly hys-

terical or nervous patients considered desirable subjects

Despite these precautionary measures reactions occurred, some quite severe. This was sufficient to discourage the use of the test, that the procedure in many of our larger institutions was discontinued. However, a few, recognizing the importance of the roentgenographic visualization of the gall bladder, continued using it

In the January, 1925, issue of *Surgery, Gynecology and Obstetrics*, Drs Lester R. Whitaker and Gibbs Milliken, of Boston, published an article entitled "A Comparison of Sodium Tetrabrom Phenolphthalein with Tetraiodo Phenolphthalein in Gall Bladder Radiology." They stated that while Tetraiodo was equally as toxic as Tetrabrom the increased atomic weight of the iodine radical in Tetraiodo over the bromine in the Tetrabrom rendered it possible to obtain the same roentgenographic results with one-half the dose, and in consequence less reaction. Their deductions were so plausible that the test was again taken up with renewed enthusiasm. Observations showed that their statements were true. Patients did not have as severe reactions from the smaller dose of Tetraiodo as had been observed following the use of the Tetrabrom. A recent article by Drs Graham, Cole and Copher accepts the advantage of the Tetraiodo over the Tetrabrom and advocates the routine use of the iodine salt<sup>1</sup>

Even with the conceded advantages of the Tetraiodo there still remained an occasional unfortunate toxic experience with the intravenous injection and the enthusiasm was suspended

In February of this year (1925) the authors began to administer the Tetraiodo into the jejunum through the duodenal tube. It was found that in the average patient only 2 to 25 grams of the dye were required to satisfactorily outline the gall bladder. The tube was inserted at night, and in the early morning the exact position of the tip was ascertained fluoroscopically, if it was well down in the jejunum, the Tetraiodo dissolved in 200 cc of freshly distilled water, was slowly injected, usually in two doses, until the full amount had been given. Roentgenographic observations were then made four, eight, twenty-four and thirty-six hours after the administration. As a rule, the normal gall bladder was outlined as beautifully and regularly and showed the same time for filling and emptying as with the intravenous method. One must be certain, however, that the solution is injected well down in the jejunum, otherwise there will be a regurgitation into the stomach with vomiting. Recently articles by Drs Samuel

Weiss<sup>2</sup> and Israel O. Palefski<sup>3</sup> have appeared advocating this method.

While in a number of ways the jejunal method was found to be superior to administering the dye intravenously, it was far from harmless, many patients having severe reactions about an hour after the injection. In short, it was still a hospital procedure.

Investigations made by the authors, supported by results reported by Dr. M. Sosman, of Boston, and Drs. T. O. Menees and H. C. Robinson, of Grand Rapids, convinced us that the drug could be given by mouth, and satisfactory results achieved thereby. Considerable experience has confirmed these deductions. We now routinely use the oral method in all cases referred to our office for the roentgenographic examination of the gall bladder. The method of procedure is as follows:

After a thorough cleansing of the intestinal tract and a light breakfast, a preliminary roentgen examination of the gall bladder is made in the regular manner at about 10 a. m. The usual lunch is then allowed. At 5:30 p. m. a light meal is advised, consisting of vegetable soup, a baked potato, bread and butter and a cup of coffee, tea, cocoa or milk. Forty grains of the Tetraiodo Phenolphthalein having been freshly made into eight five-grain pills, and well-coated with keratin, the patient is instructed to begin at 9 p. m., and take two pills with a wineglass of water every fifteen minutes until all are taken. No breakfast is allowed. At 10 a. m., the following morning, a complete fluoroscopic as well as roentgenographic examination of the gall bladder region is made. Four hours later, at 2 p. m., the examination is repeated. Regular lunch is served at 2:30 p. m., followed by another X-ray examination at 4 p. m. The patient returns the following morning for a final observation.

It is essential to make the preliminary examination before the administration of the Tetraiodo for we believe that a visible gall bladder found with the ordinary method is frequently an indication of pathology. The "test" can be used as a check on these findings, for fictitious shadows have more than once been erroneously diagnosed as a diseased gall bladder.

The starvation diet is necessary in order that the gall bladder may become distended with the opaque bile. In normal cases it should appear at the twelfth hour and should slightly diminish in size and become more intense in

outline four hours later. As soon as food is given it commences to contract and to empty itself as shown by the diminution in size and detail of the shadow. This observation is to be made during the examination at 4 p. m., after lunch. The following morning, thirty-six hours after the Tetraiodo the shadow of the gall bladder, unless pathological, should have disappeared.

So far, our patients submitting to the oral method, fifty-three cases in all, have had no severe reaction. These have been seen at our private office, Lenox Hill and Lutheran Hospitals, New York City. About ten per cent had a vomiting attack and five per cent a mild diarrhea. The majority misinterpreted the use of the pills, and claimed that they did not even move the bowels. In only four cases out of the series in which the Tetraiodo was given by mouth, did we fail to obtain a gall bladder shadow. In addition, nearly all showed increased liver detail, especially of the lower border, a most important anatomical "landmark" in the interpretation of the roentgenograms.

We are convinced that the oral method is the safest and best. It is more than likely that in time it will prove to be as reliable in the roentgen investigation of the gall bladder as bismuth and barium are in the gastrointestinal tract.

It is well to bear in mind, however, that the method to be of practical value in the diagnosis of gall bladder disease must confirm and support the clinical findings. This can only be accomplished by a close cooperation between the surgeon or internist and the roentgenologist.

We are indebted to Dr. DeWitt Stetten, of New York City, for suggestions in the preparation of this paper.

#### REFERENCES

- 1 "Cholecystography—The Use of Sodium Tetraiodo Phenolphthalein" Everts A. Graham, M.D., Warren H. Cole, M.D., and Glover H. Copher, M.D., St. Louis. *The Journal of the A. M. A.*, April 18, 1925, page 1175.
- 2 "The Rectal and Duodenal Administration of the Sodium Salt of Tetrabrom Phenolphthalein. A Preliminary Communication." Samuel Weiss, M.D., F.A.C.P., New York City. *American Medicine*, March, 1925, page 161.
- 3 "Visualization of the Gall Bladder With Sodium Tetrabrom Phenolphthalein by Oral and Intra-duodenal Administration Through the Duodenal Tube." Israel O. Palefski, M.D., New York City. *Medical Journal and Record*, April 15, 1925, page 474.

## THE TONSIL PROBLEM \*

By ALBERT M. ROOKER, M.D., F.A.C.S.

NIAGARA FALLS NEW YORK

THE tonsil, which by some is regarded merely as a herniated lymph node, and by others as a detached piece of undeveloped thymus, because it looks and grows like it at first, is present in practically all our lower animals. The size, shape and position vary considerably in animals just as in humans, but the description of Barnes, I believe, is the best I have read. He says, "The tonsil is a more or less almond-shaped mass, situated between the pillars of the fauces, extending upwards usually to the origin of the pillars in the soft palate and downward to the base of the tongue. They are composed of lymphoid tissue in a rather sparse connective tissue mesh, and lie in a fossa separated from subjacent tissue by a fibrous capsule. These masses of lymphoid tissue are penetrated by numerous crypts lined by squamous epithelium, the same as covers the remainder of the tonsil, and end very near the capsule." There are about six to eighteen of these crypts—those in the upper part being wider, deeper and often branched.

Situated as it is at the entrance to the respiratory and alimentary tract—it is exposed to all sorts of infection and abrasions. The food passes over them, and squeezed by the superior constrictor and tongue muscles, particles are forced into these crypts, where it lies and decomposes, forming a perfect culture media, so that the crypts normally contain swarms of bacteria—pathogenic and non-pathogenic. As to the significance of these bacteria, any number of observers, after most exhaustive research, have obtained an equal number of different and widely varying results. Experiments with carmine granules placed in crypts with a special canula, and also rubbed on the surface of the tonsil, showed subsequently the presence of carmine granules in the sub-epithelial tissues—on the other hand Chinese ink and soot both painted on tonsils hours before tonsillectomy and also fed to rabbits with food for a week—showed none in the tonsil itself.

Virulent bacteria, however, behave differently than inert granules. Lever succeeded in infecting rabbits by painting tonsils and pharynx with virulent streptococci. The streptococci were found in both the tonsils and pharynx beneath the epithelium, and the animals died of septicaemia—but might it not have been due to a blood stream infection that the tonsillar areas became infected?

Some claim that the lymphatics convey the infection to the tonsil from the nasal mucosa and that here it is extruded into the pharynx, others do the same experiments and arrive at diametrically opposite results. What then are we to believe? Jonathan Wright speaking of his own and others' discoveries, is impressed by the fact that within the crypts of the tonsils there are constantly pathogenic organisms, which while harmless in this location, are nevertheless sufficiently toxic and virulent to produce harmful effects if injected into animals and that while dust could be and was taken up and penetrated the mucous membrane of the tonsillar crypt, while the swarms of bacteria always present were kept out, and consequently he believed that some force succeeded in differentiating toxic from harmless protoplasts—possibly something like surface tension as applied to colloids. It is possible and probable as shown by recent experiments by Mudd and Grant that this surface tension or resistance can be changed by exposure, especially to cold, by gastric disturbances, etc.

Bacterial flora varies widely—on the surface streptococcus viridans, from the crypts the streptococcus haemolyticus, and many others as pneumococcus, diphtheria, staphylococcus albus, influenza, etc. Of 113 tonsils removed for joint lesion, endocarditis and nephritis, 90 per cent were streptococcus haemolyticus.

Many systemic infections occur due to the entrance into the blood or lymph stream, either with or without primary lesions in the tonsils themselves. The normal bacterial contents of the crypts for some reason or other in certain cases is absorbed or passed through or between the epithelial cells lining the crypts, and thus gain entrance to the body fluids and then attacks that part for which they seem to have a definite affinity as streptococcus haemolyticus seems to be the organism causing most joint lesions, S. Viridans causes most endocarditis, etc. These are considered true focal infections and may occur with absolutely no symptomatic evidence of their tonsillar origin. While we have learned much about the harm tonsils may cause, what do we know of their possible use or function? Here our knowledge is largely theoretical, and at present five theories seem to be all that have any evidence to sustain their claims.

I. Theory of protection. That tonsils protect organism from bacterial invasion—this rests upon their position at the entrance to the alimentary and respiratory tract, that they

\* Read at the Annual Meeting of the Eighth District Branch of the Medical Society of the State of New York at Batavia October 13, 1924



are of lymphoid tissue and that their acute inflammation is precursor of systemic disease. The vulnerable point here is that it is ineffective, as so few bacteria actually in proportion to the enormous number ingested, really touch the tonsil at all.

II Internal secretion. No experimental proof has ever been adduced to prove this theory, which came about through the rapid enlargement of the tonsils in the first three years of life, but the large number of tonsillectomies done in recent years without producing any change in the individual except improvement, negatives this theory.

III Theory of haematopoiesis is on more solid foundation, as the follicle has a demonstrable germinal center and from this some lymphocytes are probably produced, but in proportion to the rest of the active lymphatic tissue in the body, they really are of comparatively small account.

IV Theory of elimination. This theory is that bacteria and their products are thrown off from the tonsils during septic processes elsewhere in the body. But nature never would place an organ for eliminating poisons and menacing bacteria at the entrance to the digestive and respiratory tracts, with the probability of their re-absorption assured.

V Theory of immunity is the most attractive and rational. It is that a portion of the invading organisms is held by the tonsil in its crypts and that toxins are absorbed in sufficient quantities to produce antibodies in the host. This insures an immediate auto-vaccination against the type of bacteria which are invading the organism. If this theory is true, then the tonsils are of immense value in early life until immunity is well established—then too their atrophy in later life is accounted for, and their position of vantage is explained. Then also, being at the head of a lymphatic chain which terminates in the vena cava, it is not difficult to believe that it takes on something from the pharynx and deposits it in the blood stream, and what could be more likely than that it might be a well-filtered toxin?

How are we to determine which tonsils are and which are not infected?

I History is very important. Has he ever had an attack of acute tonsillitis, no matter when or how long ago it may have occurred? Sluder says "It is very doubtful if after one attack of acute follicular tonsillitis, a tonsil ever returns to normal." Ask also if they catch cold easily and whether it begins in throat or head, ever had swollen glands as child, ever had acute articular rheumatism or other evidence of systemic infection. An affirmative answer to any of these questions is quite suggestive.

II Enlarged cervical lymph nodes, especially that one at the angle of the jaw at the anterior border of the sterno-mastoid muscle, which the patient often mistakes for the tonsil itself. Does this gland become tender—ever so slightly—at the beginning of a cold? Enlargement or tenderness here is most suggestive of tonsil infection, and is an important finding.

III Appearance of throat, and here I want to say a few words about examining the throat, which is only too frequently done in a most slipshod manner. Sometimes it is as the real estate men say, "A look means a lot," but only in rare instances is this true in regard to the tonsils. First have a good light and use a head mirror and have each in proper position before you have patient open his mouth. Use a tongue depressor with handle so your own hand is out of the line of vision, and use it most carefully. Place it not too far back on tongue, and have your middle finger under patient's chin to steady both him and your own hand, so it doesn't slip a particle, all this time telling him to take quick, short breaths and to continue doing so, for as long as his mind is on this voluntary rapid breathing, he won't gag. These simple measures if followed carefully will permit a thorough examination of the throat in nine cases out of ten. By this time you may have caught a whiff of the patient's breath, which if bad is frequently an indication of much debris in the tonsils, however, not necessarily infected, but still suggestive. Observe first the pillars—redness of the anterior pillar at its edge, when the throat is at rest, is, I believe, the most constant of all signs of chronic tonsillar infection. Compare it to the other pharyngeal mucosa—not while gagging, nor after it has been irritated by pressure, as then one gains a false idea, as redness immediately develops. Next view the tonsils (if they are not visible draw back the anterior pillar with a hooked probe, and don't say a patient has no tonsils just because they are not staring you in the face, for unfortunately patients like to believe such statements), are they large or small, and if large do they obstruct? Is there any exudate on the surface? Are the crypts numerous and are they wide open? Any debris visible in them? Any sealed in the crypts shining through the thin epithelium? Then take tonsil searcher or heavy bent probe, and press on anterior pillar and somewhat exterior to tonsil, to bring it more into view, note whether pus or debris is extruded, the thin, yellow pus is most significant, though the debris, too, may be highly infectious. This pus and debris may be examined, both smear and culture, and if found to be strep-haemolyticus, and your pa-

## THE TONSIL PROBLEM\*

By ALBERT M ROOKER, M D, F A C S

NIAGARA FALLS NEW YORK

THE tonsil, which by some is regarded merely as a herniated lymph node, and by others as a detached piece of undeveloped thymus, because it looks and grows like it at first, is present in practically all our lower animals. The size, shape and position vary considerably in animals just as in humans, but the description of Barnes, I believe, is the best I have read. He says, "The tonsil is a more or less almond-shaped mass, situated between the pillars of the fauces, extending upwards usually to the origin of the pillars in the soft palate and downward to the base of the tongue. They are composed of lymphoid tissue in a rather sparse connective tissue mesh, and lie in a fossa separated from subjacent tissue by a fibrous capsule. These masses of lymphoid tissue are penetrated by numerous crypts lined by squamous epithelium, the same as covers the remainder of the tonsil, and end very near the capsule." There are about six to eighteen of these crypts—those in the upper part being wider, deeper and often branched.

Situated as it is at the entrance to the respiratory and alimentary tract—it is exposed to all sorts of infection and abrasions. The food passes over them, and squeezed by the superior constrictor and tongue muscles, particles are forced into these crypts, where it lies and decomposes, forming a perfect culture media, so that the crypts normally contain swarms of bacteria—pathogenic and non-pathogenic. As to the significance of these bacteria, any number of observers, after most exhaustive research, have obtained an equal number of different and widely varying results. Experiments with carmine granules placed in crypts with a special canula, and also rubbed on the surface of the tonsil, showed subsequently the presence of carmine granules in the sub-epithelial tissues—on the other hand Chinese ink and soot both painted on tonsils hours before tonsillectomy and also fed to rabbits with food for a week—showed none in the tonsil itself.

Virulent bacteria, however, behave differently than inert granules. Lexer succeeded in infecting rabbits by painting tonsils and pharynx with virulent streptococci. The streptococci were found in both the tonsils and pharynx beneath the epithelium, and the animals died of septicaemia—but might it not have been due to a blood stream infection that the tonsillar areas became infected?

Some claim that the lymphatics convey the infection to the tonsil from the nasal mucosa and that here it is extruded into the pharynx; others do the same experiments and arrive at diametrically opposite results. What then are we to believe? Jonathan Wright speaking of his own and others' discoveries, is impressed by the fact that within the crypts of the tonsils there are constantly pathogenic organisms, which while harmless in this location are nevertheless sufficiently toxic and virulent to produce harmful effects if injected in animals and that while dust could be and was taken up and penetrated the mucous membrane of the tonsillar crypt, while the swarm of bacteria always present were kept out, and consequently he believed that some force succeeded in differentiating toxic from harmless protoplasts—possibly something like surface tension as applied to colloids. It is possible and probable as shown by recent experiments by Mudd and Grant that this surface tension or resistance can be changed by exposure, especially to cold, by gastric disturbances, etc.

Bacterial flora varies widely—on the surface streptococcus viridans, from the crypts the streptococcus haemolyticus, and many others as pneumococcus, diphtheria, staphylococcus albus, influenza, etc. Of 113 tonsils removed for joint lesion, endocarditis and nephritis, 90 per cent were streptococcus haemolyticus.

Many systemic infections occur due to the entrance into the blood or lymph stream, either with or without primary lesions in the tonsils themselves. The normal bacterial contents of the crypts for some reason or other in certain cases is absorbed or passed through or between the epithelial cells lining the crypts, and thus gain entrance to the body fluids and then attacks that part for which they seem to have a definite affinity as streptococcus haemolyticus seems to be the organism causing most joint lesions, S. Viridans causes most endocarditis, etc. These are considered true focal infections and may occur with absolutely no symptomatic evidence of their tonsillar origin. While we have learned much about the harm tonsils may cause, what do we know of their possible use or function? Here our knowledge is largely theoretical, and at present five theories seem to be all that have any evidence to sustain their claims.

I. Theory of protection. That tonsils protect organism from bacterial invasion—this rests upon their position at the entrance to the alimentary and respiratory tract, that they

\* Read at the Annual Meeting of the Eighth District Branch of the Medical Society of the State of New York, at Batavia October 13, 1924.

ications have been clean-cut and properly interpreted and the tonsils have been completely removed, I believe there is no other single surgical measure which gives such uniformly good results, and sometimes almost miraculous cures. But with border line cases, where our indications are less clear and possibly the operation has been done as a last resort in a focal infection, in these cases naturally we meet with many disappointments.

How long after operation is improvement to be expected? Occasionally it occurs in 24 hours, even in long standing cases, but this is exceptional. In an analysis of 261 chronic cases operated at the Mayo Clinic, the average length of time before actual improvement was noted was three months, and in some cases a full year passed before real improvement was observed. Kaiser in a study of 1,200 children, three years after tonsillectomy and compared

with an equal number of children unoperated arrived at the following conclusions. Children have much relief from sore throat, head colds and mouth breathing, and also lessens the chances of their having discharging ears with their complications, it assures some protection against glandular infection and materially lessens their susceptibility to contracting diphtheria—but their susceptibility to scarlet fever and measles is not influenced. Malnutrition was definitely reduced.

In conclusion I want to emphasize the importance of a careful examination, the use of palliative measures, X-Ray and suction in inoperable cases, not promising too much in border line cases, eliminating other sources of infection, and when operating to remove the entire tonsil, as a small stub can cause as much harm as the entire tonsil, and at the same time discredit both the diagnostician and operator.

## HORNELL BREAST FEEDING DEMONSTRATION\*

By B. R. WAKEMAN, M.D.

HORNELL, N. Y.

AT the May, 1924, meeting of the Medical Society of the County of Steuben, Dr. H. R. Lohnes, of Buffalo, read a paper on "Breast Feeding Recent Advances in Promoting and Maintaining the Supply." All the Hornell physicians who heard Dr. Lohnes' paper were very much interested in the subject and expressed a desire to have the topic further discussed at one of the meetings of the local medical society.

Arrangements were made with Dr. Florence McKay, Director of the Division of Maternity, Infancy and Child Hygiene of the State Health Department, to send us one of the consulting pediatricians to address the society and tentative plans were made to organize a breast feeding campaign similar to the one in progress in Long Island. Early in October, 1924, Dr. Frank Howard Richardson, of Brooklyn, addressed the Hornell Medical and Surgical Association. Dr. Richardson stated that, with few exceptions, every mother could nurse her baby provided she had proper instruction in manual expression, had the proper attitude toward breast feeding, and her physician was "sold" to the breast feeding project. See S. M. Journal p. 17. In the discussion of Dr. Richardson's paper it was pointed out that a breast-fed child is usually protected from communicable diseases and seldom suffers from digestive troubles. In an adjoining city ten babies died last summer of cholera infantum, all artificially fed.

As a result of Dr. Richardson's talk the Association, by resolution, invited the health officer to organize a breast-feeding demonstration similar to the one in operation in Nassau County, Long Island. The Division of Maternity, Infancy and Child Hygiene immediately assigned to the city, Miss Mary J. Dunn, one of the specially trained department nurses, to assist in the breast-feeding campaign.

In some respects this city is ideally suited for a demonstration such as this, in that it has a united medical profession, two well-trained public health nurses, a baby clinic, two 75-bed hospitals, each maintaining a maternity pavilion, and a training school for nurses.

Arrangements were made with both hospitals for talks to the nurses by Miss Dunn. The following lectures were given in both hospitals:

### First Talk

- a Value of Breast Feeding
- b Relation of Nurse to the Physician
- c Methods for Maintaining Breast Feeding

### Second Talk

- a Technic of Manual Expression
- b Demonstration of Expression

### Third Talk

- Difficulties of Breast Feeding
- a Those Affecting the Mother
- b Those Affecting the Baby

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse, May 12, 1925.

tient has joint lesions, or strep-viridans, and he has endocarditis, or kidney lesion, or diphtheria, he is probably a carrier—your evidence is more complete. Sometimes, however, no pus is expressed by pressure—then I use a suction tube. This will often remove pus and debris which pressure is too painful to bring about, and sometimes an astonishing amount comes worming its way out. By now you are ready to give an opinion of the tonsil that is based upon a real examination and correspondingly valuable. But before condemning the tonsil and giving a favorable prognosis, if a tonsillectomy is done, carefully search out for other possible sources of infection, as teeth, sinuses, chronic discharging ears, gall bladder, appendix, kidney infection, prostate, seminal vesicles, pus tubes, etc. Sometimes tonsils alone do not cause all the mischief, and two foci may be at fault. I wish to emphasize this for we are so prone to jump at conclusions and remove the one focus and cease in our efforts to locate any other possible source.

Now our tonsil is infected—chronic I mean—what are we going to do with it? What are our remedies—outside of surgery—for many patients don't part with them so easily? Swabs and applications to crypts seem to be of no use whatever—at least that is my experience. Electric cauterization of crypts and slitting them open so they can discharge more readily, has also been passed into the discard by most men.

X-Ray and Radium—Recent publications by Witherbee, Craig and Hussey, and Murphy, have drawn attention to the action of X-Ray and Radium on tonsil tissue—their first enthusiastic reports have been considerably modified by other observations and the present status of this form of treatment would be about as follows. A certain percentage of tonsils treated by experienced operators may undergo more or less atrophy, and as a result of this, pathological conditions depending on retention in the crypts will improve in direct ratio to the amount of atrophy. The bacterial content of the crypts may even be materially changed, due to the improved drainage, and not to any sterilizing action of the radiation—but at present we cannot say how permanent this result may be. The method cannot take the place of surgery as was at first predicted. In both children and adults it should be advised only when an operation is contra-indicated or flatly refused. Recently in the use of suction as a diagnostic measure I noted that patients reported marked improvement in their condition after my examination, and as a consequence I wish to present for your consideration and trial, suction as a therapeutic as well as a diagnostic measure.

In applying the suction you sort of vacuum clean the tonsil, the crypts are opened wider, the pus and debris are extruded, and as a result the patient who has been suffering from a backache, stiff neck, arthritis, etc., frequently the next day reports marked improvement. I have found this so often the case, that now when I am sometimes in doubt about infection being present, I apply suction as a therapeutic test—repeating at three-day intervals and if the patient improves it is probably the tonsil but still if he doesn't improve the tonsil isn't necessarily ruled out, for suction cannot do what enucleation does. But I do want to offer this to you as being worthy of a trial especially in old people, who so often look askance at surgery, in tuberculosis, diabetes, haemophiliacs, etc. So far some of my cases have held their improvement for five months with only three treatments. It is not and cannot be permanent, but it is worthy of trial.

What are the contra-indications to tonsillectomy?

I True haemophilia. This precludes all possibility of tonsillectomy.

II Status lymphaticus. Though here the enlarged thymus might be treated by X-Ray and reduced and then be operated.

III General systemic conditions such as diabetes, and active pulmonary tuberculosis. Insulin, however, has practically restored the diabetic to the operable class. Here also could be placed acute infection of the tonsils. I usually wait until two full weeks after its subsidence, and also exacerbations of arthritic or heart conditions, though the latter by some are not considered as contraindications.

What effect on the singing voice has tonsillectomy? Provided that no undue injury is done to the palate or the faucial arches, the singing voice is not injured by tonsillectomy. However, any cicatricial contractions interfering with palato-pharyngeal movements (the muscle of the posterior-pillar) or any injury that restricts the forward and backward movements of the soft palate—has a deleterious effect—for the palato-pharyngeus tilts the thyroid cartilage on the cricoid and thereby tenses the cords and is a regulator of pitch and especially the higher notes. After tonsillectomy the voice should not be used for at least three months, and better still, for six months, as a sufficient time must elapse for the nerve fibres and muscles of the throat to accustom themselves to their new relation and position, so that they co-ordinate properly to produce the desired note.

I am not going to touch upon the operation itself, for we all have our favorite method, and I hope get good results, as far as the throat is concerned. But does the patient get the systemic relief we had hoped for? When the in-

Three apparently healthy mothers did everything they could do to maintain a supply of breast milk but failed

At the end of the first month every mother but two was nursing her baby either wholly or partially. Complementary feeding was given to 16 babies. Before this demonstration was put on "complementary feeding" was a rare thing. Previous to the demonstration much condensed milk and proprietary food was used in the feeding of babies. Now all the babies taken off the breast are placed on modified cow's milk.

A study by Barrino of Italy showed that practically half of the prematurely weaned babies were weaned during the first two weeks of life. For that reason particularly good work for breast feeding can be done with our hospital patients. During this six months' period, 57 or 46 per cent of the Hornell births occurred in the hospitals.

Active supervision of all maternity patients during the nursing period with the encouragement of breast feeding will be maintained here by the public health, hospital and private duty nurses, as long as the medical profession wishes it.

During the past three months we have had

an epidemic of whooping cough. Only one breast fed baby has contracted the disease.

### SUMMARY

The Hornell Breast Feeding Demonstration covers a period of six months, October 1, 1924, to April 1, 1925. One hundred and twenty-seven babies were born and registered for the demonstration. One hundred and six babies completed this six months' period on the breast. Of the nineteen discharged patients, thirteen did not have the benefit of the demonstration, except for the first month, for reasons cited above. Seven of these discharged babies might have been kept at the breast if we had had a little more cooperation on the part of the mothers and their physicians.

In the Long Island Breast Feeding Demonstration covering a period of two years, 92 per cent of the babies were breast fed at the end of the first month. In the Hornell Demonstration 98 per cent were breast fed at the end of the first month. Fifty-nine per cent of the Long Island mothers were nursing their babies at the nine months' period. Eighty-four per cent of the Hornell mothers were nursing their babies at the end of the six months' period.

## Deaths

ADAMS, HENRY FREDERICK, Brooklyn, College of Physicians and Surgeons of New York, 1890, Fellow American Medical Association, Member State Society. Died May 17, 1925.

ALLEN, THOMAS GILCHRIST, Buffalo, State University, Iowa, 1886, Fellow American Medical Association, Member State Society. Died May 6, 1925.

BENNETT, ALICE, New York City, Women's Medical College, Pennsylvania, 1876, Member State Society. Died May 31, 1925.

BERRY, JOHN McWILLIAMS, Albany, Johns Hopkins, 1901, Fellow American Medical Association, Fellow American College of Surgeons, Member State Society, Orthopedic Surgeon and Roentgenologist Albany Hospital. Died May 13, 1925.

BROWN, LE ROY, New York City, Vanderbilt University, 1887, Fellow American Medical Association, Fellow American College of Surgeons, American Gynecological Society, New York Academy of Medicine, Member State Society, Consulting Surgeon Woman's Hospital. Died April 22, 1925.

CLARK, FRANCIS CHARLES, Oswego, Medical College South Carolina, 1903, Fellow American Medical Association, Member State Society, Consulting Physician Oswego Hospital. Died May 11, 1925.

DOUGHTY, ISAAC LINTON, Corona, College of Physicians and Surgeons of New York, 1898, Fellow American Medical Association, Member State Society. Died May 20, 1925.

GIBSON, WILLIAM MEREDITH, Cazenovia, New York University, 1878, Fellow American Climatological and Clinical Association, Member State Society. Died May 17, 1925.

HINDSALE, ROY SEYMOUR, New York City, College of Physicians and Surgeons of New York, 1898, Member State Society. Died April 25, 1925.

LETOURNEAU, G. E., Rouses Point, Victoria Montreal, Canada, 1879, Member State Society. Died May 24, 1925.

MCGINNIS, EDWARD L'H., New York City, Long Island College Hospital, 1883, Fellow American Medical Association, New York Academy of Medicine, Member State Society, Consulting Electro-Therapist Women's and Manhattan Hospitals. Died April 28, 1925.

NICHOLS, CALVIN E., Troy, University of Vermont, 1868, Member State Society, Consulting Physician Troy, and Leonard Hospitals. Died April 23, 1925.

ROBSON, JOHN A., Hall, Albany Medical College, 1886, Fellow American Medical Association, Member State Society. Died May 11, 1925.

SCHAEFFER, JOSEPH WILLIAM, Brooklyn, Long Island College Hospital, 1897, Member State Society. Died May 3, 1925.

SUTER, AUGUSTUS WALTER, Herkimer, College of Physicians and Surgeons of New York, 1871, Fellow American Medical Association, New York Academy of Medicine, Member and Ex-President State Society. Died May 28, 1925.

SULLIVAN, JOHN D., Brooklyn, New York University, 1867, Fellow American Medical Association, Fellow American College of Surgeons, Member State Society, Surgeon St. Mary's Hospital. Died May 15, 1925.

TRIMBLE, WILLIAM B., New York City, New York University, 1891, Fellow American Medical Association, American and N. Y. Dermatological Associations, New York Academy of Medicine, Member State Society, Director Dermatology Bellevue Hospital. Died May 23, 1925.

Several physicians dropped in to hear these talks and expressed their approval of the method used in instructing the nurses. The success of a demonstration like this depends very largely on the grasp the nurses get of the subject.

The department nurse was instructed to visit each physician and get his consent before visiting any of his patients. In the Long Island Demonstration the nurse did not visit a patient until she secured a written consent from the attending physician for each patient.

In the Hornell Demonstration this did not seem to be necessary as every physician gave a blank consent to visit any and all of his present and future maternity patients. The first contact of the department nurse with the doctor is the most important part of the demonstration, for the success of the work depends very largely on the interest in breast feeding which she arouses in the physician.

Some of the comments and statements the physicians made to the demonstration nurse may be noted in this connection.

Dr One Believes that most good can be accomplished by putting the message across to the pupil nurses.

Dr Two Says that many mothers confined in the hospital are unable to nurse their babies. Highly approves of giving special instruction to pupil nurses in the proper care of the patient during the initial breast engorgement. States that in cases of breast infection, baby need not be taken from the breast unless pus is mixed with the milk.

Dr Three Believes in re-education of medical profession and laity. Many mothers are indifferent in regard to their duty of nursing their babies, and urges the nurses to make every effort to instruct mothers in methods of conserving breast milk.

Dr Four Interested and indorses breast feeding work. Does not approve of baby being kept at the breast during severe illness of the mother. Thinks it is too much of a strain on the mother.

Dr Five Would like to see method of manual expression.

Note—A premature baby, under this doctor's care, is now being nourished on mother's milk, manually expressed, and given to the baby through a medicine dropper.

Dr Six Believes that efficient follow-up work by the nurses is essential to success, as the physician has little available time to do follow-up work even in the office.

Dr Seven Suggests importance of training mothers to consult their physician frequently during the nursing period.

Dr Eight Out of town when the demonstration began. Somewhat skeptical but on going over the work in detail, finally endorsed

it. Should emphasize to pupil nurses reasons why we do not use the breast pump, and should show them the various ways of urging a disinterested baby to take the breast.

Dr Nine Feels it is unnecessary to stress on value of breast feeding. He believes everyone knows its value. Upon mentioning a few facts as to death ratio between breast and bottle babies, and the less susceptibility to contagion in breast fed babies which can be told to mothers, he was convinced that here was a real field for education.

The seven other doctors visited were all interested and were willing to do their part to make the demonstration a success.

Arrangements were made with the registrar of vital statistics to furnish the two public health nurses a weekly list of all births. This enables the nurses to make earlier contact with the new mothers. The nurses keep list of all births registered, which includes the date of birth, the date of first visit and the date of each subsequent visit with a brief note of the conditions found at each visit. The first contact is made within two weeks of birth. Normal patients are visited at least once a month. Patients having difficulty with breast feeding are visited much oftener. When the nurse finds the mother is having some difficulty in nursing her baby, she immediately notifies the physician and carries out his instructions.

As soon as the mother is able to be out, she is urged to bring her baby to the clinic at the health center to be registered, weighed and measured. This tends to conserve the time of the nurses. By contact with the clinic physician and other mothers attending the clinic the new mother's interest is still more stimulated.

During the first six months of this demonstration (from October 1, 1924, to April 1925,) 127 babies have been registered and each mother visited by the nurses. Of this number 21 have been discharged, leaving April 1st, 106 mothers who are either wholly or partially feeding their babies on breast milk.

Of the 21 patients discharged

One baby died of acute dilation of the heart at the end of two weeks.

Three have moved out of town.

Two mothers have tuberculosis.

Three mothers are non-cooperative—do not wish to be tied down to a nursing baby.

One mother in poor health, had a severe shock (father burned to death).

Four mothers anaemic, poorly nourished had some concurrent infection.

Four babies placed on the bottle by physician as it was easier.

have gathered some idea of the trend of thought of the physicians of New York State. It has been suggested that state-wide conferences be called for secretaries of county medical societies and chairmen of the local committees on economics, legislation, public health, and other committees of the county societies. A conference of each committee would involve about 70 men, and if it lasted three hours, and every man spoke, each speaker would have two and a half minutes, and if he did not speak, he may as well read a letter that is sent to him by the chairman. We believe most thoroughly in conferences, but we would like to see them held by small groups, such as those of the District Branches. The conferees in each Branch are familiar with their own problems, and as they sit around a table, they will have abundant opportunity to discuss all phases of their problems.

The District Branches need a common purpose. An evident objective is the promotion of graduate education and clinical programs of county society meetings. In order to carry on this educational work, there must be an organized machinery. The 10,000 members of the State Medical Society constitute an army under the command of General Van Etten. The District Branches are the regiments, each under a colonel—the President and Councilor. Each county society is a company under a captain—the local President. The natural and necessary system is that the General and his Staff shall reach the companies through the regimental commanders. This was the intention of the founders of the State Society, and it will probably be the plan which will be developed by the present leaders of the State Society.

F O

---

### GRADUATE MEDICAL INSTRUCTION

The House of Delegates at the annual meeting in Syracuse unanimously accepted the reference reports upon the report of the special committee on graduate medical instruction. These reports not only strongly endorsed the principle and need of graduate medical extension instruction, but urged upon the Council the wisdom of putting this work into definite action and appropriating such an amount of money as might seem expedient for this purpose.

This marks a progressive evolutionary development in the work of the State Society, and is the beginning of a new era fraught with the greatest possibilities of scientific growth for the general practitioners of medicine of this State.

Wisconsin, North Carolina, and Pennsylvania have for some years carried out extension medical teaching, and in all three the reaction has been the same. Their work has shown a steady growth in interest and attendance. It is, no longer an experiment, but has become a real necessity now demanded by the physicians. Our own County of Kings has developed a plan of graduate education which has been extraordinarily successful in meeting their needs. Their methods will without doubt serve as a model for this work in other large communities of the country. The idea underlying this graduate extension instruction is to make it possible for every physician to keep in touch with the tremendous

strides of modern medical progress without neglecting the work of his practice.

Medicine has been and continues such a rapidly progressive science that the practitioners who are not in close touch with the activities of the great medical centers should be periodically reinvigorated and kept up to date in order that these great discoveries can be made available for mankind. Such continuous and effective extension education is the greatest possible contribution that can be made to public health, and is the most efficient weapon against charlatanry and quackery. The Empire State is to-day in a better position than any other state to lead the way and to make rapid advance in everything pertaining to graduate extension education its goal. The concurrence of our great medical schools and research laboratories, and our well equipped hospitals, with the leadership of the State Society, awaits only a comprehensive and well worked out plan in order to make graduate extension work in New York State of the greatest possible help to the community and aid to the physician.

Nothing more worthy in medicine is possible at this time than to make available all the great advances in diagnosis and treatment to the physician who is desirous of keeping abreast of the times.

ANDREW MACFARLANE



# EDITORIALS



The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

Editor-in-Chief—ORRIN SAGE WIGHTMAN, M.D.,

New York

### COMMITTEE ON PUBLICATION

E. ELIOT HARRIS, M.D., *Chairman*

New York

WILLIAM H. ROSS, M.D.

Brentwood

DANIEL S. DOUGHERTY, M.D.

New York

Executive Editor—FRANK OVERTON, M.D. Patchogue

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

President—NATHAN B. VAN ETTEN, M.D. New York  
First Vice President—WILLIAM H. ROSS, M.D. Brentwood  
Second Vice President—FREDERICK H. FLAHERTY, M.D. Syracuse  
Speaker—E. ELIOT HARRIS, M.D. New York  
Vice Speaker—GEORGE M. FISHER, M.D. Utica  
Secretary—DANIEL S. DOUGHERTY, M.D. New York  
Assistant Secretary—HOWARD GILLESPIE MYERS, M.D. New York  
Treasurer—CHARLES GORDON HEYD, M.D. New York  
Assistant Treasurer—JAMES PEDERSEN, M.D. New York

COUNSEL  
GEORGE W. WHITESIDE, Esq., 27 William St. Telephone, Broad 1744

New York

ATTORNEY  
ROBERT OLIVER, Esq., 27 William St.

New York

EXECUTIVE OFFICER  
JOSEPH S. LAWRENCE, M.D. 51 Chapel Street, Albany

### SECTION OFFICERS

Medicine  
Chairman—L. WHITTINGTON GORHAM, M.D. Albany  
Secretary—WARDNER D. AYER, M.D. Syracuse

Surgery  
Chairman—EDWARD S. VAN DUYN, M.D. Syracuse  
Secretary—GEORGE E. BEILEY, M.D. Albany

Obstetrics and Gynecology  
Chairman—ALFRED C. BEAR, M.D. Brooklyn  
Secretary—NATHAN P. SEARS, M.D. Syracuse

Pediatrics  
Chairman—ROGER H. DENNETT, M.D. New York  
Vice Chairman—ARTHUR W. BENSON, M.D. Troy  
Secretary—JOHN ALKMAN, M.D. Rochester

Eye, Ear, Nose and Throat  
Chairman—EUGENE E. HINMAN, M.D. Albany  
Secretary—JAMES W. WHITE, M.D. New York

Public Health, Hygiene and Sanitation  
Chairman—ARTHUR D. JAGUES, M.D. Lynbrook  
Secretary—LEO F. SCHIFF, M.D. Plattsburg

Neurology and Psychiatry  
Chairman—CLARENCE O. CHENEY, M.D. Utica  
Secretary—THOMAS K. DAVIS, M.D. New York

### CHAIRMAN, STANDING COMMITTEES

Arrangements—EDWARD R. CUNIFFE, M.D. New York  
Public Health and Medical Education,  
CHARLES A. GORDON, M.D., Brooklyn  
Scientific Work—ANDREW MACFARLANE, M.D. Albany  
Medical Economics—WILLIAM WARREN BRITT, M.D. Tonawanda

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex-President and the Councilors of the District Branches

First District—JOHN A. CARD, M.D. Poughkeepsie  
Second District—JOSEPH S. THOMAS, M.D. Flushing  
Third District—CHARLES P. MCCABE, M.D. Greenville  
Fourth District—HORACE M. HICKS, M.D. Amsterdam  
Fifth District—NELSON O. BROOKS, M.D. Oneida  
Sixth District—GEORGE H. FOX, M.D. Binghamton  
Seventh District—WILLIAM I. DEAN, M.D. Rochester  
Eighth District—HARRY R. TRICK, M.D. Buffalo

For a list of the officers of the county medical societies, see April 24th JOURNAL, advertising page v

For list of District Branch Officers, Standing Committees and Special Committees, see this JOURNAL, advertising page xxiii

## THE DISTRICT BRANCHES

The founders of the present Medical Society of the State of New York builded better than they knew when they devised the system of eight District Branches that should span the gap between the county medical societies and the State Society. But the plan has been merely partly developed, and along two lines only—1, the President of each District Branch is a Councilor of the State Society, and, 2, a scientific meeting is held annually in each District.

The by-laws require each councilor to visit each county society in his district once a year, but even that has seldom been done. The last annual reports of the councilors regarding

their districts averaged about 200 words, and two reports were missing.

Why have the District Branches functioned so meagerly? We were told by one of the very best of the recent councilors that he made a careful study of his district and a full report, and felt embarrassed because his report was peculiar in that it was the only one that indicated activity in any district.

Our medical surveys of counties convince us that the officers of the District Branches are ready, and eager, to work—it only remains to suggest a unified scheme of practical activities for them to follow. Our editorial duties have required us to listen in at conference meetings and private conversations, and we



he would have had not only the humiliation of an adverse verdict, but the necessity of responding in money damages

The State Medical Society having all of these things in mind and actuated by a desire to assist, encourage and protect the members of the Society in the practice of their most difficult and hazardous profession, some four years ago, after long study, painstaking inquiry and thorough investigation, instituted and set up the present plan of group insurance. It is our observation that the doctors who have been sued and who have experienced the worry and concern attendant upon an action for malpractice, have had little difficulty in appreciating the value, indeed the necessity, of participating in this insurance plan. There are in the up-State counties 3,993 doctors who are eligible for the benefits of this protection, yet we find that only 2,147 of such doctors (or 53.9 per cent) have availed themselves of this opportunity to protect themselves against the legal risks attendant upon the practice of their profession.

The State Society and your counsel, consider-

ing all of these facts, have felt it an imperative duty frequently to bring these matters before you. The doctors who have failed to avail themselves of the opportunities presented by this well-considered plan of the State Society have only themselves to blame when suddenly they find themselves in the rôle of defendants in malpractice actions. By constant reiteration of any thought one runs the risk of tiring an auditor. Nevertheless our acquaintance with conditions and with the imperative necessity, from the doctor's standpoint, of protecting himself from the financial hazard of a malpractice suit, is such as to require the frequent presentation of this matter to the profession. What a doctor decides to do, after considering the facts, of course is his own business. Our wish and desire is that no doctor who has given of his time, skill and strength to an ungrateful patient, but nevertheless is sued, will be able to assign as his reason for not having availed himself of this insurance protection that the matter had not been brought to his attention.

---

### INFECTED FINGER

The plaintiff in this action had gone to the defendant physician and upon examination he found that the index finger of the left hand was infected, and showed signs of pus. Under a local anaesthesia of novocaine, four incisions were made and the pus evacuated. He then dressed the wound and put in sterile gauze drains. On the following day the patient returned and the finger was again dressed.

A day later, upon the plaintiff's return to the doctor's office, an examination disclosed that the infection had spread and necessitated further incisions in the finger. When the patient was advised of this condition she refused to permit the defendant further to operate upon or treat her, stating that she was going to a hospital.

Nothing further was heard by the physician from this patient until the institution of a malpractice action against him, charging

him generally with negligence and carelessness in his treatment and operation upon the plaintiff, the plaintiff claiming that by reason of such negligence she sustained permanent injuries to her finger and hand.

About five weeks after the treatment by the defendant a physical examination was had of the plaintiff's finger and at that time it was found that the infection had not entirely cleared, and that a pus pocket was still present at about the end of the first phalanx. It was also found that the finger was stiff, with ankylosis of the phalangeal joints, due to the swelling and to arthritis.

The plaintiff's attorney failing to prosecute this action, a motion was made to dismiss the same for lack of prosecution, which motion was granted, and the action terminated in favor of the defendant.



# LEGAL



By GEORGE W. WHITESIDE, Esq.  
Counsel, Medical Society of the State of New York

## MALPRACTICE SUITS—PROTECTION THEREFROM

In our editorial of April 24, 1925, we discussed the medical hazards attendant upon the practice of medicine in the metropolitan district. We shall now consider the same question in connection with the other counties or "up-State."

We there pointed out that the vast hordes of foreigners, many of them newly arrived and unfamiliar with American standards of fair play and good faith, constitute a large proportion of the litigants against members of the medical profession on charges of malpractice.

This menace to the doctor's good name is less threatening in the up-State counties containing, as they do, a far more American population and consequently imbued with American standards of ethics, and therefore less prone to the making of reckless accusations. The past decade has brought an infiltration of foreigners into our up-State cities and rural districts, many of southern European birth, which is unprecedented in our history.

Irrespective of the character of the population, the practice of medicine in up-State cities and rural districts presents distinct and serious legal hazards.

The desirability of hospital care and treatment in large classes of cases, if not in all, and the superiority of this method to such treatment as can be afforded in the ordinary home environment, is now thoroughly recognized. While it is true that in many sections doctors, with a commendable zeal for the welfare of the public health, have joined together and erected private hospitals, many of them containing the highest type of equipment and service, there nevertheless remain in various parts of the State large rural districts remote from hospital facilities. In every type of human disease or malady the likelihood of full and complete recovery is strongly dependent upon the systemic condition of the patient. The condition is dependent upon a number of factors, among which are care, food, nursing and a clean sanitary environment. On isolated farms and in small rural centers there still is found a notable lack of sanitary improvements and surroundings which complicate and increase the burden of the conscientious doctor seeking in the particular case to bring about a good result.

We have observed cases of general septicæmia—attributable wholly or in part to unsanitary surroundings, care and treatment by unskilled

assistants—where the doctor has been most unjustly blamed, where wholly unfounded and unjust charges and accusations of malpractice have been leveled against him for results in no wise caused or contributed to by his lack of care, skill or conscientious devotion to his duties. Obstetrics, perhaps, more than any other branch, has offered a fertile field for litigation due to these causes.

Both the profession and the laity today recognize the diagnostic value of X-rays in fracture cases. Yet where a fracture has occurred in some rural or isolated district many miles from a hospital or other place possessing X-ray equipment, it may not be feasible or even desirable to remove a patient before the fracture is reduced. It may well be that the value of an X-ray in such a case is counterbalanced by the disadvantage to the patient's system and condition which would be occasioned by a long and painful ride to some point where an X-ray picture might be taken. It is the doctor's duty in all cases to "use his best judgment in exercising his skill and applying his knowledge" and to do "what he thinks is best after careful examination." That is his legal duty. It may well be that in using his best judgment and doing what he thinks is best after such careful examination, he is forced to counterbalance the relative importance to a patient of an X-ray diagnosis as compared with the physical disadvantage of a long and painful journey to a point where an X-ray can be made. We have in mind a recent case in an up-State county where this exact situation occurred. The doctor was confronted with this precise problem and in view of the age and physical condition of the patient he decided that desirable as an X-ray would have been, the attendant risk of a journey to the place where it could be taken, many miles from the accident, more than offset the value of an X-ray. The patient instituted a malpractice action against the doctor, charging him with negligence in not having had an X-ray taken of the fracture. We thought that under the circumstances he was right and fortunately he was exonerated by the court. He had, however, hanging over him like a pall for many months the danger, annoyance, anxiety and worry, as well as the injury done to his reputation by the institution of the suit. This particular doctor was not insured. Had he not been successful in vindicating his course in court,

# Medical Society of the State of New York

## MEETING OF THE COUNCIL

A meeting of the Council of the Medical Society of the State of New York was held at the Hotel Syracuse, Syracuse, N. Y., on Thursday morning, May 14th, 1925

Dr Nathan B Van Etten, President, in the chair

Regrets were received from the Secretary, Dr Dougherty, who had been obliged to return to New York the previous afternoon

A quorum being present, the meeting was called to order by the President at 9 45 A. M., and on roll call the following answered to their names

Drs Nathan B Van Etten, William H Ross, Frederick H Flaherty, E Eliot Harris, George M Fisher, Owen E Jones, Andrew MacFarlane, William Warren Britt, John A Card, Joseph S Thomas, Nelson O Brooks, George H Fox, William I Dean

Dr James N Vander Veer and Dr Joseph S Lawrence were also present

On motion duly made and seconded, the reading of the minutes of the last meeting was dispensed with

The following recommendations from the President were upon motion duly made and seconded, approved

That the minutes of the previous meeting be read and after they have been approved, signed by the Secretary

That following the reading of the minutes, action be taken on the business of the preceding meeting before any new business is considered

That all discussions be limited to three minutes

That after the minutes of the Executive Committee have been approved, a typewritten copy

be sent to every member of the Council, with a request that he sign and return to the Secretary

On motion, duly made and seconded, the following recommendations were approved

That a vote of thanks and appreciation be sent by the Council to Dr Flaherty for the remarkable work he had done as Chairman of the Committee on Arrangements

That the Council send a letter of appreciation and thanks to the City of Syracuse for its hospitality

That the Council extend its sincere thanks and appreciation to the Women's Committee for the delightful entertainments which they had provided for the visiting ladies

That Dr Vander Veer be requested to reconsider his decision declining reappointment as Chairman of the Committee on Legislation and that he be given until the next meeting to decide

That Dr Vander Veer be appointed Chairman of the Committee on Legislation until the next meeting of the Council

That Legislative bills of interest to the profession be sent to the President and Counsel of the Society and that they be appointed a committee to give an opinion on them and return to the Chairman of the Committee on Legislation, who would act as the ultimate judge

On nomination of the President, Drs E Eliot Harris, John A Card, Frederick H Flaherty, William H Ross, and George M Fisher were elected members of the Executive Committee for the ensuing year

There being no further business, the Council adjourned

## MEETING OF THE COUNCIL

A meeting of the Council was held at the State Society Rooms, 17 West 43rd Street, New York City, on Wednesday, June 3rd, 1925

Dr Nathan B Van Etten, President, in the Chair, Dr Daniel S Dougherty, Secretary

A quorum being present, the meeting was called to order by the President at 3 P. M., and on roll call the following answered to their names

Drs Nathan B Van Etten, William H Ross, Frederick H Flaherty, E Eliot Harris, George M Fisher, Daniel S Dougherty, Charles A Gordon, Andrew MacFarlane, William Warren

Britt, John A Card, Joseph S Thomas, Charles P McCabe, Owen E Jones

The minutes of the last meeting were read by the Secretary and on motion adopted

The Secretary read a letter from Dr James N Vander Veer stating that, much as he regretted doing so, he felt it necessary for him to decline the position of Chairman of the Committee on Legislation for the coming year

On motion, Dr Vander Veer's resignation was accepted and the Secretary instructed to express to him the Council's appreciation of his devotion and untiring work in the interests of the State



# State Department of Health



## VALUE OF MEDICAL PROPHYLAXIS IN PREVENTING VENEREAL DISEASES

From time to time the subject of medical prophylaxis, its value and its place in venereal disease control, comes up for discussion. The State Departments of Health, with possibly one exception, have not officially applied this factor in their control measures.

The annual report of the Surgeon General of the Navy for 1924 contains some interesting information upon this subject. It is estimated that careful disinfection early applied will prevent over 50 per cent of infections that would occur without chemical prophylaxis. The rate of infection is materially reduced by the use of medical disinfection, the value depending largely upon the lapse of time between exposure and treatment. It has been concluded that

22 cases of disease per 100 exposures occur when treatment is applied within one hour,

31 cases of disease per 100 exposures occur when treatment is applied within two hours,

43 cases of disease per 100 exposures occur when treatment is applied within three hours.

Colonel Ashburn estimates (Military Surgeon, 1920) from an extensive survey in the Army, one infection in thirty without prophylaxis, and but one infection in ninety with prophylaxis.

Colonel George Walker, from observations in the American Expeditionary Forces of 240,000 prophylactic treatments, states that 13 per cent were followed by infection or one infection to seventy-seven contacts.

The report of the Surgeon General of the Army for 1920 states that "it may safely be said that venereal prophylaxis is not so efficient as to justify any man in assuming any risk of infection and counting upon its use to compensate for his lack of control, but is sufficiently effective to warrant its employment in the most thorough manner as a very important part of any campaign directed against venereal diseases."

## ACCURACY NECESSARY IN BIRTH CERTIFICATES

From time to time some of our friends among practising physicians do not see the point in our insistence on definite categorical statements in birth and death certificates, whenever the facts are known.

The following letter from an attorney in a city of Western New York will illustrate the importance of accurate records.

"I herewith return questionnaire relating to the birth of a child born January 27, 1890, to

"If the child born to

was

born alive, the father is entitled to the life use of the real estate owned by his wife at the time of her decease. If the child was born dead, Mrs.

's brothers and sisters, nephews and nieces are entitled to immediate possession and use of the property."

Our records show that the child "died at birth."

Here is one instance where a legal decision depended upon the exactness of a statement in a birth certificate.

## TRICHINOSIS FREQUENCY

The experience of the Boston Health Department indicates that trichinosis may be a more common condition and may be more often confused with typhoid fever than is generally realized. (*Monthly Bulletin, Health Dept., March, 1925*) For the last two years, the Department has, for epidemiological reasons, made extraordinary efforts to trace the source of infection in cases reported by physicians as typhoid fever. While these investigations have been undertaken usually for the purpose just stated and without any intention of confirming or disproving the correctness of a diagnosis of typhoid fever reported by a physician, they have neverthe-

less disclosed the existence of nearly twenty hitherto unrecognized cases of active trichinosis. Moreover, these cases have been disclosed because of suspicions aroused by the objective symptoms, by puffiness of eyelids or cheeks or an injected conjunctiva, presented by patients whom medical inspectors have seen in connection with their visits to trace sources of typhoid infection. Recognition of trichinosis in such supposed typhoid cases has led to the discovery of other persons likewise suffering from trichinosis, some of whom had not gone to a physician for relief.—*The Nation's Health, May, 1925*

FRAUDULENT SUBSCRIPTION

MEDICAL SOCIETY, KINGS COUNTY

When renewing my subscription to the STATE JOURNAL, I was told that \$3.50 would be deducted from my county medical society's dues. No mention was made on my statement. Will you please look into the matter and let me know.

Yours sincerely,

C. E. KRETZ

RECEIPT

Renewal for 1925, No 1047

11/24/1924

Received from Dr C E Kretz, 293 State Street, three and 50/100 dollars for NEW YORK STATE JOURNAL OF MEDICINE. Paid in advance.

L. F. WHITTAKER,

*Rep International Sales Co*

Referred to Legal Counsel

Invitation from the Medical Society of the County of Niagara to hold the next annual meeting of the Medical Society of the State of New York at Niagara Falls

Referred to the President for reply

Communication registering a complaint against a physician in Buffalo

Referred to Medical Society of the County of Erie.

The recommendations of the House of Delegates to the Council were read by the Secretary and on motions duly made and seconded, disposed of as follows

That an appropriate expression of appreciation be forwarded by the Secretary of the Society to Governor Alfred E. Smith and to other members of the Legislature mentioned in the report of the Committee on Legislation

Referred to the Secretary and the President

That the Executive Editor be directed to go to Albany during the Legislative session and spend one or more days in Albany each week at the expense of the Society

Referred to Executive Committee

That a special committee be appointed with power to put into immediate effect a plan of graduate medical extension instruction which will meet the greatest need today this committee to co-ordinate the existing medical schools and hospital staffs according to their geographical zone to the end that in and around each may be created a center for post graduate medical education, with which adjacent county societies shall co-operate in every way possible

Referred to Executive Committee to appoint at the next meeting

*Whereas*, there exists in the State of New York today, a situation which menaces the public health and threatens to undermine public confidence in the legitimate practice of medicine, and

*Whereas*, there are a large number of individuals and establishments actively opposing the best interests of the ill, the defective, and the growing youth, through illegal, deceptive and fraudulent practices, and

*Whereas*, many of these individuals and establishments appear to be operating under a system of charlatanism whose chief function is to obtain money from the unlettered, the uninformed, the alien and the ignorant through such frauds, and

*Whereas*, these conditions exist not only in every large city but in many of the small towns and villages throughout the State, thereby making this problem an issue of the State Society,

*Therefore, Be it Resolved*, that the Council properly investigate and take such measures as will correct these deplorable conditions

Referred to Executive Committee with power

That the Committee on Legislation be authorized to secure the co-operation of various groups of physicians who are not affiliated with the Medical Society of the State of New York officially

Referred to Executive Committee with power

That the Journal be sent during the Legislative Session to all legislators, newspapers published in the State, officers and members of the Executive Committees of the allied professions, State or District Societies of nurses, dentists, school medical inspectors, health officers' associations, and the like, and to a selected group of lay societies

Referred to the Executive Committee with power to investigate and refer to Council for referendum vote

That conferences be held in the Council as to certain other selected medical and educative publications which should be sent to these groups

Referred to Executive Committee with power

That legislation which has come up in the past session in reference to the State Institute for the Study of Malignant Disease at Buffalo, and the State Hospital for Crippled and Deformed Children at West Haverstraw, be referred to the Council for study and suggestions as to action for your next Committee on Legislation

Referred to Executive Committee

That the New York State Journal of Medicine be published weekly or semi-monthly throughout the year

Referred to the Executive Committee

That the services of the Executive Officer be wholly under the direction of the Committee on Legislation from the first day of December until one month after the closing of the Legislative Session

Referred to the Executive Committee

That the Committee which was appointed to study the Workmen's Compensation Law be continued, or a similar committee be appointed, and that they be directed to place in the hands of

Society, and the deep regret felt that he would be unable to continue as Chairman of the Committee on Legislation

On motion, the appointment of a Chairman of the Committee on Legislation was referred to the Executive Committee

The Secretary presented the following recommendations from the Executive Committee to the Council, which were on motions duly made, and seconded, adopted

That the report of the Budget Committee, including the tentative budget, be approved

That all appropriations for money, not included in current expenses of the Society, be made in detail to the Executive Committee for action before any indebtedness is incurred

That under Section 30 of the By-Laws the Executive Committee shall transact all the business of the Council, in the interval of the meetings of the Council

That the Executive Officer's report be accepted, the portion pertaining to medical education be referred to the Committee on Public Health and Medical Education, and the portion pertaining to scientific work be referred to the Committee on Scientific Work

That the Executive Officer's expense account for May be approved

The following amendments to the by-laws of the Bronx County Medical Society were presented for approval and on motion referred to the Executive Committee

Section 7—OFFICERS Add after Treasurer "and three Censors to represent every one hundred members, in good standing, of our Society. Censors shall be elected each year to serve for a term of two years. No Censor shall succeed himself in office. The Censors shall assume office on the first day of January following their election"

Omit Section 8.

Add to Section 14 "There shall be an Advisory Council composed of the retired Presidents of the Society whose function shall be to meet with the Comitia Minora in an advisory capacity, but shall have no voting power"

Add to Section 16 "Two meetings of the year shall be devoted to the consideration of the welfare of the members of the Society"

Section 11 Add to the list of standing committees "A Program Committee which shall be composed of three members elected by the Society at the annual election. The duty of this Committee shall be to co-operate with the President of the Society in arranging the program for the stated meetings."

Section 55 Omit the words, "and a ballot containing all nominations shall be sent to each member with the notice for the annual meeting"

Add "Additional nominations may be made at the annual meeting before the opening of the polls. Ballots should be printed having only the offices printed, but no names of candidates shall be printed"

Moved and seconded that the bill presented by Dr Lytle as a member of the special com-

mittee on the Nurse Problem be paid in accordance with the by-laws Carried

Moved and seconded that the expenses of the program guests at the recent annual meeting of the State Society be paid, but that it be done with the understanding that it was not establishing a precedent for payment in the future. Carried

Moved and seconded that the Council confer upon Miss Baldwin the title of Business Manager, and that the honorarium of \$500 recommended by the House of Delegates, be given her Carried

Moved and seconded that Mrs Delehanty be appointed Secretary of the Legislative Bureau at a salary of \$2,400 a year Carried

Moved and seconded that Dr Britt be empowered to draw up a plan of a meeting of the Chairmen of the Committees on Medical Economics of the County Societies to be held in the fall and report to the Executive Committee. Carried

On motion, Dr MacFarlane and Dr Lawrence were appointed a committee to redistrict the State with a special appropriation for maps, charts, etc

On motion, the Speaker and the Secretary were appointed a committee to draw up suitable resolutions on the death of Dr A Walter Suiter, ex-President of the Medical Society of the State of New York, and for many years Secretary of the Medical Society of the County of Herkimer

On motion, the report of the Committee on Medical Economics of last year was referred to the Committee on Medical Economics to report back to the Executive Committee

On motion, Dr E R Cuniffe was appointed Chairman of the Committee on Arrangements for the ensuing year

It was moved, seconded and carried that the next annual meeting of the State Society be held in New York City

On recommendation of the Committee on Publication, Dr Frank Overton was re-appointed Executive Editor at the same salary as last year

The following letters were read by the Secretary

ÆTNA LIFE INSURANCE COMPANY

May 2, 1925

DEAR MR. WHITESIDE

We are very anxious to reprint in pamphlet or mimeograph form your very excellent article which appeared in the April 3rd issue of the NEW YORK STATE JOURNAL OF MEDICINE, pages 577-578.

At your earliest convenience will you please let me know where you have any objection to our reprinting this article, giving you the proper credit of course.

Yours very truly,

STANLEY F WITHE, Assistant Director,  
Department of Publicity

Request granted with Mr Whiteside's consent



# MEDICAL SURVEY



## MEDICAL SURVEY, NUMBER 12—STEBEN COUNTY

**Editor's Note**—The information on which this Survey is based was given principally by Dr B R Wakeman, Secretary of the Medical Society of the County of Steuben, and Dr W W Bachman, President, and by Dr John A Conway, District State Health Officer

The Executive Editor also had the pleasure of attending a meeting of the Steuben County Medical Society, which is reported on page 848 of this issue

**S**TEUBEN County is the fourth on the lower tier of counties beginning at the west end of New York State. It has an area of 1398 square miles, and is approximately square in form. It consists principally of rolling farm land, which is used largely for dairying.

The common routes of travel are determined principally by the topography of the county. A broad, hilly tableland extends down the center of the county from the northwest to the southeast, and is bounded by two broad river valleys—the Canisteo on the west and the Cohocton on the east. Two main lines of railroad lie in the valleys—the D L & W and the Rochester division of the Erie in the east, and the main line of the Erie in the west. The principal centers of population and trade are on those railroads. The city of Corning is in the southeast corner of the county, and the village of Bath, which is the county seat, is on the same railroad in the north central part of the county. The city of Hornell is situated in the west valley, about halfway between the north and the south boundaries of the county.

Travel is easy up and down each of the two valleys, but it is difficult across the hilly country which separates them. Although good automobile roads connect the two valleys, they are often impassable during the snow season, and travel is then by long circuitous railway journeys.

The result of its topography is that the physicians of Steuben County naturally divide themselves into three groups—one centering in Corning, one in Hornell, and one in Bath. This same triple division is felt politically, for the county maintains three court houses—one in each center—in order that they shall be easily reached by witnesses and lawyers.

**Population** The population of Steuben County is 80,627, according to the U S Census of 1920, and it has been nearly stationary for over forty years. There has been about ten per cent decrease of the rural population of the county during the last forty years, and

a corresponding increase in that of the cities of Hornell and Corning. About one-fifth of the people now live in each of the two cities of Corning and Hornell, one-fifth in the incorporated villages of the county, and two-fifths in strictly rural communities.

There are thirteen incorporated villages, the largest of which, Bath, contains nearly 5,000 inhabitants, and the smallest, 300 or less.

The impression that one gets of both the cities and the rural sections is that the population is stable and well-to-do, and that Steuben County is an excellent county in which to live.

**Physicians** There are 92 physicians in Steuben County, located in 14 centers, according to the Directory of the Medical Society of the State of New York, but a careful check, made by the Secretary of the County Society, shows that 86 are in active practice. This gives one physician to every 925 persons in the county.

The physicians in Hornell, Corning, and Bath number 54, which gives a ratio of one physician to every 675 people. The physicians outside these three centers number 33, or one physician to every 1300 people. The ratio of physicians to population is not much different from that in Queens, Nassau and Suffolk counties, in each of which the ratio is about one to every 1100 persons.

There is a strong tendency of the physicians of Steuben county, as elsewhere, to congregate in the cities and larger villages. As the older physicians in the smaller places drop out of practice, no younger doctors come to take their places. Yet good automobile roads enable the physicians to give good service in every part of the county, except in the four townships in the southwest corner. There is a section ten miles in radius around Greenwood in which no physician is located, although it formerly supported two. The people in this section number about 3,000, and are mostly well-to-do dairymen, and can well support a doctor who is willing to drive considerable distances in order to reach his patients. He would also be within reach of the hospitals in Hornell.

The health authorities of Steuben County are advocating the plan that the county shall maintain an ambulance in order that the people of the rural sections may have the means of reaching a hospital during the winter season when the roads are impassable for ordinary automobiles.

the Counsel their recommendations for amendments to the Workmen's Compensation Law in relation to the medical features thereof by September 1st, 1925, in order that the Counsel may draft the proper bills for introduction, and submit them to the Council by the 1st of December, 1925, should the Council pass favorably upon their recommendation

Referred to the Executive Committee in cooperation with Dr Britt, Chairman of the Committee on Medical Economics

That the Council be authorized to request the American Medical Association to co-operate with the Medical Society of the State of New York to the end that all available material for graduate medical instruction—including teachers, charts, lantern slides, moving pictures, etc, be made available to the appropriate committee of the Medical Society of the State of New York for carrying out this plan and that the Council be authorized to appropriate as much money as they may deem expedient for the work of graduate medical instruction

Referred to Committee on Public Health and Medical Education to report back to the Executive Committee

That there be established a broad dissemination of education on public health questions through the public press by means of some one of the adjunct committees of the State Society

Referred to Committee on Public Health and Medical Education

That a Section on Dermatology and Syphilology be established

Referred to Committee on Scientific Work for further investigation and report

That some means be devised whereby articles on medical topics may be syndicated to newspapers through the editorial office of the Journal, or a press bureau to be established within one of the standing committees of the Society, from whence can be sent to newspapers, lay organizations, churches, schools and the like, authentic and interesting articles concerning the public health and the duty of the individual in relation to the health of his neighbor. Also it might be of advantage were some journalist engaged upon half or full time to help the committee upon whom such work would fall

Referred to Committee on Publication

That the Council institute legal proceedings

to prohibit such unauthorized use of the title "Doctor" by those conducting an occupation involving or pertaining to the public health

Referred to Legal Counsel for opinion

That a committee of five be appointed by the President annually, with the approval and advice of the Council, including himself and the Chairman of the Committee on Legislation, in order that a body be created which can speak with authority on allied matters of public health from all angles pertaining to the people of the State.

Held over under advisement at the present time

On motion, the recommendation that the Tuberculosis Film which was shown at the annual meeting of the State Society be reproduced at the meetings of the District Branches and County Societies, was referred to Committee on Public Health and Medical Education

The Council duly approved of the following appointments by the President

Dr Samuel J Kopetzky as a member of the Committee on Scientific Work

Dr John E Jennings, Chairman of a Special Committee of Seven with power to draft a Medical Practice Act which shall be the official bill of this Society, and be published in the September issue of the State Journal

Dr Arthur W Booth, Chairman of a special committee to work in conjunction with the committee on Medical Economics to study the problems of the nurse and report back to the Council, other members of the committee to be appointed later

Dr Britt, Chairman of the Committee on Medical Economics, nominated the following as members of his committee for the coming year

Dr C C Boswell, Rochester

Dr Henry Burton Doust, Syracuse

\*Dr L Whittington Gorham, Albany

Dr Arthur S Chittenden, Binghamton

On motion, they were declared elected

Dr Gordon, Chairman of the Committee on Public Health and Medical Education, requested that he be given more time for the nomination of his committee

On motion, Dr Gordon's request was granted

DANIEL S DOUGHERTY, *Secretary*

\* Unable to serve, Nelson K. Fromm, Albany appointed in his place



ments, but will receive most kinds of chronic diseases, except those of a contagious nature

The Corning Hospital is open to all the physicians of Corning and its immediate vicinity. It has just completed a compliance with all the conditions of the American College of Surgeons, and will be listed among those approved

*Public Health Work* The official public health work of Steuben County is done by 31 health officers whose districts comprise 2 cities, 7 incorporated villages, 26 townships, and 5 consolidated districts. There is an average population of 1,600 served by each health officer outside of the two cities.

The public health nurses employed in Steuben County are as follows

County Tuberculosis	1
Hornell School	1
Hornell Health Center	2
Corning School	1
Corning City Public Health	2
Corning Red Cross	1
Corning Industrial	1
Total	9

The city of Hornell maintains a Health Center in one of the municipal buildings. The Center is the headquarters of the Health Officer, and the center for his ordinary work. In addition, the Center is the headquarters for the following activities

1 A tuberculosis clinic once a month conducted by the Superintendent of the County Tuberculosis Hospital

2 A mental clinic monthly by the Staff of the Willard State Hospital

3 A monthly clinic in mental deficiency conducted by the State Commission for Mental Defectives

4 A venereal disease clinic conducted every Monday afternoon by the city

5 A Child Welfare clinic twice a month conducted by the city

6 A breast-feeding demonstration every month under the auspices of the nurses and committee of members of the Hornell Medical and Surgical Association. This activity is popular with all classes of people, and all mothers are proud to show their babies at the monthly inspections. Over 300 babies are on the list of the clinic

The City of Corning maintains a health center whose activities are almost like those of Hornell in scope and extent, but in addition the city conducts a weekly clinic for tonsil operations

The insane cases of Steuben County are in the District of the Willard State Hospital at Willard. This is seventy-five miles distant, and the physicians and health officers have difficulty in controlling the violent cases until they can be removed to the hospital. The Health Center of Hornell has a room prepared to receive those cases

The tuberculosis work of Steuben County centers in the County Sanatorium at Bath, of which Dr Isaac Brewer is Superintendent. It is called the Pleasant Valley Sanatorium, and has a capacity for 30 patients. Dr Brewer holds monthly clinics at Corning and Hornell, and clinics in other places as occasion requires. A field nurse is employed by the County

There is a tuberculosis committee in Hornell, and one in Corning, and another functions for the rest of the county. The committees are supported by the sale of Christmas Seals. One activity of each committee is to support a summer camp for undernourished children. Each of the three camps has a capacity for about 20 children. The general county committee also supports an executive secretary, and does publicity work through the local newspapers

*Laboratories* The county of Steuben has maintained a public health laboratory in Corning for some years, and the Board of Supervisors has recently voted to establish branches in Hornell and Bath. Each laboratory will be located in a municipal building owned by the county

*Impressions* We were favorably impressed with the physicians of Steuben County, and with their organizations. They are entirely loyal to the State Medical Society, and practically every member has paid his 1925 dues. We heard few criticisms, and the principal question was "What can we do to raise the standard of the practice of medicine?" The physicians of Steuben County take a deep interest in the newer lines of activity such as graduate education, and approve the progressive plans of the Medical Society of the State of New York

**Medical Societies** The Medical Society of Steuben County has 70 members, or 81 per cent of the practising physicians of the county. The Society is active and holds the interest of its members. It holds two meetings each year, which are attended by an average of about 30 physicians. The programs are principally scientific, and speakers are often secured from the Rochester and other large medical centers.

The County Society has recently held joint meetings with the societies of Allegany, Livingston, and other neighboring counties. It held a two-day meeting at the Willard State Hospital, at which an extensive clinical program was presented.

The difficulties of travel between the two main sections of Steuben County have led the physicians to form two local medical societies which are active in a social, scientific, and civic way. The Hornell Medical and Surgical Association was organized in 1878, and is composed of the physicians of Hornell and vicinity, and some from Allegany County. It has about 25 members, and meets on the first Monday evening of each month, and concludes each session with a supper. This Society instituted a breast-feeding campaign in the city of Hornell in the Fall of 1924, and a committee has supervised the regular visitation of every baby which has been born in Hornell during the past Winter and Spring. The activity has been originated and conducted by the physicians, with some nursing assistance from the State Department of Health. A report of this activity is found on page 831 of this issue.

The local Society has also promoted the establishment of a county laboratory.

The Corning Medical Society was similar to that in Hornell, but about a year ago it changed its name to that of the Medical and Surgical Staff of the Corning Hospital. It has about 25 members and holds its meetings on the third Wednesday evening of each month. The meetings are the staff meetings of the hospital and doctors.

The Keuka Lake Medical Association is a loose organization which originated about fifteen years ago among the physicians of Steuben and the surrounding counties. It holds a two-day meeting annually at some resort on Keuka Lake, and the date is the Thursday and Friday nearest the full moon of July. The membership consists of those physicians who attended the meeting, each of whom pays two dollars in order to pay the postage, printing, and other expenses of the meeting. The physicians bring their wives and enjoy a two-day outing, and at the same time they carry out an excellent scientific program. The average attendance at the meetings of the Association is

between two hundred and three hundred physicians. The interest shown in the Association suggests the thought that there is a great field for activity lying open to the Sixth District Branch of the Medical Society of the State of New York.

**Hospitals** Six hospitals are located in Steuben County as follows:

Name	Location	Number of beds
St James Mercy	Hornell	75
Bethesda	Hornell	50
Corning City	Corning	110
Bath Hospital	Bath	40
Steuben Sanitarium	Hornell	70
County T B (Pleasant Valley Sanitarium)	Bath	30
Total, beds		375

The total number of hospital beds available to the 80,000 people of Steuben County is 375, or 4.7 beds for each one thousand of population. This is a rather high ratio compared with that of other counties which we have surveyed.

The hospitals of Steuben County are exceptionally well equipped and managed. The St James Mercy Hospital is one of the oldest in the County. It was started in 1890 by Father James Early, pastor of the St. Ann's Catholic Church of Hornell, as the result of the death of a young man who ran out of a boarding house while he was delirious with a fever. It is managed by a board whose ex-officio members are the mayor of Hornell, the pastor of St. Ann's Church, and the Mother Superior in charge of the Hospital. It is supported in part by city funds, and is non-sectarian.

It maintains a nurses' training school with 18 pupil nurses. It has an excellent X-Ray equipment, and a laboratory in charge of a technician. It has a staff of 16 physicians, who hold staff meetings on the second Monday evening of every month. Each meeting ends with a supper given by the Hospital, and the attendance is practically one hundred per cent.

The Bethesda Hospital is located just outside the north limits of the city of Hornell. It is open to practically every physician of Hornell and vicinity who hold monthly staff meetings. The hospital has a laboratory and an X-Ray equipment, and conducts a training school for nurses.

The Steuben Sanitarium is a private institution for the treatment of chronic conditions, especially those of the heart and kidneys. It is equipped to give hydrotherapeutic treat-

The object of the treatment is to keep up the normal peristalsis of the stomach and intestine without spasm, and also to give so much food that the patient gains weight. In an ulcer patient when the stomach is empty, the normal hunger contractions become painful and cause spasm. Food produces normal regular contractions and relieves spasm. The ulcer makes the stomach irritable, and increases the peristalsis. The doctor aims to control the peristalsis by food which soothes the tender ulcer and excites slow, normal waves of peristalsis.

A standard diet for ulcer cases has a basis of milk. To this are added cereals, puddings, ice cream, bread, toast, baked or mashed potatoes, eggs (soft boiled), and cream cheese. Such foods as these are both soothing and nourishing. Coarse vegetables are omitted for the first six weeks because they tend to irritate the stomach and cause excessive peristalsis. After six weeks, vegetables and fruit are added to the three principal meals, but the frequent feeding schedule is kept up for from four to six months. Olive oil, one tablespoonful before meals, is soothing and nutritious.

As for medication, none is needed, but for the mental effect we may give bismuth in ten grain doses suspended in one dram of mineral oil before meals.

Alkalies do more harm than good, for while they reduce the acidity of the stomach temporarily, they increase it after half an hour.

The relief of symptoms is effected by dieting, a cure can be effected only by the removal of the foci of infection. This can seldom be secured at once, but patients usually have to experience several attacks before they will consent to the removal of their infected teeth, tonsils, or other infective foci.

Answers to questions

(1) Carcinoma seldom follows ulcers (estimated at 4%), but a cancer may begin as an

ulcer which was carcinoma from the outset—the so-called *ulcus carcinomatosum*.

(2) Acid regurgitation of food is usually accompanied by heartburn and is due to reverse peristalsis secondary to some reflex irritation.

(3) Epigastric pain is of two types, (a), that immediately after eating, and (b), that coming on an hour or two after eating.

A pain that comes on immediately after eating is of a reflex or nervous type, and is due to something outside of the stomach, such as an appendix, gall bladder, kidney stone, gynecological conditions, or any other condition of inflammation and irritation in the abdomen.

A pain and regurgitation that comes on an hour or two after eating is that which points to an ulcer, or to a very severe chronic inflammation of the stomach or duodenum—chronic *gastro-duodenitis*.

(4) The newer conception of inflammation of the stomach and intestine is that when one part is effected, all parts are affected. Symptoms are more apt to occur where there is a narrowed part of the gastro-intestinal tube as, for example, the pylorus, or ileocecal region, or in an organ with a small lumen, like the bile duct or appendix, but the inflammation is a general one.

(5) Too little food may cause pain in the gall bladder. Food is the natural stimulant to the flow of bile. When patients stop eating, the bile ceases to flow and is stored in the gall bladder, and there its liquid parts are absorbed, and it becomes thick and deposits cholestrin tending to form tones. Feed these cases, and the bile will flow and become thinner, the cholestrin will dissolve and symptoms will abate.

The modern method of teaching about these gastro-intestinal infections is to group them all together, emphasizing the importance of eradication of all focal infections as a curative measure and frequent feedings as a palliative one.

F O

## COLUMBIA COUNTY MEDICAL SOCIETY

Dr C R. Skinner of Hudson, Secretary of the Columbia County Medical Society, has sent us the minutes of a special meeting of his Society which contains an idea worthy of imitation by other societies. The County Society held a joint meeting with the staff of the Hudson City Hospital at 9 P M on May 19th, which was attended by 16 doctors, or 42 per cent of the members of the County Society.

We note that the plan of joint meetings with hospital staffs has been adopted in some of the counties in Michigan, and that the Lycoming County Medical Society of Pennsylvania has assumed definite obligations toward the Williamsport City Hospital. Columbia County is to be congratulated on the direct connection between

the Hudson City Hospital and the County Medical Society.

It was voted that the Society accept the invitation of the Hospital Staff that the two organizations meet jointly the 3d Tuesday of each month.

Dr J P Rupee, of the Philmont Sanatorium, described the method of collapsing the lung of the tuberculous patients by the production of artificial pneumothorax. He showed X-rays illustrating the good results of the operation when adhesions did not prevent the collapse of the lung.

Dr Skinner, Health Officer of Hudson, described his work with toxin-antitoxin among children of the school and pre-school age.

Dr Mambert, of Hudson, presented a case of hemiplegia complicated with diabetes and high blood pressure.

F O



# NEWS NOTES



## CLINICAL PROGRAMS OF THE ORANGE COUNTY MEDICAL SOCIETY

The Orange County Medical Society, which has held four meetings annually, has adopted the plan of conducting a clinical meeting each month, and rotating its place among the larger centers of population. A clinic will be held on the third Tuesday of each month at four o'clock. The Medical Society of the State of New York is assisting in arranging for the clinics as a part of the medical educational plan of the Committee on Public Health and Education, of which Dr Charles A. Gordon, of Brooklyn, is Chairman.

The first clinic of the series was held in the City Hall in Middletown on May 19th, and was conducted by Dr Blake F. Donaldson, Clinical Instructor in Medicine in the Post Graduate Medical School of New York City, on the subject of "The Heart." He based his remarks on six heart cases which had been brought by the physicians of Middletown. Over thirty doctors were present, and unanimously agreed that the clinic gave them a clear insight into the modern conception of pathological hearts.

The second clinic of the series was held in St. Luke's Hospital, Newburgh, on June 16th, by Dr A. F. R. Anderson, Clinical Professor in Gastro-Enterology at the Long Island College Hospital, Brooklyn. Dr. Andresen used as his subject a case of duodenal ulcer brought by Dr E. C. Waterbury, of Newburgh, and talked in a simple, clear way of the causes, recognition, and treatment of gastro-duodenal ulcers. We are printing the following abstract of the lecture, both for its intrinsic value, and as a model for a clinical lecture before a county medical society.

The case, a married woman, age 26, with 3 children, began to have abdominal pains about 18 months ago. The pain was under her heart, came on from half an hour to an hour after eating, and continued until she took food again. She had much gas on her stomach, her tongue was coated, and she was constipated. Her blood pressure was considerably below normal, and her urine contained much indican. She was weak and underweight and unable to care for her family.

The X-ray showed the stomach reaching into the pelvis. A diagnosis of gastroposis was made about two months ago, and a supporting belt gave her relief for a time, but the symptoms soon recurred. She has been in the hospital for about three weeks, and is gaining in weight and feeling better.

The patient is emaciated from lack of food. A complete physical examination of such a patient is important. This case has large, cryptic

tonsils from which much pus can be pressed. This condition has a bearing on her sickness.

The abdomen is flabby and wrinkled from child-bearing. It is somewhat distended with gas, but we cannot be sure from palpation and percussion whether the gas is in the stomach or transverse colon. There is tenderness in the mid epigastrium and in the right lower quadrant.

This patient has ptosis of the stomach—the X-ray shows it—but her pain is not that of ptosis, there being no real symptoms due to ptosis alone.

The important point in this woman's case is the pain, which comes late after eating and is relieved by food. A further point is that the pain has come in attacks covering 18 months.

These characteristics of the pain point to a diagnosis of peptic ulcer. The opinion is confirmed by the X-ray plates. Although only one film shows the duodenal cap, this one shows the characteristic defect and protrusion due to an indurated ulcer.

The cause of an ulcer of the gastro-intestinal tube is an infection, usually secondary to a focal infection. In this case the tonsils are the probable cause. But the removal of the tonsils may not cure the case, for there may be other foci or infection—for example, the teeth or the gall bladder, the sinuses, the pelvis or the urinary tract. Cases like this one nearly always get better for a time and then recur, unless every focus of infection is removed. The doctor or surgeon who treats them takes the credit of a cure, and then in a few months the patient gets another attack and goes to another doctor to be "cured" again.

Since a gastro-duodenal ulcer is due to infection, a surgical operation is not indicated, except for a complication, such as a hemorrhage long continued, or a perforation or obstruction.

The treatment of these cases, aside from the removal of focal infections, is dietetic. Medicine does no good, except to relieve the mind of a nervous case. The principal feature of feeding is that it shall be frequent—every two and a half or three hours—and also abundant and nutritious. Two things are to be avoided: 1, meat, and 2, coarse vegetables during the first six weeks. It is good psychology to tell the patients at the outset to eat no meat for six months.

Another item of explanation is to tell the patients that the diet acts like a salve to soothe the sore ulcer, and that the food itself is a salve and a medicine.

## CLINTON COUNTY MEDICAL SOCIETY

The semi-annual meeting of the Clinton County Medical Society was held at the Dannemora State Hospital, Dannemora, N Y, at 2 30 P M, May 25, 1925, with the president, Dr C M Burdick, presiding

The following members were present Robert, Webster, Briggs, Taylor, Sartwell, Everett, Holcombe, Ryan, McDowell, Schneider, Allen, Kosseff, Nichols, Spratt, Ladue, Rogers, and Schiff, also Dr Max Lauterman of Montreal, and Dr W L Munson of Granville, the invited guests of the Society

The minutes of the last meeting of the Society were read and approved, as were also the minutes of the intervening meetings of the Comitia Minora A report of the delegate to the State Medical Society was read and on motion ordered printed and copies sent to every member of the Society

Moved by Dr Sartwell, seconded by Dr Rogers, that the Medical Society express its sense of appreciation to Dr J G McKinney for his many years of service as Treasurer of the Society Carried unanimously

Drs Taylor and Everett were appointed a committee to draw up resolutions in regard to Dr G E Letourneau, recently deceased, and presented the following

"Resolved, That through the death of Dr G E Letourneau of Rouses Point, N Y, this Society has met a loss that only time can fill

"Of more than ordinary skill, his devotion to his work won the confidence of his patients, and his kind heart and sympathy won love As a member of this Society his opinion, when expressed, received the respect of those who heard him

"Resolved, That a copy of these resolutions be sent to his family as an expression of the sympathy of the Society, and that they be made a matter of record by the Secretary"

(Signed) W U TAYLOR,  
W H EVEREST

On motion these resolutions were unanimously adopted

## OTSEGO COUNTY MEDICAL SOCIETY

Semi-annual meeting of the Otsego County Medical Society was held in the Hotel Fennimore, Cooperstown, on June 9 The meeting was called to order at 4 30 p m Eighteen members were present

After routine business, the subject of Training Schools for Nurses in small hospitals was discussed at length Censure of those trying to drive the small hospital out of this work was passed

A committee on 'Certified Milk' was appointed by request

The secretary read letters from the American Society for Birth Control, from the Gorgas Memorial, and from the Physicians' Home, which were on motion laid on the table

A letter from Dr Page Thornhill referring to a course of obstetrics which might be given to the members of Franklin and Clinton County Societies was on motion referred to the Comitia Minora with authority to arrange for such a course

Dr Munson spoke in regard to pre-school clinics in various parts of the County for which he stated the Division of Maternity, Infancy and Child Hygiene of the State Department of Health, was willing to pay local physicians up to \$15 for their services as consultants at such clinics On motion this was referred to the Comitia Minora with the request that they co-operate with Health Officers throughout the County in securing such appointments for clinics should they so desire

Dr Burdick appointed Drs Rogers and Sartwell a nominating committee to present nominations for officers to be acted upon at the annual meeting They presented the following For President, Dr C R Hutchins, Vice-President, Dr George Allen, Secretary, Dr L F Schiff, Treasurer, Dr F K Ryan, Censors, Drs Ladue, Macdonald and Everett

The meeting then proceeded to the scientific part of the program

Dr Munson read a paper on "Differential Diagnosis," which was discussed by Drs Rogers, Burdick, Lauterman, McDowell, Ladue, Webster, Kosseff and Schiff

Dr Lauterman then read his paper, entitled, "Incidence of Syphilis and Tuberculosis as Seen in General Practice," discussed by Drs Munson, Schneider, Kosseff, Robert, Webster and Schiff

Dr Burdick expressed the thanks of the Society to our guests for their courtesy in coming to the meeting and delivering their addresses

On motion of Dr Ladue, a rising vote of thanks was extended to Dr Burdick for the hospitality of himself and his associates on the Hospital staff

The payment of traveling and necessary expenses of the Society Secretary in attendance at the meetings of all County secretaries was approved Dr Bissell gave a report of the State Society Meeting, also reported a case under his care of spontaneous expulsion of gall stones, some years after a gall stone operation, through the original wound

Dr R W Ford spoke on "Some Possibilities of Endocrinology," which led to considerable discussion

Dinner was served to the members and the visiting ladies after the Society adjourned

## STEUBEN COUNTY MEDICAL SOCIETY

THE Executive Editor had the pleasure of attending a regular meeting of the Medical Society of the County of Steuben on May 19th, while making the medical survey of Steuben County, which is printed on page 843 of this Journal, and his impressions were entirely favorable. The Society met in the Hotel Sherwood, at Hornell, with the President, Dr W W Bachman, of Plattsburg, presiding. The session was begun at noon with a social dinner, at which 40 members were present. This was an excellent plan, for it promoted good will and placed the members in a receptive frame of mind for the serious work of the afternoon.

We were interested in the reports of the representatives to the House of Delegates of the Medical Society of the State of New York, and in what they said about the proceedings of the meeting of the House which was held on May 11th and 12th in Syracuse. Dr H B Smith, of Corning, reported on malpractice defense and indemnity, and urged the members of the Steuben County Medical Society to take advantage of the insurance offered through the State Society.

Dr W J Tracy, of Hornell, reported on the action of the House of Delegates regarding the use of the title of doctor, the prescribing of alcohol, and the annual budget. He summed up his impression of the meeting of the House of Delegates by saying "The oratory was fine, the opposition to many measures was marked, and the conclusion of the session was happy." We appreciate Dr Tracy's excellent summary of his impressions of the session.

Dr L M Kysor, of Hornell, Chairman of the Legislative Committee, reported on the difficulty of reaching the legislators during the few weeks between their election and the opening of the session of the Legislature, and stated that one of the legislators from Steuben County had not voted as the physicians had suggested that he should. A discussion which followed showed that the physicians of Steuben County are alive to their opportunities and responsibilities in legislative matters.

Dr John A Conway, of Hornell, Chairman of the Public Health Committee, reported on the activity of the Society in regard to the promotion a breast-feeding campaign in Hornell (see this Journal, page 831), and the establishment of two branch laboratories by the Board of Supervisors.

The Secretary, Dr B R Wakeman, reported that only two members had resigned from the Society on account of the raise in the dues of the State Society. Our impression gained from talking with the members is that they will be satisfied with the dues, provided they can see tangible results from the expenditure of the funds.

There was a lengthy discussion regarding methods of increasing the interest in the meetings of the Society. There was an undercurrent of feeling that the responsibility rested mostly on the members and leaders of the local Society, but that the State Society could do much to instruct and advise the County Society. In our capacity as Executive Editor and Reporter of medical activities throughout the State, we suggested the adoption of clinical programs for the meetings of the county societies as we outlined in our editorial on page 818 of the June Journal.

Dr J S Lawrence, Executive Officer of the Medical Society of the State of New York, explained the relation of the Society of the State to that of the County, and offered the assistance of the State Society in any activity that the County Society should undertake.

The scientific program was of practical interest to all the members. Dr John J Lloyd, of Rochester, Medical Superintendent of the Monroe County Tuberculosis Sanatoriums, showed lantern slides illustrating the general subject of "Common Sense and Tuberculosis" to the accompaniment of a running comment on practical points.

Dr John A Conway, of Hornell, demonstrated the use of the Petroff Needle in obtaining blood for laboratory purposes.

Dr Howard L Prince, of Rochester, gave a practical talk on "Bad Surgical Risks."

The meeting adjourned at five o'clock, after a session which had continued from noon, counting the informal transaction of business and reports which were carried on during the dinner hour. A stranger attending the meeting would have been favorably impressed with the proceedings, but to us who had just made a medical survey of the County, the meeting was confirmatory of our impressions that the physicians of Steuben County are entirely alive to their opportunities, and are anxious to promote the practice of both personal medicine and of public health.



# THE DAILY PRESS



The House of Delegates at its meeting on May 11th, approved the plan of syndicating medical articles to the newspapers throughout New York State. We have expressed our views on this subject in this department of the JOURNAL several times, and have kept in close touch with the lay press through a clipping bureau that has an eagle eye for everything that contains the word health or medicine, or anything related to diseases. We have classified and arranged the articles which we have received, and all the time while we were doing it, we felt that somehow the articles were not the kind that make health messages effective. Then we considered the subject from the angle of the reader. We asked ourselves, "What phases of health interest us?" The amount of health literature is amazing, and we could spend all our time reading it and preparing articles for the press, and then we would be back where we started. We can write articles, but we can't make folks, including doctors, read them.

Now, some statistics. During the first half of June we received 381 clippings, which we classified under seven heads. The following table shows the number of clippings which we received in each group:

1 Epidemics	47
2 Medical Societies, doctors, hospitals, etc	8
3 Health Departments	116
4 Lay health organizations	72
5 Popular health articles	80
6 Quacks	8
7 Not medical	50
	<hr/> 381

This is an average fortnight, and the clippings run in about the same proportion week after week. Epidemics always make good reading. The big source of news was the epidemic of smallpox in the northwest corner of Nassau County bordering on Greater New York. Twenty-three clippings were on the subject, and 7 more were on vaccination in connection with the epidemic.

Rabies in dogs in the vicinity of New York City took 5 clippings, food poisoning, 3, and scarlet fever, 2.

The clippings on epidemics would be increased in value if more explanations of the nature of the diseases were inserted, but it is doubtful that the newspapers would find space for special information unless the epidemic was alarming.

Health departments were the source of clippings to the number of 116—the greatest number in any of our classifications. The items were on a wide range of subjects which included every activity of a department of health. They included

reports of health officers, accounts of clinics, budgets, milk ordinances, sewage disposal, and housing. We confess that most of the items had little human interest, and were routine in their nature, but still we think that the newspapers are giving the official departments plenty of space, and are writing the articles in as interesting a style as the subjects will allow.

Lay organizations were the subjects of 72 clippings. We had been under the impression that organizations of laymen that are interested in health supplied the greatest group of clippings, but at present these organizations do not seem to be supplying so much publicity matter as they formerly did.

A large proportion of the items regarding lay organizations are those on the activities of county tuberculosis committees, and the health camps which they are conducting.

District Nursing Associations also supply a considerable number of news items.

Health talks and hints were covered by 80 clippings. One-third of these were inspired by the larger health departments, especially those of New York State and City. The source of the information insures its being printed widely throughout the State. The range of subjects covered is wide, and the articles generally are well written. However, we do not believe any one can possibly comply with the ten or fourteen rules of health that are frequently repeated in the clippings. These rules remind us of the oft-repeated health hints of our early life: "To keep the feet warm, the head cool, and the bowels open."

Our criticism of the usual daily press health hints is that many are on trivial subjects. But then, if they were on serious subjects, few people would read them. "Don't waste energy on a palm-leaf fan," may not be very important advice, but it is good advice so far as it goes, and may tend to reduce worrying by those who seriously think that fanning will revive a person who faints or has heart disease.

We set aside one group for quacks and the knockers of the medical profession, but we placed only eight clippings in it, and half of those came from one publication. It is to the credit of the newspapers of New York State that they support the medical profession. The exceptions are few.

Finally we made a group of those clippings which had no concern with health or medicine. These numbered 50. The reason that these clippings are sent to us is that the eager clipper sees the word "health," and at once cuts out the whole article without reading it. One clipping was on planting flowers at the health building, and sev-

## NIAGARA COUNTY MEDICAL SOCIETY

Dr George L. Miller, Secretary of the Medical Society of the County of Niagara, has sent us the accounts of two meetings of his Medical Society. The outstanding feature of the meeting of January 13th was the inaugural address by the new President, Dr Frederick J. Schnell, of North Tonawanda. The by-laws of most medical societies provide for an annual address by the president. And Dr Schnell has set an excellent example for other societies by taking his duties seriously and preparing a practical address. He first dealt with purely local matters, mentioning efforts to increase the membership, the careful preparation of scientific programs, and the agitation for a county laboratory. He then commended the activities of the State Society advocated by Dr Owen E. Jones, President of the State Society, and mentioned three—nursing, workmen's compensation, and the chiropractic propaganda. He described two cases of injured workmen whom he treated, and although both had informed their employers in writing that they were injured and under the care of Dr Schnell, yet the Commissioner disallowed his bills on the ground that no demand had been made on the employer for the treatment. These cases were cited as evidence for the need of amending the law.

Dr Schnell also commended the officers of the State Society and in mentioning the work of Dr Vander Veer, he said: "If it is a big effort to attend a meeting once in two months, how big a sacrifice is it to Dr Vander Veer to give many hours attention to organization affairs every day? I am anxious that all officers and members of this Society give all possible aid and encouragement to the State organization. I am particularly anxious that our Committee on Medical Legislation will be one hundred per cent efficient in its duties."

Dr Schnell spoke of the irksome restrictions which were placed on physicians, but he concluded: "After all, the doctor of today is pretty

well thought of, even as well as the doctor of old was thought of. To what other profession or class of men is shown the consideration and deference that is invariably shown the doctor. In the courts, as a witness, the judges and lawyers give him preference so that he does not have to wait and waste his time, in business matters and in business interviews, we tell the business man's secretary who we are, and she says, 'are you a doctor?' and we say, 'we are a doctor,' and she says, 'just a moment, please,' and 'Mr Highup will see you right away.' Even the policeman generally overlooks our shortcomings, because he feels that we are always on errands of mercy and wants to help speed us along our way.

"Hats off, the flag goes by," thrills all with solemn pride and gladness. 'Stand aside, the doctor comes,' also thrills the doctor with pride for it tells him that those who speak and that those who heed are glad he has come, for by their action they express their confidence in the doctor's ability to meet the duties of the emergency before them. As doctors we should ever strive to merit that confidence, that trust, that faith."

It was voted that the President and the Legislative Committee inform the legislators of Niagara County regarding the attitude of the Society toward chiropractors. It was also voted that a committee be appointed to consider advertising against chiropractors. Drs Wixson, Bishop and Peart were appointed.

The following committees were appointed:  
Public Health—Drs Gillick, Spalding and Lapp.

Legislative—Drs Moore, Kerr and Fitzgerald.  
Membership and Information—Drs Guillemont, Crosby, Muller, Schoemaker and Jayne.

The scientific paper of the day was given by Dr Hoffman of Buffalo, on "New Methods of Prevention and Treatment of Scarlet Fever."

F O

## NIAGARA COUNTY MEDICAL SOCIETY

The regular meeting of the Niagara County Medical Society on March 10th at the Tuscarora Club, Lockport, President Schnell presiding.

Doctors Schnell, Moore, and Fitzgerald gave a very complete report on legislation.

Dr Schnell, our representative at Albany to the Governor's conference, gave a report upon that meeting.

The death of Dr Thomas Calladine was reported to the Society and the chair was instructed to appoint a committee to draft suitable resolutions.

It was decided to send each member of the Society a new series of form letters to be forwarded by them to their respective Senator and Representative, again calling their attention to our desires on various medical legislation.

The President announced that he had obtained Dr Frederick W. Hipwell, of Toronto, Ontario, for our speaker at our next meeting, Dr Hipwell to speak on the following subject, "The Management of Diabetics as It Applies to General Practitioners."

Owing to the prominence of the speaker and his subject, the Secretary was instructed to send invitations to all medical organizations and clubs in Western New York to this meeting.

Dr Arthur Schaefer, of Buffalo, the speaker for the evening, read an interesting paper on "Aortitis."

A vote of thanks was extended to Dr Schaeffer and the meeting adjourned to lunch.

GEORGE LESLIE MILLER, *Secretary*



# BOOKS RECEIVED

Acknowledgment of all books received will be made in this column and this will be deemed by us a full equivalent to those sending them. A selection from this column will be made for review as dictated by their merits or in the interest of our readers.

**PATHOLOGY AND BACTERIOLOGY OF THE EYE.** By E. TREACHER COLLINS, F.R.C.S. and M. STEPHEN MAYOU F.R.C.S. Second Edition. Octavo, 731 pages, 306 illustrations, 4 colored plates. Philadelphia, P. Blakiston's Son and Co. 1925. Cloth, \$10.00.

**SURGICAL CLINICS OF NORTH AMERICA.** Volume 5 No. 1, February, 1925 (New York Number). Published every other month by the W. B. Saunders Co., Phila. and London. Per Clinic Year (6 issues). Cloth, \$16.00 net, paper, \$12.00 net.

**MEDICAL CLINICS OF NORTH AMERICA.** Volume 8, Number 5, March, 1925 (Boston Number). Published every other month by the W. B. Saunders Co., Phila. and London. Per Clinic Year (6 issues). Cloth, \$16.00 net, paper, \$12.00 net.

**ARTS PEDIATRICS.** By 150 Specialists. Edited by ISAAC A. ABT, M.D. Volume 5, containing 736 pages with 127 illustrations (set to be complete in eight octavo volumes). Philadelphia and London, W. B. Saunders Co. 1925. Cloth, \$10.00 per volume. Sold by subscription.

**LECTURES ON GONORRHOEA IN WOMEN AND CHILDREN.** By J. JOHNSTON ABRAHAM, C.B.E., D.S.O., M.A., M.D., F.R.C.S. 12mo of 142 pages illustrations. London, William Heinemann. 1924. Cloth, 7s. 6d.

**INSULIN IN GENERAL PRACTICE.** A Concise Clinical Guide for Practitioners. By A. CLARKE BEGG O.B.E., M.D., Ch.B., M.D. 12mo of 130 pages illustrated. London, William Heinemann. 1924. Cloth, 5s.

**PNEUMONIA.** Its Pathology, Diagnosis, Prognosis and Treatment. By the late R. MURRAY LESLIE, M.A., B.Sc., M.D. Edited and revised by J. BROWNING ALEXANDER, M.D., M.R.C.P. (Lond.). Octavo of 351 pages. London, William Heinemann. 1924. Cloth, 4s. 2s. 6d.

**THE MEDICAL YEAR BOOK AND CLASSIFIED DIRECTORY.** 1925. Second Annual Issue. Edited by CHARLES R. HEWITT. 12mo of 596 pages. London, William Heinemann. 1925. Cloth, 12s. 6d.

**THE THEORY AND PRACTICE OF THE STEINACH OPERATION WITH A REPORT ON ONE HUNDRED CASES.** By Dr. PETER SCHMIDT (Berlin) and an Introduction to the English edition by J. JOHNSTON ABRAHAM, C.B.E., D.S.O., M.A., M.D., F.R.C.S. (Eng.). 12mo of 150 pages. London, William Heinemann. 1924. Cloth, 7s. 6d.

**THE NATURE OF DISEASE.** By J. E. R. McDONAGH, F.R.C.S. Part 1. Royal octavo of 327 pages, with illustrations. London, William Heinemann. 1924. Cloth, £3. 3s.

**A COMPEND OF GYNECOLOGY.** By WILLIAM HUGHES WELLES, M.D. 5th Edition revised and enlarged, by WILLIAM BENSON HARER, M.D. 12mo of 371 pages, with 167 illustrations. Philadelphia, P. Blakiston's Son and Co. 1925. Cloth, \$2.00.

**TEXTBOOK OF DIFFERENTIAL DIAGNOSIS OF INTERNAL MEDICINE.** By M. MATTHEWS, M.D. Authorized translation of the fourth German edition with extensive additions by I. W. Held, M.D., and M. H. Gross, M.D. Royal octavo of 908 pages with 176 illustrations. Phila., P. Blakiston's Son & Co. 1925. Cloth, \$12.00.

**X-RAY ATLAS OF NORMAL AND ABNORMAL STRUCTURES OF THE BODY.** By ARCHIBALD M'KENDRICK, F.R.C.S. (Edin.), D.P.H. F.R.S.E., Surgeon-in-Charge Surgical X-ray Department, Royal Infirmary, Edinburgh, and CHARLES R. WHITTAKER, F.R.C.S. (Edin.), F.R.S.E., Assistant Lecturer Anatomy, Surgeon's Hall. William Wood & Co., New York and Edinburgh. 1925. Price \$10.00.

**LABORATORY DIAGNOSTIC METHODS.** PATHOLOGICAL, BACTERIOLOGICAL, SEROLOGICAL AND CHEMICAL. A manual for physicians, medical students and laboratory technicians. By JOHN A. KOLMER, Professor Pathology Graduate School of Medicine, University of Pennsylvania and Fred Boerner, Associate in Bacteriology Graduate School of Medicine, University of Pennsylvania. D. Appleton and Co., New York, 1925.

**PYE'S SURGICAL HANDICRAFT.** A Manual of Surgical Manipulations. Minor Surgery, and other Matters connected with the work of house surgeons and surgical dressers. Edited and largely rewritten by W. H. CLAYTON-GREENE, C.B.E., B.A., M.B., B.C. (Camb.), F.R.C.S. (Eng.). Ninth Edition, fully revised. Illustrations. Vel de minimis curat chirurgicus. William Wood and Co., New York, 1924. Price, \$7.00.

**LEPROSY.** By SIR LEONARD ROGERS, M.D., F.R.C.P., F.R.C.S. (Retired). Physician and Lecturer, London School of Tropical Medicine, and ERNEST MITT, M.D., F.R.C.S., Edin., Research Worker in Leprosy School of Tropical Medicine and Hygiene Calcutta. Illustrations. Map showing world distribution of Leprosy. William Wood and Co., New York, 1925. Price \$4.75.

**GYNECOLOGY FOR NURSES.** By M. J. SEIFERT, A.B., M.D., F.A.C.S. Attending Surgeon and Gynecologist, Columbus Hospital, Chicago. D. Appleton and Co., New York, 1925.

**ESSENTIALS OF IMMUNOLOGY FOR MEDICAL STUDENTS.** By ARTHUR F. COCA, M.D. Octavo of 194 pages, 16 plate illustrations. Baltimore, Williams and Wilkins Co., 1925. Cloth, \$3.50.

**PRACTICAL CLINICAL PSYCHIATRY FOR STUDENTS AND PRACTITIONERS.** By EDWARD A. STRECKER, A.M., M.D., and FRANKLIN G. EBAUGH, A.B., M.D. Octavo, 375 pages illustrated. Philadelphia, P. Blakiston's Son and Co., 1925. Cloth, \$4.00.

**NEWER METHODS OF OPHTHALMIC PLASTER SURGERY.** By EDMUND B. SPAETH, M.D., F.A.C.S. Octavo of 258 pages with 168 illustrations. Philadelphia, P. Blakiston's Son and Co., 1925. Cloth, \$5.00.

**THE HEALTH-CARE OF THE BABY.** A Handbook for Mothers, Nurses and Physicians. By LOUIS FISCHER, M.D. 15th Edition, completely revised, rewritten and reset. 12mo. Cloth. 267 pages. \$1.00 net. Funk and Wagnalls Co., New York.

**SIMPLIFIED NURSING.** By FLORENCE DAKIN, R.N., Inspector of Schools of Nursing, State of New Jersey. Illustrated. J. B. Lippincott Co., Phila.

eral were on the alleged illegality of hiring a hundred or two lay inspectors by the New York City Health Department. But we are not concerned about the inclusion of useless clippings so much as we are about the omission of essential ones. Clipping bureaus fail to catch a large proportion of important medical items.

A discussion of the group of clippings relating to purely medical matters has been left to the last. We have included in these clippings items regarding physicians, medical societies, and hospitals. This group includes just 8 clippings. Here is where physicians are weak. The meetings of County Medical Societies is excellent news for all the county newspapers. Do the County Societies invite the reporters to their meetings? Do the officers go to the reporters and give them the news items? We think not. They do not always send the items to the *NEW YORK STATE JOURNAL OF MEDICINE*, much less to the lay press.

Dr Vander Veer has repeatedly called the attention of the members of the Medical Society of the State of New York to evidences which come to the Committee on Legislation revealing the appalling ignorance of people generally regarding the basic facts on which medicine is founded, and the result is that people run off to those who promise impossible cures. The point is that people have little conception of the earnestness and honesty of physicians generally, and of their intense desire to prepare themselves to serve humanity. Witness the immense growth of the movement for graduate medical education. We believe that newspaper publicity can be well given to the broad activities of the Medical Society of the State of New York, especially to its educational plans.

This whole subject of popular medical education of the people is new. Neither departments of health nor health organizations of laymen have solved it, but that is no reason why the Medical Society of the State of New York should not attempt its solution.

We have frequently stated that an essential procedure is that the local County Medical Societies and smaller groups should seize occasions as they arise, and prepare articles for their local papers. There must be a timely news subject in order that the article shall make an impression on the people. The people don't care much about the health limits of Moses, but they do care about the proposal of Moses Jones to sue the town of Dewville for maintaining a smelly public dump beside the highway. Then the local editors will be glad to print health articles on smells, and rats, and decaying matter, and flies, and other things connected with garbage disposal.

What can the State Medical Society do in the way of publicity? It can sponsor articles on such subjects as graduate education, the proposed Medical Practice Act, medical economics, and other major activities and can syndicate them as departments of health do. It will cost money to send out some 1,200 copies each week.

Is this plan worth trying? The House of Delegates has submitted the problem to the Council.

Other State Medical Societies are wrestling with this problem of medical publicity. The *Journal of the Michigan State Medical Society*, June, 1925, page 324, contains a statement by the Editor, Dr F C Warnshuis, telling what subjects he thinks should be considered in medical publicity. It reads:

"The plan that I conceive—I don't know as I can give you all the light—I conceive medical publicity to be of an educational type, to convey to the public that there is such a thing as a germ and that germs produce disease, to convey to the public the means and measures by which an individual is afflicted or becomes afflicted with tuberculosis, and the means and measures that have been proved under modern scientific investigation and experience to be the curative ones. Also to convey to them the foolishness of trying to palpate or manipulate any vertebrae or rub on any kind of medicine in the form of a liniment and buying any electric pad or belt, or taking any sort of concoction that somebody may have gotten up, that is not effective. To acquaint them with the truths in medicine, as to the cause, the course and the means that are proving available for the treatment and relief of physical ailments."

Dr Warnshuis believes in giving publicity to the basic facts of medical practice, and we believe he is right. But we wonder how far we can get in our teaching. We have had somewhat to do with the teaching of hygiene in the public schools, and in the making of syllabi and texts and we have made careful estimates of the subjects that must be covered. We found that the necessary topics numbered at least forty, and that there were about ten subdivisions under each topic, and these were only hygienic topics with nothing about medicine.

We believe it to be worth while to prepare a series of articles, say fifty, along text book lines, only in a more lively style, that shall set forth the basic principles of anatomy, physiology, hygiene, and medicine, and then to offer them to the daily and weekly newspapers under the sponsorship of the Medical Society of the State of New York.

F O

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 19

NEW YORK, N Y

AUGUST, 1925

## PRELIMINARY REPORT OF PRIMARY CARCINOMA OF THE CERVIX UTERI TREATED WITH RADIUM IN THE WOMAN'S HOSPITAL IN THE STATE OF NEW YORK \*

By LILIAN K. P. FARRAR, A B, M.D., F.A.C.S.

NEW YORK CITY

IN February, 1919, the Board of Governors of the Woman's Hospital, upon the request of Dr. George Gray Ward, the Chief Surgeon of the hospital, purchased 250 milligrams of radium salt. The present report is based upon the use of this amount of radium in cases of cancer of the cervix uteri in the past six years and is presented by the kind permission of Dr. Ward with whom I am associated and under whose supervision all the ward cases come and who has directed the dosage and personally seen the cases in the Follow-up Clinic. The ward cases were from the beginning assigned to the first division in the hospital to which Dr. Ward is the Attending Surgeon, in order that the dose of radium should be uniform, and this report includes all the ward cases of cancer of the cervix treated with radium and also the private patients of Dr. Ward and my own patients as I have employed the same dosage and technique. The private patients of other physicians are not included merely from the desire to know what the results are by the present methods of treatment. Radium alone, either in a tube or in needles or both together (Illus 1 and 2—C and D) has been the only treatment given the cases upon whom this preliminary report is based. A Wertheim operation has been done after radiation in several cases, but the follow-up of the end results will appear in a later report. X-ray treatment together with radium we have not used at the Woman's Hospital until the past six months and these cases are too recent to be included in this paper. This report then includes all classes of primary carcinoma of the cervix—the early, borderline or advanced, who were treated with radium alone.

*The Preparation and Dosage.*—The radium salt is in a glass capsule (100 mgms) which is contained in a silver tube, which is in turn placed in a brass tube 1 mm in thickness. This brass tube when ready for use is put into a hollow rubber

tube. We have found the rubber ink container of fountain pens to be of sufficient thickness (1 mm) very inexpensive and of suitable length for use. The open end of the rubber tube is securely tied by two strands of braided silk approximately 16 inches long and these are tied to two strands of silk previously drawn through the eyelets in the brass tube, thus ensuring the recovery of the brass tube should by any chance the rubber tube be torn in removing the radium (Illus 1-A). After sterilization in alcohol for ten minutes of the rubber covered tube containing radium, the ends of the silk are tied to an 18-inch piece of  $\frac{1}{4}$ -inch gauze (which is to be packed in the cervical canal if wide enough to permit doing so) and this in turn is tied to a two-yard strip of two-inch gauze which is to be used to distend the vaginal canal (Illus 1-B). One of these strands of silk is threaded into a needle which passes through the cervix, after the tube containing the radium is placed against the carcinomatous growth in the cervix to ensure the radium remaining in position, and this strand of silk is held taut by the assistant while the vagina is tightly packed with the wide gauze to keep the bladder and rectum as far from the radium rays as possible (Illus 2-A). When the vagina is packed this silk is wiped carefully with iodine and fastened to the vulva orifice (2-A). The intern in removing the radium needs only to cut this stitch at the vulva and pull out the wide gauze, the narrow gauze must follow and then the radium, should the patient get out of bed before it is time for the radium to be removed the tube can not be lost as it is securely tied to the vulva. The patient is prepared as for a vaginal operation and general anesthesia is given usually nitrous oxide gas is sufficient. It is thought advisable to give a general anesthetic to facilitate a thorough examination of the pelvic organs for frequently what seems to be an early case of carcinoma is found to belong to the advanced class, and also to pack the vagina more fully with gauze as the freedom of irritability of bladder

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse, May 13, 1925.



# BOOK REVIEWS



**A TEXT-BOOK OF PRACTICAL THERAPEUTICS** With Especial Reference to the Application of Remedial Measures to Disease. By HOBART AMORY HARE, B Sc., M D, LL.D., Nineteenth Edition, enlarged, thoroughly revised 1061 pages, 144 engravings, 8 plates Phila, Lea and Febiger, 1925 Cloth, \$7 00

Dr Hare's text-book has been enlarged and rewritten, and, as a result, is more in accord with modern practice. Especially noteworthy are the diagrams illustrating the chief actions of the important drugs. Any book that goes through nineteen editions should be able to present the subject of Therapeutics in an informative and accurate manner, and this book may be cited as one that does this in a most readable way.

The modern therapist cannot consider his library complete unless it contains a copy of this book.

M F D

**DISEASES OF THE RECTUM AND PELVIC COLON** By MARTIN L. BODKIN, M D, F A C S, New York. Illustrated Second Edition, Revised and Enlarged E B Treat & Co, New York, 1925 Price, \$6 00

The second edition of Diseases of the Rectum, by Dr Martin Bodkin, compares very favorably with other books on the same subject. The general arrangement of the book, the type and paper used, are excellent. This edition contains several new chapters and a number of new illustrations. The chapter on Intestinal Flora will undoubtedly cause much discussion and all the statements may not be accepted. One would expect a chapter on the technic of the use of local anesthesia in the treatment of anorectal diseases in a new work on diseases of the rectum.

The book may be recommended to the student and general practitioner as an authoritative work on diseases of the rectum.

CHARLES GOLDMAN

**A TEXT-BOOK OF GENERAL AND SPECIAL PATHOLOGY** By J MARTIN BEATTIE, M A, M D, and W E CARRIEGIE DICKSON M D Second Edition, in two volumes Octavos of 1084 pages, with 498 illustrations and 17 plates London, William Heinemann, 1921 31/6 net per vol

This work is presented in two attractive volumes of 500 pages each, one of which is devoted to general and the other to special or regional pathology. Vol I is a masterly presentation of the fundamentals of pathology. Step by step the reader is led from a study of the cell in health and disease through the various reactions of tissues to injury, such as degenerations and infiltrations, necrosis and gangrene, atrophy, disturbances of circulation, inflammation and repair, the granulomata and hypertrophy and hyperplasia. There are many fine illustrations some in color, which aid the descriptions. Several chapters are then devoted to neoplasms, following which are chapters on animal parasites, immunity and fever. Because of the clear presentation and the attention to fundamentals, this would make an excellent text-book for medical students.

Vol II deals with the pathology of special tissues. The reviewer would particularly commend the account of the diseases of the circulatory system and blood-forming organs with the beautifully illustrated description of bone-marrow pathology, the remarks upon suprarenal pathology and the fine article upon kidney pathology. The chapter on diseases of the nervous system stands out because of the full consideration given this often neglected subject. It contains a description of the specific pathology of lethargic encephalitis.

Although there are many textbooks upon pathology,

this is a valuable addition to the list. The authors are pupils of the late Professor Greenfield, for many years professor of pathology at the University of Edinburgh where the first chair of pathology in Great Britain was established.

E. B. SMITH.

## MEDICAL CLINICS OF NORTH AMERICA.

Published every other month by the W B Saunders Company, Phila and London Per Clinic Year (6 issues) Cloth, \$16 00 net, paper, \$12 00 net.

Volume 8, Number 2, September, 1924 (Chicago Number) This number continues the high standard of these clinics. There is difficulty in selecting the most instructive articles in this number as the field is so thoroughly covered. The article by Byfield on the 'Diagnosis of Splenomegally with Hematemesis,' together with Abt's "Case of Aleukemic Leukemia with Clinical Symptoms of Plastic Anemia," gives much information on the difficult subject of the anemias and function of the spleen. Reports of pyloric stenosis in infancy, cardiospasm, peptic ulcer, mucous colitis, multi-ocular cysts of the pancreas and primary carcinoma of the liver cover thoroughly the digestive tract. Mix gives an excellent picture of the slow development of a chronic nephritis in a patient whom he was able to observe over a period of fourteen years. The efforts to prevent heart disease are given in Hamburger's article on the Prevention of Heart Disease and articles on Cardiac Aneurysm and Cardiovascular Syphilis cover the circulatory system. This issue contains a fund of useful information for the practitioner.

H M M.

Volume 8, Number 3, November, 1924 (Philadelphia Number) Much is given in the small space of this volume. Each paper is valuable, full of information, carefully written and thoroughly presented. Mohier in his article on Digitalis points out some of the unexpected results in the use of this drug and gives attention to the cases in which the drug does not act or gives unfavorable results. Riesman concisely presents a lecture on Pneumonia, with special reference to diagnosis and treatment, in which he has reviewed much of the subject in a brief article. Diabetes and its treatment is reviewed and cases presented. To realize how much there is in this issue, one must study the articles.

H M M.

Volume 8 Number 4, January 1925 (Mayo Clinic Number) The present number follows the usual scope and method of handling of the Medical Clinics of North America. There are forty-two contributors and the topics chosen are diversified and of current interest.

HENRY M FEINBLATT

**AIDS TO PSYCHIATRY** By W S Dawson, M A., M D, Oxen, M R C P Lond, D P M, Senior Assistant Medical Officer, Maudsley Hospital, Nervous Diseases. William Wood and Co, New York, 1924 Price, \$1.50

This book is a safe guide for those who would like to rapidly survey the field of psychiatry. Though brief it will give the general practitioner a very reliable idea of mental diseases. The chapter devoted to the legal aspects of insanity gives the law as applied in Great Britain. For American readers, the value of the book would be enhanced if a few notes on American rules of evidence and procedure were added. We are glad to recommend the book as scientific and carefully written.

J F W MEAGHER, M D

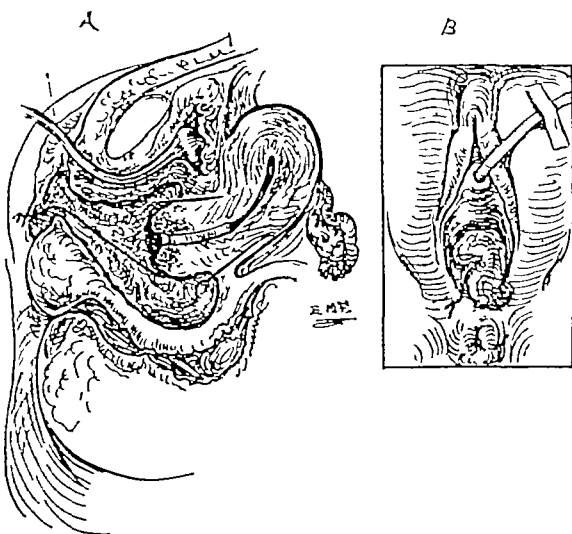


ILLUSTRATION II

(a) Sagittal section showing the wide distention of the vagina with gauze packing and the position of radium tube with anchoring suture and radium needles in situ

(b) The self-retaining catheter in situ and suture in the vulva

dium action is exerted on proliferating connective tissue. For the first time in the history of medicine we are in possession of an agent which will control the growth of connective tissue."

"From the study of much material, from operation and autopsy, in cases treated by deep radiation I have become convinced that the clinical results are *not* usually due to the direct killing effect of radiation but are generally brought about indirectly and mainly by interference with the circulation—capillary venous, arterial and lymphatic. In many cases the main part of the destruction has been caused by occlusion of blood vessels."

In an admirable article by Dr. John Clark and Dr. Keen of Philadelphia, the healing process in the cervix after radium application is described as, "First, local destruction, then a considerable fibrous and tissue formation, with an ultimate condensation cicatrix followed by more or less hyalinization." To the latter process Dr. Clark says, "We attribute the chief possibilities of a cure. To thrive, cancer requires vascularization on its frontier zone. A hyaline or fibrous barrier is therefore an effective block against the invasion of new blood vessels and serves excellently in the process of incarceration or segregation of malignant cells." Dr. Clark quotes Dr. McCarty of the Mayo Clinic as laying especial emphasis on the beneficence of the latter processes in the retardation or starving out of cancerous growths. We know that there are few blood vessels in dense scar tissue and in order that cancer cells should thrive, there must be a sufficient blood supply at its border. Cut off that blood supply and cancer cells are isolated.

If we watch for six to eight weeks the clinical process going on in cervical cancer that has been treated with radium we see

- (1) A hyperemia of the tissues
- (2) A local destruction or breaking down of tissue and profuse purulent discharge with more or less absorption and possibly toxic symptoms if the destruction of tissue is great or the patient cachectic
- (3) A local sloughing area in the cervix
- (4) A diminishing slough in the cervix and a beginning healing process going on around the margins of the cervix
- (5) Complete healing of the cervix, which is now red and hyperemic, and there is now a complete disappearance of the slough
- (6) Finally complete cicatrization with marked contraction of the tissue of the cervix which is now shrunken, firm in consistency and pale in color. Until this stage is reached we do not consider the patient has had sufficient radium.

#### DOSAGE

The initial dose of radium has been 100 milligrams in a single tube placed within the cervix and left for 24 hours, with needles if there is involvement of the vagina, bladder or rectum. In young women under 30, in whom cancer cells are more resistant, the dose has been 100 milligrams for 30 to 36 hours. We have used this dose for all types of cancer cells and for all classes of involvement of the cervix by cancer considering it to be merely a *therapeutic* or *test dose*, and have been guided in subsequent treatments in the case by the result obtained by this initial dose. *Every case of cancer* of the cervix is a *study by itself*. There can be no uniform dose in successful treatment of cancer. Cases with the same type of cell and same stage of involvement by cancer vary greatly in their response to the initial dose. What is sufficient to cause a complete disappearance in one case and no recurrence for a five or six year period, is not sufficient to retard the growth for six to eight weeks in another case exactly similar to the first as far as the local lesion appeared. We know that radium has a selective action on tumor cells and that a dose of radium sufficient to hold in abeyance a malignant growth will not injure normal cells. We therefore do not try to give a killing dose to the tissues, believing, to quote Dr. Ewing again, "that ideal radium therapy seems to require a nice adjustment of relations between destructive effect on tumor cells and stimulation of stroma cells." In further support of the view that radiation therapy tends to employ and support nature's method of healing, rather than by prolonged radiation to produce such extensive tumor necrosis that the patient dies from hemorrhage or septic absorption from the decomposition products of the tumor, producing, as Dr. Ewing states, those rapid ter-

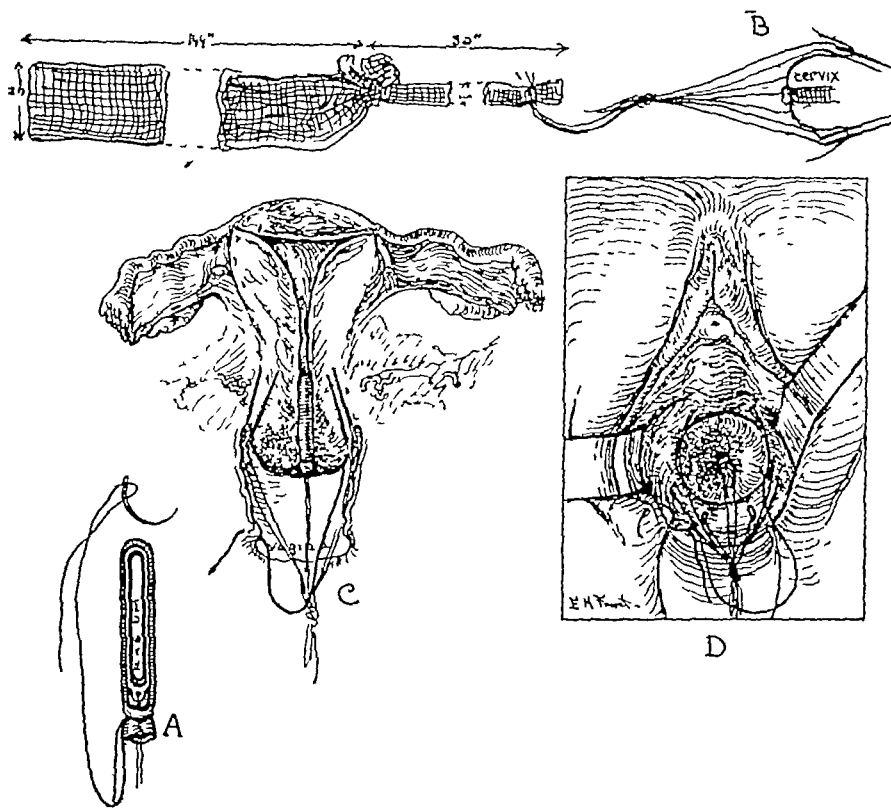


ILLUSTRATION I

Technique of the application of radium tube and needles in carcinoma of cervix

(a) Radium salt in glass and silver capsule with 1 mm brass and rubber screening. Note the tying of the silk threads, one with needle ready to anchor to tissues, and one to be attached to gauze packing

(b) Silk threads from tube and needles knotted together and tied to gauze packing

(c) Radium tube in situ in cervical canal and needles outside the cervix in adjacent tissue. Note anchoring suture passing through the cervix to be attached to the vulva

(d) Front view showing needles under the bladder and in the utero-sacral ligaments and in the broad ligaments posterior to the midline to avoid the ureters and blood vessels

and rectum depends in great measure on the distension of the vaginal canal. Early in the use of radium we found the nurses were obliged to call an interne at night to remove the gauze packing in the vagina in order to catheterize the patients who were unable to void. We then placed a mushroom catheter in the bladder (Illus 2-B) when the radium was introduced into the cervix to keep the gauze undisturbed in the patient and the internes undisturbed in bed, with satisfaction to both parties.

A punch is used to remove several pieces of tissue for pathological diagnosis before the radium is placed *in situ* and care is taken to injure the tissue as little as possible. It has been found by experience that cases treated with radium do better if preliminary care is given to the general health before administering the radium. If a patient is suffering from anaemia we have found it advisable to give a blood transfusion before

the radium and if the general resistance seems low to try rest and tonic treatment for a few days previous to administration. There is always a local destruction of tissue by the radium and by throwing into the system more toxins a marked prostration may follow from which a patient is slow to recover. We permit patients to sit up as soon as the nausea is over which is often when the radium is removed or the next day, and then let them get out of bed even though running a temperature, believing they have better drainage and absorb less by so doing. Douches of potassium permanganate are started the day after the radium is removed to flush out the purulent discharge and patients are told to douche daily after leaving the hospital. Patients are urged to live out of doors and make an effort to gain weight as we believe the beneficial effect of radium depends in part on the general body resistance. There must be a comeback in the tissues to get results from radium.

Since our recent compiling of end results the work of the radium follow-up cases has been placed under

the direct supervision of the head of the Social Service Department and a card index is being made of the housing conditions of each patient. We believe a great deal can be accomplished in this way to get favorable results in the cancer cases.

Before I speak of the dosage I would like to take a moment to consider the effect of radium salts on carcinomatous tissue and consider just what it is we hope to accomplish by giving a case of cancer of the cervix radium treatment, and upon what we base the dosage.

I will quote freely from a recent article, "An Analysis of Radiation Therapy in Cancer," by Dr. James Ewing, than whom I know no better authority in pathology. Dr. Ewing says "One can extricate and emphasize one principle of radiation therapy—viz., that radiation is capable of restraining the growth of tumor cells without causing either autolysis or necrosis" and "Ra-

## THE SPECIALIST AND THE GENERAL PRACTITIONER \*

By MATTHIAS NICOLL, Jr, M.D.,  
State Commissioner of Health

ALBANY N. Y.

IN bidding you welcome to this, the Twenty-fourth Annual Conference of Health Officers and Seventh Annual Conference of Public Health Nurses of the State of New York, I desire to express for myself and members of my staff the sincere appreciation of the loyal co-operation of the health officers and nurses with the work of the State Department of Health.

The relationship between the Department and the medical profession throughout the State continues to be most cordial. It is to be expected that the essential viewpoint of the medical practitioner and of those engaged in official public health work may occasionally lead to misunderstandings and differences of opinion. As regards the more important questions of policy and prerogatives in the fields of medical practice and public health, such difficulties as arise are becoming more readily soluble by frank and open discussion between those affected, and the number of such difficulties shows a notable tendency to decrease.

In spite of assertions to the contrary made by the ignorant, irresponsible and vicious-minded, the vast majority of the medical profession of this State, and, indeed throughout the country, stand ready at all times to defend against attack and uphold laws and regulations for the protection of the public health, not infrequently at the expense of their personal interests, and I trust and believe that the time is not far distant when the State Medical Society and the State Department of Health will be amalgamated in some closely-knit and effective organization in which the general public shall have membership and take an active part, and which shall have for its object the upholding of scientific medicine, the preservation of the public health and their successful defense against the constantly increasing number of the enemies of public welfare. That this is not impossible of realization is readily attested by the example set by the State of Washington, with which I hope that all of you will become familiar.

Physicians as a rule are poor politicians and worse lawyers, and whether they be engaged in medical practice or in official public health or both, as is usually the case among our local health officers, their work is in the definite interest of the public welfare, and that public which is the ultimate beneficiary should in simple justice bear at least a part of the burden of upholding the tenets and practice of scientific medicine.

So much has been spoken and written regarding the constantly decreasing numbers of general practitioners and the causes thereof that I have not the time nor is it necessary to dwell extensively on the many factors which are bringing about this most unfortunate state of affairs. I say unfortunate, for the reason, as I have frequently stated, that with the present organization of the public health work of the State it is to the general practitioner that we must look for the accomplishment of far-reaching results, and, it is the personal influence of the general practitioner among his patients and friends upon which we must count to a very large degree for the upholding of scientific medicine, upon which depends the prevention of disease and its proper care and treatment. The specialist, largely on account of his infrequent personal contact with the patient and consequent lack of intimate knowledge of the peculiar problems which have a bearing upon mental and physical health, is not by any means in as strategic a position to produce results as is the family physician. No more important problem confronts the people of this State and nation than that of regulating the practice of the specialties and of restoring the number and the personal prestige of the general practitioners! To that end may I be permitted very briefly to suggest certain definite means.

I am firmly convinced that the State should prohibit the practice of a specialty, in which I would include surgery, until a physician has practiced general medicine for a term of not less than five years and has qualified himself by training and experience according to established standards requisite for the competent practice of the particular specialty which he desires to undertake.

No one can dispute the fact that those, however, eminent and skillful in the more restricted specialties, with the necessarily closely-confined attention to the pathology affecting a part of the body, usually become less and less cognizant of the inter-relationship between the functions and abnormalities of other organs, even that affecting directly or indirectly conditions which may be found within their own particular field. How often do we see a patient who can afford to go the rounds treated piecemeal by one specialist after another and failing to find relief from a kaleidoscopic array of symptoms, for which in the last analysis only that physician with a broad general knowledge of medicine—and

\* Read before the Annual Conference of Health Officers and Public Health Nurses—Saratoga Springs N. Y. June 23, 1925.

minimal extensions of the disease which many observers have regarded as acceleration of growth from the stimulating effects of radiation.

A patient leaves the hospital usually at the end of a week, later if her condition is not satisfactory then, and reports to the Follow-up Clinic in one month, and from then on makes one visit each month to the clinic. If at the end of eight weeks from the first radium treatment a pale cicatrix has not formed or healing is not definitely progressing in the cervix, a second radium treatment is advised. The same dose is given or the dose is increased, according to the response to the initial dose, remembering that subsequent doses need to be greater to overcome the resistance offered by the scar tissue now formed in the cervix. In cases who do not show satisfactory retrogression of the cancerous involvement we give a third or even fourth treatment, increasing the dose as seems advisable, and some of the best results have been in cases having several treatments. Perhaps the reason for this success may be, to quote again from Dr Ewing, "Tumor tissues undergo progressive fibrosis, but usually groups of tumor cells persist in the scar tissue and later give rise to recurrence."

When one proceeds in deep therapy on the theory that therapeutic results depend not only upon injury to tumor cells but also upon defense reaction of the body and the tissues, the immediate results seem to be almost equally striking, the end result is often more satisfactory and the treatment is conducted with less damage and danger to the patient."

### RESULTS

The co-operation of the patients in the Follow-up Clinic has been remarkable, over 90 per cent of the patients have reported regularly and of the remaining 10 per cent or less, the Social Service Department has been able to trace all but eight by home visits, visits to friends of patients, and by visits to the Board of Health to inspect the list of the death certificates for the year.

It is now six years since we first began radium treatment in the Woman's Hospital and from February, 1919, to February, 1923, 196 patients have been treated, and deducting eight cases the number to be reported on is 188. I have deducted the eight cases instead of calling them dead, as recently in reviewing our Follow-up, six patients whom we had on the list as dead, as they had not reported in the Follow-up in 1½ to 4 years, walked into the clinic, every patient well and clinically free from carcinoma. So I have

stopped killing them and will report only the cases seen as being fairer to the statistics. Forty cases are in the 2 year period, 12 cases had radium and operation, and 3 cases were secondary carcinoma, so the number to be reported is 133. Since 1919, there are four periods of three years each, and I will take up these three year cases, reserving the five year cases for the report to be given at the end of the month at the meeting of the American Medical Association, as the list is not yet completed. This report includes all classes, grouped according to Schmitz classification of primary carcinoma of the cervix uteri.

Classes I and II are the operable cases

Classes III and IV are the inoperable cases

The tables are as follows

THREE-YEAR END RESULTS OF PRIMARY CARCINOMA OF THE CERVIX TREATED WITH RADIUM

Years	Classes I and II				Classes III and IV				
	No.	Traced	Living	P. C.	No.	Traced	Living	P. C.	Total
1919	11	10	4	40	32	31	7	22	268
1920	7	7	7	100	26	24	10	41.6	548
1921	9	8	6	75	21	21	7	33.3	448
1922	7	6	6	100	26	26	11	42.3	531
Total	34	31	23	74.1	105	102	35	34.3	436

All Classes I to IV 133 cases traced, 58 cases living, 43.6% total per cent

### CONCLUSIONS

- 1 Every case of cancer of the cervix uteri should be studied individually
- 2 The successful result does not depend entirely upon the direct killing of cancer cells but also upon the cicatrization of the cervix and occlusion of the blood vessels
- 3 The first dose of radium should be a therapeutic dose.
- 4 The subsequent dose should depend upon the amount of healing and cicatrization seen six to eight weeks after the initial dose.
- 5 Repeated doses of radium may be necessary to arrest the tumor cells persisting in the cicatrix.
- 6 Since results of radium treatment depend also on the defense reaction of the body and tissues every effort should be made to secure the patient a favorable environment following the treatment, and especially have we found it advantageous to use blood transfusions as an aid to this end

### BIBLIOGRAPHY

- Ewing, Dr James A "The Muttter Lectures" Paul Hoeber, 1922
- Dr John Clark and Dr Floyd E Keene "Irradiation in Cancer of the Female Genito-Urinary Organs" Vol 77, No 8, Jour A M A, August 20, 1921, p 613



so-called specialties which never should have left their hands, I am firmly convinced that it will go far toward increasing the confidence of the family physician in his own powers, and the confidence of his patients in his ability to afford them relief from physical and mental suffering

Finally, may I express the earnest hope that not only in the proposed post-graduate courses but in the undergraduate medical curricula much greater emphasis be placed upon the practice and possibilities of so-called physiotherapy. We all know more or less of the value of local applications, of heat and cold, of vapor, of baths of various kinds, of massage, of electricity, of sunlight and its modifications, and the important influence of climate, yet how much attention does the average physician give to this field and how frequently he loses an opportunity to relieve suffering and thereby earn the gratitude of a patient by failure to make use of other measures of bringing relief and frequently effect-

ing a cure than by the administration of drugs. Physiotherapy is a legitimate and valuable part of therapeutics. It should be studied and practiced extensively by the medical profession and not distorted and metamorphosed into misleading absurdities, relegated so frequently to unscrupulous, ignorant and venal charlatans. In our zeal for the spectacular and the performance of one of the medical miracles made possible by recent discoveries of specific remedies let us not forget that the cases in which they are applicable make up but a very small part of the conditions for which people seek medical advice. Cling fast then to the faith of our fathers in well-established and simple measures of treatment which so often bring comfort to the patient. Study and apply the forces of nature which we are only now beginning to understand, and do not forget that medicine is not only a science but an art which requires much more for its successful practice than casual examination and the writing of a prescription.

## ADDRESS AT THE ANNUAL CONFERENCE OF HEALTH OFFICERS AND PUBLIC HEALTH NURSES\*

By N B VAN ETEN, M D,

BRONX NEW YORK

*Commissioner Nicoll, Ladies and Gentlemen*

I am grateful for this opportunity of meeting the Health Officers and Public Health Nurses of the State of New York, because I am desirous of further developing the already cordial relations between the State Department of Health which you represent and the Medical Society of the State of New York.

Most of you are members of the State Society, all of you can render valuable aid in the attainment of our common ideals.

Your Commissioner has maintained a generous attitude toward all honest practitioners of healing arts, and especially toward organized medicine.

Your Commissioner has asked the medical profession of the State to inform him of their desires for the service of his department, has met their wishes more than half way, and in return has requested specific co-operation in public health work under departmental regulation. He has been most sympathetic toward graduate medical education, and has demonstrated it by practical performance, through the employment of regional consultants, in real courses of instruction carried directly to groups of physicians who desired them.

Possessed of administrative ability, plus the liberality, toleration, breadth of vision which

should always be the background endowment of a student of sociology, your Commissioner is giving full measure to the people of this State and to the medical profession.

The history of the State of New York reveals just one Governor who has sufficiently realized that the medical profession is pre-eminently qualified to express reliable opinion on Public Health.

The first advisory conference of representative physicians of the State was called by him. Governor Smith is really humanly interested in the happiness, health and efficiency of the elements that comprise the citizenry of the State. He earnestly desires to extend the efforts of the State in disease prevention, in the salvage of the crippled, and in the comfort of the incurable.

State institutions are insufficient, overcrowded, and growing in a diminishing ratio to necessity and demand. The Governor has a vision which he desires to realize, and his laudable ambition is to advance it now, and pass on to his successors the means to develop it. Safeguarded by a proper annual budget, it is a business project which would be taken up by any large industrial organization without hesitation.

Governor Smith has always favored our medical legislation, differences of opinion among ourselves have defeated it. While we still have such a potential ally, it surely behooves the medical

\* Delivered at the Annual Conference at Saratoga Springs  
June 23, 1925

who is becoming more difficult to find—can furnish effective advice, care and treatment

With the great increase in the number of specialists there seems to be growing among general practitioners a too firm dependence upon their advice, with a consequent disparagement of their own powers and abilities. No one has greater respect and admiration for the work and accomplishments of specialists in the various branches of medicine. To a very large extent they have been responsible for the great growth of scientific knowledge along particular lines, but I confess to a sense of resentment and a strong conviction that it is not for the public welfare that the field of the general practitioner should become year after year more restricted and to an absolutely unjustifiable degree. Just as an advancing army depends for success upon the work of outposts, scouts and observers, so must the medical profession for progress depend upon the work of the specialist and research worker, but the army can not win battles save by the efforts of the men in the ranks, nor can medical science successfully combat disease and death except by the work of the enlightened general practitioner.

There can be no question that a scientifically trained physician who devotes himself exclusively to one of the more restricted specialties is more competent to produce results in his chosen field than the general practitioner. On the other hand, in the case of such broad specialties as pediatrics, tuberculosis, and, if I may add, public health, while unquestionably the leaders in those fields have been responsible for the tremendous growth of knowledge which has taken place, such knowledge contains no element of mystery, requires no superhuman intellect, and should be placed at the disposition of and obtained by every general practitioner throughout the State. I have yet to find a reason to believe that any physician in full possession of his faculties and a desire to learn, can not, when properly instructed and within a comparatively short time, become perfectly competent to undertake the feeding of infants on the most approved and scientific basis, make a diagnosis of incipient tuberculosis, or recognize and care for the average case of acute infectious disease. Except in a comparatively small number of cases, in which the patient should be turned over to the specialist during his entire illness, in my opinion his subsequent care and treatment may usually be better conducted by an up-to-date general practitioner to whom the patient and family are personally known.

Other elements which go to make up these specialties might well be cited as definitely within the sphere of the family physician, and

this is equally true as regards the fundamental principles of diseases of the heart, kidneys, blood vessels, venereal diseases, and certain conditions which are so frequently relegated, without due consideration, to the surgeon.

I am very glad indeed to learn that the New York State Medical Society, following the example of a number of other states, is about to undertake a campaign of post-graduate medical education. The State Department of Health for a number of years has been doing what it could in this field through courses for health officers in preventive medicine and demonstrations and lectures by its regional consultants in pediatrics and obstetrics. In cooperation with county medical societies and at their invitation a series of very successful lectures and demonstrations, notably in Jefferson and St. Lawrence Counties and on Long Island, have been given, which have met the approval and elicited the deep interest of the local medical profession. The Department stands ready to continue this work, at least for a time. An increased number of regional consultants will be placed at the disposal of county medical societies who desire this service, together with such nursing and laboratory facilities as may be required. We shall, however, make no effort to instigate invitations. This, I believe, should be undertaken by the State Medical Society.

I am convinced that post-graduate medical education should be undertaken by the organized physicians of the State for their own benefit, and also for the benefit of the health and welfare of the people of the State. The time to inaugurate this work is now. The physicians of the State, especially in the more isolated counties are, I believe, not only ready but eager for this service. If anyone doubts this fact, in order to be convinced he has only to study the attendance at the few post-graduate courses that have been given, and the truly remarkable interest that was shown in the tuberculosis and other exhibits at the recent meeting of the State Medical Society.

Many details, financial and others, will have to be worked out in order to make this work effective, and the State Department of Health may be counted upon by the State Society to help in every way possible to insure success. It is a wonderful opportunity and a fruitful field of endeavor, and if as a result the general practitioners of this State—especially those who are far removed from medical centers and whose attention to the arduous duties of general practice will not permit them to visit such centers for a sufficient length of time—are granted adequate facilities for keeping abreast with the latest developments in scientific medicine so that they are competent and willing to take over again such elements of the

preventive medicine They should receive sufficient salary for comfortable maintenance, and then should carry the spirit of service and co-operation to the people, always urging consultation with their own physicians if they have them, and assisting the local physician in meeting daily and emergency problems The local physician should derive ethical material help and constant educational stimulus from such contacts

The Journal of the State Society is at your service We have been carrying State Health Department news for the past two years and we want you to use this medium for reaching the medical profession as freely as you please We have, with the cordial assent of your Commissioner, drafted one of you Dr Frank Overton, who serves us, and you, as our Executive Editor He has a receptive ear, a willing pen, and an earnest desire, from his health officer viewpoint, to turn the whole state society into public health activities "Civic Medicine," in large type, is his slogan, a truly healthy idealism which deserves a real following not only from the ranks of health officers but also from general medicine His medical surveys of counties and cities of this state have attracted wide attention and have furnished valuable informative material not only to the country at large but very often to physicians in the locality surveyed who were astonishingly ignorant of their own potentialities

Everybody practices medicine "Antiseptic Charlie," the barber, pours learned advice into your ear while he holds a gleaming razor at your throat The bootblack prescribes while he polishes your corns The cultist openly invites consultation with the title "Dr" on his sign At every contact you are told what is good for you and a very natural confusion results, which can only be clarified by a constant unrelenting stream of information distributed by every health agency and especially by a State Department which speaks with authority

Physicians and nurses are all idealists or they would not have entered their chosen fields In the varying degrees permitted by their human qualities, the spirit of service dominates them all All of them desire fruition of the seeds they now sow, but many of them think they are so busy with the infinite detail of their own daily work that they do not try to see a wider prospect or realize that their influence may extend beyond what they consider is their limited sphere As large numbers of our citizens do not vote on election day, so a considerable number of physicians and nurses are not interested in organized medicine or organized health agencies Physicians should assume their rightful leadership in all civic activities concerning the public health In counties where lay organization work of the tuberculosis type has been most successful it has been headed by the active medical members of the organization The citizen who does not vote

and the doctor who is not a member of his county society and who does not attend medical meetings has small social value and is a load on his community We should not, however, despair of waking him, we should do everything we can to show him the value to himself of becoming a real cog in the machinery of progress Another type, the doctor who is only happy when he is dropping monkey wrenches in the works is more valuable because he is awake He is a potential worker if directed and possibly merely requires adjustment

#### THE NURSE PROBLEM

When I think of the nurse problem I am reminded of the label on a certain bottle which carried these instructions, "do not put raisins in this and stand it in the sun, because it will ferment"

The nurse question seems to be an economic one which is chiefly concerned with supply and compensation Enfranchised woman very naturally is descending to the level of the male citizen from the spiritual heights she once occupied, really a more or less idealistic, largely fictitious, position of domination which men created in order to make her think she was happier than they The woman in industry is now a competitor for real wages and can no longer be contented with less than she thinks she can earn or with less than is given to a man for the same quality and amount of work The higher her educational qualifications the larger her appraisal of her value It is perfectly natural and can not be denied

One of the largest industries in New York, which employs a large number of girls and women, requiring small educational qualifications and taking all of the women they can get, foreseeing the end of their proportion of the female help of the country, are installing machines for the replacement of some of these female workers by a smaller number of highly paid experts and still employing all of the women they can get The labor life of a girl in this company is two years Another great industry employing a large number of women with no educational qualification is leaving the New York metropolitan area because the end of their proportionate supply of female help is in sight They are distributing their business into small plants, placed in small towns throughout the country where there is still a supply of women who can work in the factories and live at home

The complaint that nurses desert their profession for matrimony is silly Of course, they do and of course they should Once a nurse always a nurse is a well known saying If every family included one person trained in nursing arts the domiciliary problem would be measurably solved There is no question of the value of educating as many women as possible in the art of nursing, but it may be unwise to carry their education as

profession to present a united front this year upon our legislative program. The future may not be so kind to us.

Last year a new office was created in our State organization, and we drew upon the State Health Department for a man who has been very valuable to us in stimulating all of the general activities of the society, in carrying the messages of the state officers to the component county societies, in developing friendly relationships with legislators, in promoting the various phases of preventive medicine and medical education, in studying the relationships of Health Officers and Public Health Nurses and local practitioners and lay organizations, and in making valuable studies of every problem which was presented to him. The resultant of nearly a year's work has placed the society in possession of information which gives it a decidedly advantageous start at the beginning of a new administration. Our Executive Officer, Dr. Lawrence, has also greatly stimulated our cordial relations with the State Department of Health.

Is it not largely true that most of us are largely responsible for whatever happens to us, for our just deserts? When we consider the proportion of physicians to population, 1 to 770 in the state, in many counties 1 to 1,000 and 1 to 1,200, there seems little excuse for failure of any competent physician to earn a comfortable living if he has personality, plus industry, plus appreciation of his patient.

The failure of the doctor to study anthropology, to study the whole individual, to measure proportion, to note, in detail, external evidence, to penetrate beneath the surface, to visualize pathology, to appraise subjective symptoms, to carefully search for infected foci, to study internal secretions, to always investigate excretæ, to sympathetically study psychology, indifference in these important observations has developed dissatisfaction, restlessness and loss of confidence among his clientele and has been a natural stimulus of the rise of every shade of cultism.

May not the failure to study pain be responsible for the many forms of physio-psychic therapy which have come and gone during the past half century? Pain in the head, in the back, in the neck, pain in the renal region, pain anywhere, has been considered so casually and superficially that local applications and manipulations have multiplied. Every backache demands attention, and gets it, from all of the manipulators. If the doctor attended to his job and seriously studied spinal deformities, sacro iliac separations, weak feet, broken down feet or flat feet, if he gave to these common every day subjects the earnest study and attention for which he has been prepared by his superior education, would not the ignorant back rubber and spine puncher fade out of the picture?

Physicians who dismiss patients complaining of obscure pain, as neurotics, merely drive them into the arms of people who are more considerate, and very likely into machine shops, presided over by sub-standard practitioners, where buzzing electrical machines are very diverting and quite irresistible. Pain is the chief symptom which urges the subject to seek advice, and he goes for relief and sympathy to anyone who will try to give it.

I know a very busy doctor, you probably do too, who is a buzzing doctor, reminding one of a June bug batting his head against the wall. He does not get very far because he has lost co-ordination. He sees so many patients in an hour that he stops thinking. He descends to superficiality, to the easy morality of following fads. The infectious spirit of the times is largely responsible for such conditions, but the educated physician must change this, he must give every individual who consults him careful, thoughtful consideration. The net result of treating a dozen patients daily with studious thoroughness would be much greater than the net result of handling fifty patients superficially.

We all appreciate the need of re-education, not because of our own material necessity but because of a greater appreciation of the necessity of public health protection. The State Department of Health has been carrying on public health education for many years most actively through food protection, through pasteurization of milk our cities have greatly reduced the incidence of gastro-intestinal infection. Through improved sewer systems, water pollution has been minimized. Through protection of water-sheds, the greatest city in the world has drinking water which is not only the most delightful to sight and taste, but of such purity that it is the safest city water known.

Education in the value of serums and vaccines in preventing the spread of contagious diseases, has been of the greatest value and must be unceasingly continued in the face of the continued opposition of cultists who may be typified by the inclusive term anti-medical.

Recently quoted statistics which related that there were more than 4,000 cases of smallpox here during one month of this year, among our independent citizens, who may or may not, as they please, be vaccinated, as compared with no smallpox in the same month among the 60,000,000 disciplined citizens of Germany, surely make us feel that we are very far from perfection in our public health education or development of public health control.

Health Officers and Public Health Nurses have a wonderful opportunity for broad service. Here would seem an ideal field for young men possessing ample means, and young women with high ideals, to enter upon a real adventure in

had the militia or so-called National Guard, but this force, consisting of some 1,600 companies scattered throughout the United States, was not a federalized military force, and under the constitutional provisions and the lack of congressional laws it was not available as a first-line military force. In 1903 as a result of the passage of the Dick Bill it was recognized as the National Guard, to be organized, equipped and trained like the Regular Army. Provision was made for its participation with the Regular Army in maneuvers, and for the detail of Regular Army instructors and the allotment of federal funds for pay, equipment, and maintenance.

With the exception, therefore, of the militia, this country adhered to its traditional policy of organizing an armed force in time of war, and making practically no provisions for its defense in time of peace.

The present system of Reserves dates from the creation of the Medical Reserve Corps in 1908 when, as a result of the plans prepared by Surgeon General O'Reilly, Congress passed a law authorizing the creation of a Medical Reserve Corps and the appointment of civilian physicians in the corps in the grade of first lieutenants. The Medical Corps of the Army and the medical profession of this country take great pride in the fact that the Medical Reserve Corps was the first officer reserve organization this country ever had. Some of the most prominent medical men of the country enrolled, and one of the first duties performed by those who became reserve officers was the study of preventive inoculation against typhoid, which was first voluntary and later compulsory in the Army.

The development of the Medical Reserve Corps was slow, but the corps which began the war with a membership of 342 in 1917 was increased to 31,000 at the time of the Armistice. The incidents connected with this expansion during the World War are matters of history, depicting the many inequalities, injustices and ineffectiveness which were an inevitable consequence of unpreparedness. No definite methods or standards for appointment, classification, assignment and promotion were in operation, and all of the inequality and discrimination regarding rank and promotion which caused so much bitter feeling during and immediately after the war, are explained entirely by the fact that the medical profession was unprepared for war, and the laws governing appointment and promotion in the Reserves made it impossible to adopt and maintain definite standards and regulations.

The new Reserve Corps began recruitment in January, 1919. Until June of that year there was no law governing the grade upon appoint-

ment. It is a matter of record that appointments during this period were made in the same grade or one grade higher with only four exceptions of record in which officers received more than one grade higher than that which was held while on active duty. From July, 1919, to June, 1920, appointments could be made by law in one grade higher than that held while on active duty. For over a year after the passage of the Act of June 4th, appointments were limited to the same grade, a restriction that was removed by the decision of the Secretary of War in November, 1921. It is believed that the Reserve Corps at the present time is founded on a much firmer basis, and that the regulation governing appointment and promotion having been devised by a board, 50 per cent of whom were reserve officers, will cause no further complaint as to the matter of rank and promotion.

The present Officers Reserve Corps is composed of reserve sections corresponding to each arm and branch represented in the Regular Army, with such additional sections as the President may see fit to create. In the Medical Department we have the Medical, Dental, Veterinary, Medical Administrative Corps, and the Sanitary Corps Sections. There is also an Auxiliary Section to which officers may transfer upon reaching the age of 64, or having become disabled, or who, after having completed 20 years' service, desire such transfer. The Medical Administrative section is composed of officers, not above the grade of Captain, whose qualifications fit them for administrative positions in the Army Medical Department such as those of Adjutant, Mess Officer, Supply Officer, etc. The Sanitary section, which might properly be called the medical auxiliary section, is composed of officers from the grade of second lieutenant to colonel, whose civilian occupations and professions are essential to a well-rounded medical service in time of war. In this class we have sanitary engineers, food and nutrition experts, hospital architects, laboratory technicians, statisticians, and men engaged in the production and procurement of medical supplies on a large scale. These professional and technical officers are required in the Medical Department because in the next mobilization, there will be a more accurate and scientific classification of the men taken into the military service and the salvage of the physically unfit, sick and wounded, and their reconstruction will be carried out on a scale vastly superior to that of any previous war.

Appointments in the Medical Department of the Reserve Corps are made in the lowest grade except World War officers, who may be commissioned in a higher grade, as well as those who, though not having served as offi-

far as we do now into the sciences Hospitals favorably located may have good service from a local supply All hospital patients are more fortunate than are private patients outside of hospitals No one denies the value of the service of the individual nurse, all admit the difficulty of securing her services and large numbers are unable to pay her It does not seem possible that any artificial regulation will sufficiently increase the supply, in proportion to our growth of population, to restore former comfortable conditions Women are in industry to stay and they are going into work that pleases them both in character and reward

Committees from the state and county societies have been studying these questions from various angles and with varying reactions A special committee will continue these investigations and I shall not attempt conclusive deductions from refractory straws which may or may not indicate the direction of uncontrollable social forces

There seems to be general approval of the plans for preventive medicine which involve the examination periodically of the apparently healthy

It seems a natural development from a semi-annual examination of every school child by inspecting physicians and nurses who would weed out defectives, classify them, and follow up their physical care in co-operation with family physicians, pursuing continuous checking up until the age period when they enter industry where the general evolution of economics would bring them under the observation of other health agencies

Standardized health is not only possible but will be insisted upon by employers Annual health inventories will be taken and organized efforts will be made to maintain excellence Much of the preliminary paper work may be done by nurses which will lessen the labor of the examining doctor • Corrective instruction will be given which will be valuable in attaining results In general, the examining physician will himself learn much It is surprising how stimulating careful history taking and a complete estimate of every organ and function becomes with mere performance. The subject also becomes interested

and increasingly respects the examiner as the repository of his personal confidences and of his physical data The family physician is pre-eminently the best qualified to do this work The health officer and the public health nurse could do a real public health service by spreading in formative propaganda

One of the major activities of the Medical Society of the this year will be the inauguration of State-wide post-graduate medical education It is planned to carry this work to the doctor who is too busy to leave his practice for long enough time to take courses in advancing medicine within the walls of educational institutions It is planned to ask the doctor, through the district branches and the county societies, what special form of education he desires, give him what he wants, if possible, and thereby increase the value of his membership in the state society

It may be hoped that Medical Colleges within the State may offer courses to members of the State Society, who, by the fact of their membership, have shown that they are interested in medical progress and therefore deserve special attention from educational institutions

It is also to be desired that the State Department of Health will continue the educational work now being done by regional consultants or others, not only until the State Society is able to do practical work, but also in collaboration upon a general program The field is a large one and there is room for free co-operation of many agencies providing they are willing to avoid duplication of effort

Kipling says

"If you can fill the unforgiving minute  
With sixty seconds worth of distance run,  
Yours is the earth, and, which is more,  
You'll be a man, my son"

If every one of us, physicians and nurses, will, every day, try to practice a little better medicine, a little better surgery and a little better nursing than we did the day before, and do it in the spirit of the commandment, "Thou shalt love thy neighbor as thyself," we will travel far on the road toward the goal of our great adventure

## THE MEDICAL RESERVE CORPS\*

By LT COL CHARLES R. REYNOLDS, M C,

COMMANDANT CARLISLE BARRACKS PENNSYLVANIA

THE Organized Reserves constitute the most important component of the United States Army, the Regular Army and the National Guard, being sufficient only for a minor mobilization From a medical standpoint the Or-

ganized Reserves are necessary as a supplement to complete the military forces, for without the Organized Reserves, there is practically no provision made for the hospitalization and other medical service back of the divisions

For 125 years this country had practically no reserve military force It is true that we

\* Abstract of a Lecture before the Medical Reserve Officers in the Medical Field Service School, July 13, 1925



# EDITORIALS



The Medical Society of the State of New York is not responsible for views or statements outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

Editor-in-Chief—ORRIN SAGE WIGHTMAN, M.D.,

New York

### COMMITTEE ON PUBLICATION

E ELIOT HARRIS, M.D., *Chairman*

New York

WILLIAM H ROSS, M.D.

Brentwood

DANIEL S DOUGHERTY, M.D.

New York

Executive Editor—FRANK OVERTON, M.D.

Patchogue

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

President—NATHAN B VAN ETTEY, M.D.

New York

First Vice President—WILLIAM H ROSS, M.D.

Brentwood

Second Vice President—FREDERICK H FLAHERTY, M.D.

Syracuse

Speaker—E. ELIOT HARRIS, M.D.

New York

Vice Speaker—GEORGE M FISHER, M.D.

Utica

Secretary—DANIEL S DOUGHERTY, M.D.

New York

Assistant Secretary—HOWARD GILLESPIE MYERS, M.D.

New York

Treasurer—CHARLES GORDON HEYD, M.D.

New York

Assistant Treasurer—JAMES PEDERSEN, M.D.

New York

### CHAIRMAN, STANDING COMMITTEES

Arrangements—EDWARD R. CUNIFFE, M.D.

New York

Legislation—HENRY L. K. SHAW, M.D.

Albany

Public Health and Medical Education—CHARLES A. GORDON, M.D., Brooklyn

Albany

Scientific Work—ANDREW MACFARLANE, M.D.

Albany

Medical Economics—WILLIAM WARREN BRITT, M.D. Tonawanda

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer) the ex President and the Councilors of the District Branches.

First District—JOHN A. CARD, M.D.

Poughkeepsie

Second District—JOSEPH S. THOMAS, M.D.

Flushing

Third District—CHARLES P. MCCABE, M.D.

Greenville

Fourth District—HORACE M. HICKS, M.D.

Amsterdam

Fifth District—NELSON O. BROOKS, M.D.

Oneida

Sixth District—GEORGE H. FOX, M.D.

Binghamton

Seventh District—WILLIAM I. DEAN, M.D.

Rochester

Eighth District—HARRY R. TRICK, M.D.

Buffalo

### COUNSEL

GEORGE W. WHITESIDE, Esq. 27 William St.

New York

Telephone, Broad 1744

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St.

New York

### EXECUTIVE OFFICER

JOSEPH S. LAWRENCE, M.D.

51 Chapel Street, Albany

### SECTION OFFICERS

#### Medicine

Chairman—L. WHITTINGTON GORHAM, M.D.

Albany

Secretary—WARDNER D. AYER, M.D.

Syracuse

#### Surgery

Chairman—EDWARD S. VAN DUYF, M.D.

Syracuse

Secretary—GEORGE E. BEILBY, M.D.

Albany

#### Obstetrics and Gynecology

Chairman—ALFRED C. BECK, M.D.

Brooklyn

Secretary—NATHAN P. SEARS, M.D.

Syracuse

#### Pediatrics

Chairman—ROGER H. DENNETT, M.D.

New York

Vice Chairman—ARTHUR W. BENSON, M.D.

Troy

Secretary—JOHN AIKMAN, M.D.

Rochester

#### Eye, Ear, Nose and Throat

Chairman—EUGENE E. HINMAN, M.D.

Albany

Secretary—JAMES W. WHITE, M.D.

New York

#### Public Health, Hygiene and Sanitation

Chairman—ARTHUR D. JACQUES, M.D.

Lynbrook

Secretary—LEO F. SCHIFF, M.D.

Plattsburg

#### Neurology and Psychiatry

Chairman—CLARENCE O. CHENEY, M.D.

Utica

Secretary—THOMAS K. DAVIS, M.D.

New York

## IN VACATION TIME

While most of our friends seem to be traveling away from here this summer, Colonel Kopetzky, of Medical Week, and Major Overton, of our staff, having deserted their sancta for military manœuvres at Carlisle, and even our Business Manager having yielded, for a very brief period, to the lure of the music of ocean waves, the wheels of the State Society have been turning upon the work cut out for it by the House of Delegates.

The executive committee has held four meetings in order to clear its calendar, and takes pleasure in announcing that the new committee on legislation will be composed of very able and experienced men with Dr. Henry L. K. Shaw as Chairman, and Dr. Arthur W. Booth and Dr. Clarence F. Graham as co-workers.

The special committee on nursing, which is a sub-committee of the Committee on Economics, has organized and started an elaborate program of investigation from which we hope

for a clearer vision of a very difficult problem.

The special committee which was appointed to draft a new medical practice bill holds meetings every two weeks, and every member is giving his very best thought and study in trying to satisfy our critical membership, and construct a bill which will pass the next Legislature.

The Committee on Public Health and Medical Education has organized, will meet again on August 12th, and is working very steadily upon the development of an ambitious program for State-wide post graduate medical education, which is creating a very lively interest among our members. A part of its clinical work has already started, is eagerly received, and warmly applauded.

The President has already spoken before five societies and will disappear into the woods next week to catch his breath for the fall campaign.

N B V E

cers during the World War, contributed to the successful prosecution of the World War in occupations which prohibited their being commissioned in the Army. Among these are the essential teachers, public health officers, and those who served in the Council of National Defense. The deans of medical schools and the professors have been given appropriate rank.

The assignment of Reserve Officers is now made more accurately and scientifically as a result of a careful system of classification made in the Surgeon General's Office wherein the military record and professional qualifications are carefully surveyed to the end that officers may be assigned to the positions they are best qualified to fill. Those who are especially qualified for service with troops are placed in the Territorial Assignment Group, and turned over to the Corps Area Commander for special assignment to units, such as Infantry Divisions. The other large group formally known as the Branch Assignment Group, constitutes more than a majority of all Medical Reserve Officers. From this large group the Surgeon General must organize the medical service back of the divisions including the surgical hospitals and the auxiliary teams, such as shock teams, fracture teams, operating teams, the evacuation hospitals, station hospitals, general hospitals, laboratory units, supply units, and other medical institutions in the Theater of Operations and home territory. Under the new arrangement many of these units will be organized under Corps Area direction.

The promotion of Reserve Officers as well as many other regulations of importance are defined in Army Regulations 140-5, W D, December 15, 1924. The requirements for promotion in time of peace depend upon the length of service in the lower grade, the existence of a vacancy in a higher grade, and the holding of a certificate of capacity which is acquired after a written examination which, with a practical test, will qualify an officer for promotion, provided he meets the general rules as to age and length of service. The service requirement is extremely liberal, providing for the promotion of the officer to the grade of colonel in a period of 16 years. In the Regular Army such promotion requires 26 years of service. The specific regulations as to the requirements for the certificate of capacity and the scope of the written and practical tests for promotion will soon be issued by the War Department. A very important fact which should have a large influence upon building up the Reserve Corps is the security that a Reserve Officer has against interruption of his civil occupation by active duty requirements. The laws and regulations are extremely liberal and in substance provide that active duty is to

all intents and purposes voluntary. Active duty training can be obtained by application to the Corps Area Commander.

The system of training Reserve Officers comprises the Correspondence Courses, active duty in camps of instruction such as the C M T C, active duty with their units under training, and special courses of instruction in the Reserve Officers' camps such as the one held at the Medical Field Service School, Carlisle Barracks, each summer. In addition to these, there is a six weeks' course at Carlisle for National Guard and Reserve Corps Officers beginning September 1st, and an advanced course for the higher training of Regular, National Guard, and Reserve Corps Officers beginning October 15, and ending December 15.

The appointment of Reserve Officers contemplates their specific assignment to units organized under the general mobilization plans of the War Department. In time of a national emergency, it is probable that the Medical Department will be called upon to furnish over 40,000 officers and about 400,000 enlisted men. The organization of the units in which these officers are to serve have gone forward as fast as enrollments and the allotments of the War Department's limited appropriations have permitted. There remain to be formed a great many Medical Department units which will find their activities in the medical service back of the divisions. The plans of the War Department contemplate the organization of all these units locally and their mobilization at their home stations as the first step in the general process of mobilization. The responsibility of Reserve Officers for the organization and mobilization of the units to which they are assigned is readily apparent, and marks a decided departure from the plan in force during the mobilization of 1917.

Why should one join the Reserve Corps? This question is often asked in view of the probability that appointment in the Army of the United States may be obtained after war is declared. The answer is to be based entirely upon the matter of patriotism. Many of the former officers of the Army have declined to accept commissions in the Reserve Corps because of grievances based upon their experience in the Army. The basic cause of the inequalities, injustices, and misfits during the World War was unpreparedness. To lend no aid in the preparation of plans for the effective organization of the resources of the medical and allied professions of the country is to subscribe to unpreparedness and its results during all former wars, which will inevitably cause the same results in the future.



## HONESTY IN MEDICINE

We once wrote an editorial on Medical Honesty in which we emphasized the fact that plain honesty is the fundamental qualification of a doctor (See this Journal, February 1, 1924, page 63) This qualification recurs to us as we read the request of our counsel, Mr Whiteside, for information regarding the causes of malpractice suits brought against doctors (See this Journal, June, 1925, page 799)

We are further reminded of the importance of honesty by requests for advice that are made by members of county medical societies We have unwillingly reached the stage of life when, after twenty years of service as secretary of a county society, the doctors of our acquaintance think that our experience has given us a considerable degree of knowledge about the fine points of the ethics of the relation of one doctor to another, and so our doctor friends unburden their troubles on us in strict confidence

One of the most common complaints is that a second doctor tells a patient that his condition is somewhat different from that which his first doctor has diagnosed One doctor, for

example, makes a conscientious and thorough examination of the lungs and throat of a patient who has bloody expectoration, and he very properly asks the patient to return for a confirmatory examination, and for a sputum specimen The patient goes to a second doctor who makes a superficial examination, and tells the patient what the patient is anxious to hear—that his bleeding comes from his throat

Which doctor will that patient praise?

Which doctor is honest and reliable?

Which doctor practices the Golden Rule?

Which doctor practices modern medicine?

Which doctor would you put on a committee to investigate the causes of diphtheria deaths in your county?

It is thoughtless breaches of strict honesty, such as we have described, that start trouble between doctors, and it is greater breaches of honesty that start most of the malpractice suits against doctors

We would like to start a graduate course of instruction in old-fashioned honesty, but what's the use? Some would say that we would first have to go to school ourself

F O

## QUACKS

Why do quacks flourish? For the same reason that weeds grow Weed seeds are scattered everywhere, but the only ones that grow are those that follow a soil suited to them Quacks spread their alluring propaganda over the whole land, but only here and there does it fall on a public that is so responsive as was a community that we visited recently

It was an old city rich in worldly goods patriotic history and learned culture In its center square a crowd surrounded an automobile in which an accordion player alternated with an orator whose knowledge of practical psychology far exceeded his grammatical learning "See this bottle of muddy liquid?" said he "It contains the poison that makes you sick I pour some into this glass One drop of it would kill you, if it got inside of you Now, watch what this medicine does to it I pour ten drops of this medicine into the glass See how the brown, muddy liquid becomes pure as crystal Look carefully See those particles rising in the liquid? If they sank, they would fall into your bladder and form a stone there Now, who wants the first bottle? Let me warn you—don't you go home and give half of the bottleful to your wife or your mother

If they need any medicine, buy them each a whole bottle Half a bottle will not do any one any good at all Each bottle is exactly fitted to chase the poison from one person Four bottles, did you say? Yes, four dollars is right"

And I saw a young man and his attractive wife take away four bottles of quack stuff as tenderly as they carried their baby, and no one molested the vender save a band of Salvation Army exhorters They took their station beside the quack and sought to drown his voice with a cornet that was out of tune But the dollar bills fell not into the lassie's tambourine but into the hat of the quack

And I asked a friend of mine who was a preacher why the quack was tolerated, and he replied "We have fine doctors here who have great skill, and we all do as they tell us, and the city is healthy But what this man says may be true and, therefore, we buy his medicine, and can you prove to me that what he says is false? We are a people full of faith, and we trust both the doctors and the peddlers of medicine

These things took place in a State where science in general and medicine in particular are on a high plane

F O

## ADVERTISING AND THE JOURNAL

The Publication Committee with the approval of the Executive Committee of the Council has made arrangements with Mr Joseph Tufts to become the advertising manager of this Journal. Mr Tufts has been connected with the Journal for a number of years on part time, but now he will give it his full time with the expectation of greatly increasing the amount of advertising, and therefore the income of the Journal.

The question is often asked "Why does the Journal need to take advertising at all?" The answer is threefold

1 Physicians wish to know where they may get reliable supplies

2 Firms friendly to physicians wish to come into direct contact with their patrons

3 The advertising service is financially helpful to both the advertisers and the Journal

The members of the Medical Society of the State of New York have a great opportunity to bring in new advertising. If they know of firms that would be likely to advertise in the Journal, they can drop a line to Mr Tufts,

who will then follow up the prospective customers

There are many lines of advertising that are now untouched by our Journal. There is the long list of common foods—cereals, canned soups, and ready-to-eat foods whose value would be enormously increased through the recommendation of physicians. There is a long list of toilet articles, from tooth pastes to foot powders, about which physicians are often questioned. There are rain coats, and shirts, and stationery, and automobiles, and there are personally conducted tours for the vacation time of the doctor and his friends and patients. All these may properly be advertised in the Journal.

Reputable advertising firms are willing to pay well for space in the Journal provided they can receive an audience and some return from the advertisements which they will secure subject to the strict censorship of the Publication Committee. We believe that with the cooperation of all our members we can make the Journal far more financially self-supporting without any sacrifice of independence. O S W

## FUNDAMENTALISM IN MEDICINE

Publicity is the greatest weapon in the modern warfare between Truth and Error. H G Wells in his "Outline of History," page 396, tells how the printing press in the time of Rome's greatness would probably have saved the Roman civilization. He says that an efficient popular government depends on a steady supply of correct information upon public affairs to all. This statement is equally true in public health.

Just as the dissemination of knowledge is the principal means of promoting progress, so the suppression of a knowledge of new discoveries in science has always been the means used by the conservatives who object to changes. There is a great class of honest persons who believe that any attack on the "Foundations of the Earth," and on the stability of the "Everlasting Hills," is going to upset the balance of the world and the mentality of its people. These persons have an obsession that research workers are trying to build a tower of science by which they can scale the heights of Heaven.

The recent contest of wits between two self-appointed champions representing the extremes of the two classes of "thinkers" has made exceedingly entertaining reading, and we have envied the reporters whose privilege it was to see the contestants hurl thunder bolts and invectives at each other after the manner of the ancient heroes on the battlefield. (See the

speech of Goliath to David in Chapter 17 of First Samuel.)

There has already been a big sale of scientific books to the fundamentalist rooters. We have not heard that men of science have shown the least disturbance over the charges of agnosticism and atheism that have been brought against them. Physicians and other men of science are exceedingly humble in the presence of the great unknown, and they have a profound faith in Him who rules all things, and in the Book wherein He has revealed Himself. They render unto the Caesars of science the things that belong to science, and unto God the things that are of God. We cannot name a single physician who is an atheist, on the contrary, physicians, more than any other class of persons, honor and revere the minister of the Gospel who walks sincerely in the footsteps of the Master and tries to practice the Sermon on the Mount.

Popguns of oratory and religious polemics have no effect on physicians, whose faith withstands the daily assaults of inconsistency, hypocrisy, and cowardice. These things they soon forget, or they remember them as mere scientific phenomena. The faith of the physician is renewed daily from the great reservoir of faith of those who confess to Him their secret sins, and entrust their very lives to His care. F O

little abduction and rotation. The right trochanter was higher than the left and the clinical findings corresponded with the X-ray, which showed an old fracture of the neck of the femur with the distal part of the neck absorbed and the head very much rarified. The part of the neck attached to the femur appeared to be well nourished. It was also found that the left hip joint was limited in flexion, abduction and rotation, the disability not being as marked as on the right side. Examination of the sacro-iliac revealed no tenderness or other evidence of injury. The lumbar and gluteal muscles on both sides were extremely tender, suggesting myositis. The examining orthopedic physician was of the opinion that the disability of the right hip was due to an old fracture of the femoral neck and that the condition of the left hip was probably due to bone changes consequent upon nutritional disturbances and usually known as osteoarthritis. He was also of the opinion that the fracture of the right

femoral neck antedated the X-ray of April, 1922, anywhere from one to twenty years, the proof of this being the rarefication of the head and the absorption of the distal part of the neck of the femur. He was of the further opinion that he could conceive of no circumstances during delivery which could bring about a fracture of the femoral neck in a woman under thirty years of age or produce an injury to a hip joint which would be followed by osteo-arthritis. He believed that the condition of the lumbar and gluteal muscles is one that usually follows auto-toxemia and could not be produced by traumatism at the time of delivery.

When the case came on for trial the plaintiff's attorney strenuously sought to procure a settlement, being willing to take one hundred dollars for his trouble. When all offers of compromise were refused and we were ready to proceed in behalf of the defendant with the trial of the action, a dismissal of the complaint was consented to.

---

### CLAIMED IMPROPER ADMINISTRATION OF CHLOROFORM AND OPERATION ON CARBUNCLE

The complaint in this action charged that the plaintiff had engaged the defendant as a physician to treat a carbuncle on the right side of her face, that he prescribed a salve, the application of which caused an increase of the inflammation. That he thereafter advised and performed an operation on the carbuncle, under chloroform anæsthesia, which it was claimed was improperly administered, causing the plaintiff to be nauseated, and that the operation was carelessly and unskillfully performed, resulting in an aggravation of the plaintiff's condition and the spread of the infection to the eye, requiring the plaintiff to engage the services of another physician and to be confined to a hospital to undergo further operations and to incur medical and hospital expense, which she sought to recover in this action, together with compensation for the pain and suffering claimed to have been caused by the defendant.

When the defendant was first called to attend the plaintiff for the carbuncle, upon examination he found that the right side of her face was affected with erysipelas which involved the right eye, that her pulse was fast and she had a tem-

perature. He prescribed the application of ichthyol to the carbuncle and gave proper advice with respect to its application. Upon examination of the plaintiff a few days later the carbuncle was in such condition as to require lancing. Under a chloroform anæsthesia administered by a practical nurse under defendant's direction, he made about a two-inch incision in the carbuncle, curetted the wound, cleansed it with a solution of bi-chloride of mercury, and applied a sterile bandage. He remained with the patient until she had come out of the anæsthesia and advised against the consumption of any food that day and to partake of only a liquid diet on the following day. On the day following the operation, when the defendant called on his patient, it was claimed that because of his improper advice she had become nauseated and suffered great pain and another physician had been called in to attend her, thus terminating his services.

The case finally reached its place upon the calendar for trial, and the plaintiff not being ready to proceed with the trial of the action, upon motion the complaint was dismissed, thus favorably terminating the action in favor of the defendant.



# LEGAL



By **GEORGE W. WHITESIDE, Esq.**  
Counsel Medical Society of the State of New York

## CLAIMED DISLOCATION OF FEMUR BY FORCEPS DELIVERY

In this action instituted against an obstetrician, it was charged that by reason of his negligence at the time of delivery of the plaintiff, she suffered a dislocation of the right hip, and a flattened head and shortened neck of the femur. The plaintiff had been under the care of her family physician for her pre-natal condition, and at the time of the commencement of labor she entered the hospital at about 1 o'clock A. M. on the 24th of February, at which time a physical examination was made of her by the house physician. It was found that there was a two-finger dilatation at that time. The patient continued in labor for several days before delivery. The nurse at the hospital who attended plaintiff observed that upon her entrance and prior to delivery she walked with a marked limp of the right leg. On the afternoon of February 26th, no progress having been made by the plaintiff in her delivery, the defendant was called in consultation. He first saw the patient upon the table in the delivery room, where she had been for eight hours. Before the defendant had been called in, the attending physician had advised the performance of a Cæsarean section. The defendant, after his examination of the plaintiff, found that by reason of the delayed labor, the patient was physically exhausted. He also found that the foetal heart was scarcely perceptible, and at that time there was a complete cessation of labor through exhaustion and the foetus was lying very low. From his examination of the plaintiff it was clear that a Cæsarean section was not necessary, but that delivery could be made with low forceps without difficulty. The foetus was lying in a normal position. Upon completion of his examination he advised the husband of the patient of the results of his findings and he was then engaged to deliver the plaintiff. The necessary sterile preparations were then made by the defendant and under a general anæsthesia administered by the hospital anæsthetist, and with the assistance of two nurses and the attending physician, the defendant without difficulty made a low forceps delivery of the plaintiff's child. Prior to his forceps delivery the defendant had been told that the patient complained of pain in one of her legs and hip. He then directed one of the nurses to put into the stirrup only the foot of the leg in which there was no pain, and the leg the patient complained of he directed the nurse to hold in an extended position and not to permit any flexion. At the time of delivery there were no complications

other than a small tear of the perineum which required two or three stitches. A living child was delivered and the placenta expelled intact. Upon completion of delivery the defendant cleansed the patient and applied sterile gauze, and upon inquiry of the anæsthetist was advised that the patient's condition was all right. He then told the attending physician to take care of the after-treatment as his, the defendant's work, was finished, he having been engaged solely for the purpose of delivery. At the time of delivery the attending physician wanted the defendant to permit him to use the forceps in the delivery of the plaintiff, which the defendant refused to permit, stating that he had been engaged for that purpose and it would not be fair or proper to allow the attending physician to use the forceps. The defendant while visiting other patients at the hospital, observed that the attending physician had failed to remove the stitches at the proper time, and he himself removed the same. On March 7th the attending physician ordered the discharge of the plaintiff from the hospital, noting that her condition at that time was O. K. She left the hospital on March 11th.

Several months after the delivery the patient's husband called on the defendant and stated that the patient had difficulty in walking. The defendant then visited the patient's home and procured from her a history that she experienced some difficulty with her hip when a small child, at which time she was operated upon. An examination made of the plaintiff's hip by the defendant disclosed that there was some difficulty and pain when the patient walked. The defendant then referred the patient to an orthopedic surgeon, which was the last time that the plaintiff was seen by the defendant.

The interpretation of an X-ray taken of the plaintiff in April, 1922, by the orthopedic surgeon was "Flat in the head of the femur, with very short niche of femur, with downward dislocation, most likely congenital."

Shortly before the action was about to come on for trial a physical examination by another orthopedic surgeon was had of the plaintiff in behalf of the defendant. On this examination it was found that the plaintiff had a bi-lateral hip limp more marked on the right side, the lower right extremity being about three-quarters of an inch shorter than the left and there being restriction of motion at the hip joint preventing any flexion beyond 110 degrees and allowing very

little abduction and rotation. The right trochanter was higher than the left and the clinical findings corresponded with the X-ray, which showed an old fracture of the neck of the femur with the distal part of the neck absorbed and the head very much rarified. The part of the neck attached to the femur appeared to be well nourished. It was also found that the left hip joint was limited in flexion, abduction and rotation, the disability not being as marked as on the right side. Examination of the sacro-iliac revealed no tenderness or other evidence of injury. The lumbar and gluteal muscles on both sides were extremely tender, suggesting myositis. The examining orthopedic physician was of the opinion that the disability of the right hip was due to an old fracture of the femoral neck and that the condition of the left hip was probably due to bone changes consequent upon nutritional disturbances and usually known as osteoarthritis. He was also of the opinion that the fracture of the right

femoral neck antedated the X-ray of April, 1922, anywhere from one to twenty years, the proof of this being the rarefaction of the head and the absorption of the distal part of the neck of the femur. He was of the further opinion that he could conceive of no circumstances during delivery which could bring about a fracture of the femoral neck in a woman under thirty years of age or produce an injury to a hip joint which would be followed by osteo-arthritis. He believed that the condition of the lumbar and gluteal muscles is one that usually follows auto-toxemia and could not be produced by traumatism at the time of delivery.

When the case came on for trial the plaintiff's attorney strenuously sought to procure a settlement, being willing to take one hundred dollars for his trouble. When all offers of compromise were refused and we were ready to proceed in behalf of the defendant with the trial of the action, a dismissal of the complaint was consented to.

---

#### CLAIMED IMPROPER ADMINISTRATION OF CHLOROFORM AND OPERATION ON CARBUNCLE

The complaint in this action charged that the plaintiff had engaged the defendant as a physician to treat a carbuncle on the right side of her face, that he prescribed a salve, the application of which caused an increase of the inflammation. That he thereafter advised and performed an operation on the carbuncle, under chloroform anæsthesia, which it was claimed was improperly administered, causing the plaintiff to be nauseated, and that the operation was carelessly and unskillfully performed, resulting in an aggravation of the plaintiff's condition and the spread of the infection to the eye, requiring the plaintiff to engage the services of another physician and to be confined to a hospital to undergo further operations and to incur medical and hospital expense, which she sought to recover in this action, together with compensation for the pain and suffering claimed to have been caused by the defendant.

When the defendant was first called to attend the plaintiff for the carbuncle, upon examination he found that the right side of her face was affected with erysipelas which involved the right eye, that her pulse was fast and she had a tem-

perature. He prescribed the application of ichthyol to the carbuncle and gave proper advice with respect to its application. Upon examination of the plaintiff a few days later the carbuncle was in such condition as to require lancing. Under a chloroform anæsthesia administered by a practical nurse under defendant's direction, he made about a two-inch incision in the carbuncle, curetted the wound, cleansed it with a solution of bi-chloride of mercury, and applied a sterile bandage. He remained with the patient until she had come out of the anæsthesia and advised against the consumption of any food that day and to partake of only a liquid diet on the following day. On the day following the operation, when the defendant called on his patient, it was claimed that because of his improper advice she had become nauseated and suffered great pain and another physician had been called in to attend her, thus terminating his services.

The case finally reached its place upon the calendar for trial, and the plaintiff not being ready to proceed with the trial of the action, upon motion the complaint was dismissed, thus favorably terminating the action in favor of the defendant.



# State Department of Health



## HEALTH OFFICERS' CONFERENCE

The Twenty-fourth Annual Conference of the Health Officers of New York State was held on June 23, 24, and 25, in Saratoga Springs, in connection with the Seventh Annual Conference of Public Health Nurses. The sessions, in recent years, have always been held in the Grand Union Hotel, for it is almost the only hotel in the State which can accommodate the thousand or more delegates under one roof. The visitors all ate in the dining room of the hotel, and the meals were three daily social functions.

There are over 900 health officers in the State, most of whom are active members of the Medical Society of the State of New York. We see the same faces in the two organizations, and the Health Officers' Conference is a big factor in promoting the morale of the physicians who are active in the State Medical Society. The records show that 521 health officers registered themselves at the Conference, or over 50 per cent of all the health officers.

The Conference is official, and the Public Health Law makes the attendance of every health officer mandatory at the expense of his municipality.

There are about 1,200 public health nurses in New York State, of whom 308 registered at the Conference. While the payment of their expenses is not compulsory, yet it is to the credit of the employers that they nearly always have paid the expenses of the nurses.

Probably the greatest value of the Conference is in the opportunity for the public health workers of New York State to become acquainted with one another. We have been attending these conferences since their inception in 1902, and we eagerly look forward to the sight of comrades whom we have met every year for a quarter of a century. This annual renewal of friendships promotes unity of purpose, loyalty to the ideals of the State Department of Health, and a fine spirit of service in the cause of public health. The informal sessions (conferences they should be called) in the corridors of the hotel and in the health officers' rooms, and the swapping of stories and experiences, are quite as valuable as listening to addresses from the platform.

This year's conference was of special significance because for the first time the Medical Society of the State of New York was officially recognized on the program. Dr. N. B. Van Etten,

President of the State Society, had a prominent place on the opening program, and both he and Dr. Matthias Nicoll, State Commissioner of Health, emphasized the need of graduate medical education, and each approved the educational plans of the other. The spirit of both addresses was the same, and it was extremely gratifying that each leader should express the identical views of the other without previously consulting together. It augurs well for the future of medicine and of public health that the two great medical organizations of the State should act in close harmony.

We are printing the addresses of both Dr. Nicoll and Dr. Van Etten on pages 859 and 861 of this issue.

A striking feature of the Conference was the spirit of comradeship and democracy in which Drs. Nicoll and Van Etten set the example. The Commissioner of Health spent his time in the corridors where he was one with the health officers. We are sure that every health officer and public health nurse will go home with a new spirit of morale because of the friendliness of the Commissioner. We are sure, too, that the health officers and nurses will have a friendly feeling of co-operation with the State Medical Society because of the opportunity to meet its President on intimate terms during his two-day stay at the Conference.

We had the opportunity to consult health officers from widely separated parts of the State on the subject of graduate education, and found the physicians receptive to the plan of the co-operation of the county societies with the Committee on Public Health and Education of the State Medical Society in planning clinical programs for the meetings, and in arranging graduates' courses of instruction in general medicine, such as heart diseases, tuberculosis, and renal conditions. A large proportion of the health officers of New York State have already taken courses of instruction in their own specialty, and have had experience in making arrangements for lectures and demonstrations. The co-operative attitude of Commissioner Nicoll will be a great factor in the post-graduate education of physicians generally.

This year's official conference of the health officers and public health nurses of New York State marks not one, but several milestones of progress in all that relates to health and the preventive phases of medicine.

F O



# MEDICAL SURVEY



## MEDICAL SURVEY NO 13—SARATOGA COUNTY

Editor's Note—The information on which this Survey is based was supplied principally by Dr J R MacElroy, President of the Medical Society of the County of Saratoga, Dr A R Dimock, Superintendent of the Tuberculosis Hospital of Saratoga County, and Drs George Scott Towne, John B Ledlie, and Carl R. Comstock of Saratoga Springs

**HISTORY**—Saratoga County is one of the best known communities in New York State and the United States, historically, socially, and medically. The physicians of Saratoga County, with those of Montgomery and Washington counties, took the initiative in securing the Medical Practice Act of 1806 under which county medical societies were formed for the purpose of examining and licensing medical students for the practice of medicine, and they were active in the formation of the Medical Society of the State of New York

**POPULATION**—Saratoga County is situated on the west side of the Hudson River, above Albany. It has an area of 823 square miles. Its population was 60,029, according to the census of 1920, and has not increased for twenty years. The distribution of the population was as follows:

The City of Saratoga Springs	13,181
The City of Mechanicsville	8,166
Eight villages	15,100
Strictly rural	23,582
Total	60,029

The people outside of the greater centers are largely prosperous farmers and dairymen.

**PHYSICIANS**—The physicians practicing in Saratoga County are 72 in number, according to the directory of the Medical Society of the State of New York. They are distributed in 15 centers, as follows:

	No of Physicians	Ratio to Population
Saratoga Springs	28	1 to 550
Mechanicsville	9	1 to 900
Ballston Spa	9	1 to 460
Rest of the County	26	1 to 1350
Whole County	72	1 to 830

Saratoga County seems to be well supplied with physicians, even in its rural section. But the directory contains the names of at least a dozen physicians who are no longer practicing medicine. Deducting these, there are left 60 physicians in active practice. This makes a proportion of one doctor to every 1,000 of population.

**COUNTY MEDICAL SOCIETY**—The Medical So-

ciety of the County of Saratoga has 51 members, or 70 per cent of the physicians listed in the directory. This proportion is about the same as that for the whole state. If only the active physicians are considered, 83 per cent belong to the County Society—a high percentage.

The Society holds two meetings annually. While the programs of its meetings are almost entirely scientific, yet the Society has practiced excellent civic medicine along three lines:

1 It has been the means of securing a County Laboratory.

2 It has established a system of certifying milk.

3 It has sponsored a series of lectures for the physicians of the County.

The County Medical Society has a milk commission composed of Drs Towne and Comstock. They have formulated rules and regulations regarding the production of certified milk in Saratoga County. The County Society, through its President, Dr MacElroy, also secured an appropriation from the Board of Supervisors for the purpose of testing dairy heads for tuberculosis.

The lecture series was planned and conducted by Dr J R MacElroy, President of the Society, who secured speakers from Albany, Schenectady, and other medical centers. Thirteen lectures in all were given during 1924, with an average attendance of about a dozen physicians. Some of the subjects of the lectures were: The Causes of Prolonged Labor, Diabetes, Pneumonia, the Differential Diagnosis of Surgical Conditions of the Abdomen, the Nervous Child, Non-Tuberculous Diseases of the Chest, Acute Infections of the Nasopharynx, Non-Surgical Diseases of the Abdomen, and Fractures.

These lectures are along the lines which will be promoted by the Medical Society of the State of New York during the present year, and the physicians of Saratoga County are true to the traditions of their predecessors who, a century and a quarter ago, took the lead in a movement which became state-wide, and resulted in the formation of the Medical Society of the State of New York.

Dr H J Hawk, Superintendent of the Mount McGregor Sanatorium, has frequently arranged lectures on medical subjects in his institution, and has invited the physicians from the surrounding counties to them. An attendance of 100 has been common, and physicians have come from Albany, Troy, Glens

Falls, and Schenectady, to hear the lectures

Graduate Medical Education has been well started in Saratoga County by the spontaneous impulse of its own physicians

The Medical Society of the City of Saratoga Springs is composed of about 30 physicians who practice in the city and its vicinity. It meets on one evening in each month, and holds a scientific session followed by a social supper. Its attendance averages twenty-five. It is a great factor in promoting the practice of scientific medicine by its members.

Hospitals. Saratoga County has three hospitals for the care of its own sick, as follows:

1. The Saratoga Hospital, in Saratoga Springs, with 100 beds.

2. The County Tuberculosis Sanatorium, at Middle Grove, with 50 beds.

3. The McCarthy Hospital, with 20 beds.

The county has 170 hospital beds available, or 2.8 beds for every 1,000 of population. This is a rather low proportion.

The Saratoga Hospital is housed in a well-planned, roomy brick building which at present prices would cost \$400,000. It receives all kinds of general medical and surgical cases. It is an open hospital, but conforms to the standards of the American College of Surgeons. Staff meetings are held monthly which are attended by over fifty per cent of the physicians listed on the staff—a high percentage for an open hospital.

The histories of the cases are well kept, but much credit for their high standard belongs to the history clerk, who takes the physicians' dictations on call. Another factor in promoting their good histories is the rule that no patient can be discharged unless the history is complete—and the rule works.

The County Laboratory is located in the hospital, and three technicians are employed. The laboratory and hospital also have the services of the experts from the research laboratory at Mt. McGregor on call.

The hospital has the use of an extensive X-ray equipment which belongs to Dr. E. H. King of the Staff, who gives free services to poor patients in the wards.

A training school is maintained with 33 pupil nurses, and a staff of 6 graduate nurses.

**Tuberculosis Work.** The County Tuberculosis Sanatorium has a capacity of 50 cases, but it is nearly always over-filled, and always has a waiting list. Tuberculosis clinics are held frequently in several parts of the County by the Superintendent, Dr. A. R. Dimock. Two public health nurses are employed to do field work in tuberculosis.

Saratoga County has appropriated \$3,000 for a camp for about 30 tuberculous children. This sum is duplicated by the State of New York.

The County has a lay Tuberculosis Com-

mittee which raises about \$3,000 annually by the sale of Christmas Seals, and gives the money toward the support of a field nurse.

The physicians of Saratoga County are well disposed toward the tuberculosis work, and give loyal support to the field nurses and the Superintendent of the Sanatorium.

**Public Health Work.** The official public health work of Saratoga County is carried on by 20 health officers who serve 25 cities, 8 villages, and 19 rural districts. Each health officer of a rural district serves an average of 2,200 population. About three-quarters of the health officers have taken a special course of instruction conducted by Dr. C. C. Duryee for the State Department of Health.

A public health laboratory was established by the Supervisors of the County in Saratoga Hospital, and every physician in the County has patronized it during the past year—a gratifying record.

**Mount McGregor Sanatorium.** The Sanatorium conducted by the Metropolitan Life Insurance Company at Mount McGregor has an excellent influence on medicine in Saratoga County. This Sanatorium is a model of its kind, both in equipment and the manner of carrying on its work. About half of the cases are tuberculous, and the rest are of general diseases, such as cardiac, renal, and diabetic. A Research Laboratory is maintained at which excellent original work is done. One piece of work was the demonstration that tubercle bacilli could be excreted continuously by the urine of tuberculous animals through microscopic foci in kidneys which appear normal on gross examination. The results of this research are published in the American Review of Tuberculosis for January, 1925.

The members of the Hospital Staff are on friendly terms with the physicians of the County. They take an active part in all local medical activities, and invite the local physicians to lectures and conferences at the Hospital, and the invitations are eagerly accepted.

**Mineral Waters.** When Saratoga is mentioned, the mineral springs come to mind. But the mineral waters are no longer the dominating factor in the prosperity of the County, and the private sanatoriums are now devoted to other uses. One of the largest is now a dormitory for the students of Skidmore College.

**Impressions.** The physicians of Saratoga County are going about their work modestly and quietly. When they have measured themselves by their own yardsticks, they have given themselves low marks, but when we have measured their activities and aspirations by state-wide standards, we are inclined to give them an honorable rating. F. O.





# GRADUATE EDUCATION



## THE COMMITTEE ON PUBLIC HEALTH AND EDUCATION

The Committee on Public Health and Medical Education is preparing its program. Plainly charged with a definite responsibility to the public and the profession, it sees in the continuous education of the practicing physician the greatest possible contribution to the cause of public health. It will, then, emphasize graduate education.

We do not expect to train specialists, nor, for the present at least, do we plan comprehensive courses in the laboratory sciences. We do, however, hope to reach every doctor in the State, and to do our best to solve for him the common ordinary problems of the everyday practice of medicine. We will create opportunity.

There have been gaps in the education of all of us. The curriculum of the school from which we graduated was by no means perfect, nor is it now. Our internship was what we made it. Experience has been our best teacher. We have learned by observation, and by giving careful thought to the problems which beset us. We are, in a sense, self-taught. There is much that we do not know.

We have done our best. Our morale has always been high. Medical societies, journals and books, hospitals and an occasional post-graduate course have all helped us to keep the faith. We were always ready to give our best.

It may, perhaps, be trite to say that medicine is an art as well as a science, and that the majority of diseased conditions yield to clinical methods. Bedside healing, however, calls for science as well as art, and many problems may be solved by adequate knowledge and the proper evaluation of modern methods of inquiry.

It may be said that this is self-evident, and that graduate education needs no defense. This may or may not be true, but New York State at any rate, we feel, is ready.

The House of Delegates, at its 1924 meeting, authorized a special committee to study the problem. It renewed the authorization in 1925, and recommended "That the promotion of graduate medical education be one of the major activities of the State Medical Society during the coming year. The need and desire for graduate medical education exists, and it only awaits practical organization of method. In these times of rapid change of knowledge and practice, there is need for some method of providing a steady stream of medical information to all sections away from medical centers, as well as to make available to city practitioners the results of medical progress. This work belongs to organized medicine."

The practical difficulties are enormous, and the Committee will welcome help from every quarter of the State. The work is new, and the Committee is spending much time in organization. Made up with a definite idea as to geographical distribution, knowledge of the problem, and ability and willingness to devote much time to the service of the State, the Committee on Public Health and Medical Education is

Dr Charles A. Gordon, Brooklyn, Chairman  
Dr George F. Chandler, Kingston  
Dr Louis A. Friedman, Bronx  
Dr Frank D. Jennings, Brooklyn  
Dr William D. Johnson, Batavia  
Dr Robert S. Macdonald, Plattsburgh  
Dr Edwin MacD. Stanton, Schenectady  
Dr Martin B. Tinker, Ithaca  
Dr Herman G. Weiskotten, Syracuse

The special Committee on Graduate Instruction authorized by the House of Delegates and appointed by the President, consists of

Dr Charles A. Gordon, Brooklyn, Chairman  
Dr Stanhope Bayne-Jones, Rochester  
Dr Andrew MacFarlane, Albany  
Dr Grant C. Madill, Ogdensburg  
Dr Grover C. Wende, Buffalo

There will be no overlapping of function or effort. Both committees have the same chairman, and joint action in the field of graduate education will be carried on.

The Presidents of the District Branches have been constituted an Advisory Council, and as time goes on, they will become increasingly useful in that capacity. The Committee is surveying the State along the geographic lines of the District Branches, much time and effort will be given to a careful study of the field before any complete plan of action can be announced. The problem, however, will not wait upon the time of the survey, so it is the intention of the Committee to begin courses of instruction at once among those groups that are prepared for it, or very anxious to receive it. Courses which the Committee approve had been given in six counties—Jefferson, Kings, Saratoga, Steuben, St. Lawrence and Suffolk—before this Joint Committee of the State had been formed, and a clinical course is now being conducted in Orange County under the auspices of the Committee.

We are considering clinical courses, demonstrations, and graduate education by mail, but a comprehensive program can only develop when district branches, county societies and their officers, and every doctor in the State interests himself in

what we are trying to do, and offers his assistance. Progress will come. The Committee hopes that county societies will look to it for assistance, as we are ready to provide clinical programs at once for those that desire them. We will secure and assign teachers at once for those groups who will agree to provide cases for demonstration when required, and have histories, physical examinations and other data written up and available for the lecture. Only in this way can any real good come from the teaching material used.

The State Department of Health has placed at our command its entire list of Regional Consultants in Pediatrics and Obstetrics. This is our most important ready asset.

The Tuberculosis Committees—National, State and County—are organized to aid in health and education, and the staffs of the tuberculosis hospitals are available for clinics and demonstrations. The latest knowledge in the recognition and treatment of tuberculosis could be easily brought within the reach of every physician, as is done now in Suffolk County under the direct auspices of the County Medical Society.

The members of the staffs of the State hospitals for the insane and the mental defectives are available for teaching purposes, for they are most anxious to lend their aid in stressing the importance of early treatment. In the Utica State Hospital one-fifth of the cases have entered the institution of their own accord as a result of clinics conducted in various cities by the staff of the hospital. (See this Journal, August, 1924, page 813.)

Possibly there are many lay health organizations which may be found willing to co-operate with the Medical Society of the State of New York, their special interests can best be advanced through the ranks of the medical profession itself.

This rather superficial outline of the hopes and thoughts of the Joint Committee is submitted to the members of the Medical Society of the State of New York as a partial account of our stewardship. We are ready to give service at once. More later. We hope to stimulate thought and suggestions. We invite correspondence.

CHARLES A. GORDON, *Chairman*,

## A COURSE IN OBSTETRICS

The Medical Societies of the Counties of Jefferson and St. Lawrence have arranged and conducted a valuable course in obstetrics through the initiative of Dr. Page E. Thornhill of Watertown. Dr. Thornhill is Regional Consultant in Obstetrics for the State Department of Health, and after consulting with Dr. S. W. Sayer, District State Health Officer, a course of six lectures and demonstrations was planned under the auspices of the State Department of Health, which met the necessary expenses. After the plan was developed, it was presented to the leaders of the Medical Societies of Jefferson and St. Lawrence Counties, and on their approval the following letter was sent to every member of both societies:

"In an effort to keep abreast with progress in Obstetrics when there is no opportunity locally for post-graduate study, the undersigned physicians express interest in the short lecture and demonstration course in this subject proposed for Watertown. If there can be arranged a course of lectures, to be given during the early spring months by obstetricians from the teaching centers, we promise our regular attendance.

"It is understood that, through the courtesy of the Division of Maternity and Child Hygiene, no expense is attached."

Signed

Nearly all the doctors in both counties signed the note and showed their earnestness by attending the lectures, some driving 35 miles.

The course consisted of six lectures, one a week, beginning April 16, 1925. As finally carried out, the schedule was as follows:

1 April 16—Prenatal Care. Dr. J. O. Polak, F.A.C.S., Professor of Obstetrics and Gynecology, Long Island College Hospital, Brooklyn.

2 April 23—Management of Normal Labor. Dr. J. K. Quigley, F.A.C.S., Obstetrician, Rochester General Hospital, Rochester, N. Y.

3 April 30—Post-Partum Care. Dr. Harold Bailey, F.A.C.S., Associate Professor in Obstetrics and Gynecology, Cornell University Medical College, New York City.

4 May 7—Pathology of Pregnancy (1). Dr. Polak.

5 May 21—Pathology of Pregnancy (2). Dr. Francis Goldsborough, F.A.C.S., Professor of Obstetrics and Associate Professor of Gynecology, University of Buffalo, Department of Medicine, Buffalo, N. Y.

6 June 4—Pathology of Labor. Dr. Bailey.

Each lecturer gave his talk and demonstration twice—in the afternoon at Ogdensburg to the St. Lawrence County doctors, and in the evening to the Jefferson County men. Some doctors from Lewis County also attended. Each Watertown lecture was preceded by a social supper, when the lecturers formed the acquaintance with the doctors. The local physicians supplied cases for clinical demonstrations whenever the subject permitted.

The average attendance at each lecture was about forty-five. The lectures were simple and practical, and dealt with common points of everyday practice. They afforded a striking demonstration of the eagerness of the physicians to hear up-to-date descriptions of modern methods in obstetrics. They are a model which other county

societies may follow with a certainty of success.

Similar courses in other counties may be arranged through Dr C A Gordon, Chairman of the Committee on Public Health and Education of the Medical Society of the State of New York.

F O

## HEALTH OFFICERS' COURSE IN JEFFERSON AND ST LAWRENCE COUNTIES

An extensive course in all phases of modern public health work has recently been completed at Watertown for the benefit of the health officers of Jefferson and St Lawrence Counties. The course was arranged by Dr F W Sears of Syracuse, assisted by Drs S W Sayer, Gouverneur, and C H Hervey, Oswego, all District State Health Officers. Twenty-three health officers enrolled for the course, as follows: Dr John T Fowkes, LaForgeville, Dr John T Fowkes, Jr, Clayton, Dr Elmer E Eddy, Redwood, Dr S C Hollis, Adams, Dr Byron Haskin, Theresa, Dr Oliver J LaFontaine, Chaumont, Dr Charles C K. Phelps, Sacketts Harbor, Dr F Edward Jones, Beaver Falls, Dr Cyrus J Severance, Mannsville, Dr Willard S Perrigo, Antwerp, Dr M D Barnette, Watertown, Dr Stanley W Sayer, Gouverneur, Dr David M Mills, Gouverneur, Dr William H Cramer, Copenhagen, Dr C W Bullard, Black River, Dr T A Lewis, Hammond, Dr G S Farmer, Watertown, Dr R F Gates, Brownville, Dr M M Ryan, Philadelphia, and Dr Frank Loomis, Watertown.

The attendance was over 95 per cent. A fee of \$25 was charged to cover necessary expenses.

The course was held on two mornings of each week, beginning April 14, 1925. Nineteen sessions were held in Watertown, and one in the

State Hospital in Ogdensburg. The class met one week at Syracuse during the meeting of the State Medical Society, and another week in Saratoga Springs at the Annual Conference of Health Officers.

Thirty-one lecturers composed the teaching staff. The subjects included bacteriology, serology, epidemiology, tuberculosis, sewage disposal, mental hygiene, milk and water supplies, goiter, pediatrics, public health administration, school inspection, and medical publicity. The subjects were treated from the standpoint of the physician rather than that of the official health officer.

At the close of the last session the doctors said among themselves: "Now this course has showed us how to do better practice of medicine. Let us show our appreciation to Dr Sears in a tangible way"—and they did by buying him a fine traveling bag.

This is the twentieth course that has been conducted by Dr Sears during the eleven years that he has been connected with the State Department of Health, and over 200 physicians have been under his instruction. The importance of the courses is increased by the fact that about one in every six doctors up-State are health officers, and most of them have taken a course of instruction.

F O

## HEALTH OFFICERS' COURSE IN ALBANY

A Course for the Health Officers in the vicinity of Albany has been directed by Dr Charles C Duryee, Consultant in City Health administration, State Department of Health. It was given under the joint auspices of the State Department of Health and the Albany Medical College. The course began on March 5, 1925 and was held every Thursday until June 18th, with nine extra sessions, making twenty-five days of teaching. The sessions were concluded on June 19th with a dinner at the Ten Eyck Hotel, Albany. Forty-one instructors were listed on the teaching staff, and sixty-one lectures, clinics and demonstrations were given, covering every phase of public health work. The subjects were those which every physician must meet in his daily work, and attendance on the course will make any doctor a better practitioner of medicine.

This is the seventh annual course that has been directed by Dr Duryee, and 175 doctors have

graduated under him. The present class numbered twenty-two, as follows: Dr Charles Bailey, Hudson Falls, Dr Walter S Bennett, Granville, Dr Ray D Champlin, Oneonta, Dr Wm Burgess Cornell, Albany, Dr J C E Daunais, Cohoes, Dr Lyman Driesbach, Middleburgh, Dr James M Dunn, Schenectady, Dr Samuel H Hodgson, Stuyvesant, Dr C D Hulbert, Westerlo, Dr Leonard A Hulsbosch, Fort Edward, Dr James F Johnston, Albany, Dr William R Lee, North Creek, Dr Wilbur F MacDonald, Corinth, Dr Thomas Leo Mahony, Poughkeepsie, Dr Alexander F Mosher, South Glens Falls, Dr William L Munson, Granville, Dr Louis A Parmenter, Corinth, Dr Chas A Prescott, Hudson Falls, Dr Bertrand E Roberts, Albany, Dr Benj W Stearns, Unadilla, Dr W U Taylor, Mooers, Dr Melvin T Woodhead, Amsterdam.

F O

what we are trying to do, and offers his assistance. Progress will come. The Committee hopes that county societies will look to it for assistance, as we are ready to provide clinical programs at once for those that desire them. We will secure and assign teachers at once for those groups who will agree to provide cases for demonstration when required, and have histories, physical examinations and other data written up and available for the lecture. Only in this way can any real good come from the teaching material used.

The State Department of Health has placed at our command its entire list of Regional Consultants in Pediatrics and Obstetrics. This is our most important ready asset.

The Tuberculosis Committees—National, State and County—are organized to aid in health and education, and the staffs of the tuberculosis hospitals are available for clinics and demonstrations. The latest knowledge in the recognition and treatment of tuberculosis could be easily brought within the reach of every physician, as is done now in Suffolk County under the direct auspices of the County Medical Society.

The members of the staffs of the State hospitals for the insane and the mental defectives are available for teaching purposes, for they are most anxious to lend their aid in stressing the importance of early treatment. In the Utica State Hospital one-fifth of the cases have entered the institution of their own accord as a result of clinics conducted in various cities by the staff of the hospital. (See this Journal, August, 1924, page 813.)

Possibly there are many lay health organizations which may be found willing to co-operate with the Medical Society of the State of New York, their special interests can best be advanced through the ranks of the medical profession itself.

This rather superficial outline of the hopes and thoughts of the Joint Committee is submitted to the members of the Medical Society of the State of New York as a partial account of our stewardship. We are ready to give service at once. More later. We hope to stimulate thought and suggestions. We invite correspondence.

CHARLES A. GORDON, *Chairman*,

### A COURSE IN OBSTETRICS

The Medical Societies of the Counties of Jefferson and St. Lawrence have arranged and conducted a valuable course in obstetrics through the initiative of Dr. Page E. Thornhill of Watertown. Dr. Thornhill is Regional Consultant in Obstetrics for the State Department of Health, and after consulting with Dr. S. W. Sayer, District State Health Officer, a course of six lectures and demonstrations was planned under the auspices of the State Department of Health, which met the necessary expenses. After the plan was developed, it was presented to the leaders of the Medical Societies of Jefferson and St. Lawrence Counties, and on their approval the following letter was sent to every member of both societies:

"In an effort to keep abreast with progress in Obstetrics when there is no opportunity locally for post-graduate study, the undersigned physicians express interest in the short lecture and demonstration course in this subject proposed for Watertown. If there can be arranged a course of lectures, to be given during the early spring months by obstetricians from the teaching centers, we promise our regular attendance.

"It is understood that, through the courtesy of the Division of Maternity and Child Hygiene, no expense is attached."

Signed

Nearly all the doctors in both counties signed the note and showed their earnestness by attending the lectures, some driving 35 miles

The course consisted of six lectures, one a week, beginning April 16, 1925. As finally carried out, the schedule was as follows:

1 April 16—Prenatal Care. Dr. J. O. Polak, F.A.C.S., Professor of Obstetrics and Gynecology, Long Island College Hospital, Brooklyn.

2 April 23—Management of Normal Labor. Dr. J. K. Quigley, F.A.C.S., Obstetrician, Rochester General Hospital, Rochester, N. Y.

3 April 30—Post-Partum Care. Dr. Harold Bailey, F.A.C.S., Associate Professor in Obstetrics and Gynecology, Cornell University Medical College, New York City.

4 May 7—Pathology of Pregnancy (1). Dr. Polak.

5 May 21—Pathology of Pregnancy (2). Dr. Francis Goldsborough, F.A.C.S., Professor of Obstetrics and Associate Professor of Gynecology, University of Buffalo, Department of Medicine, Buffalo, N. Y.

6 June 4—Pathology of Labor. Dr. Bailey.

Each lecturer gave his talk and demonstration twice—in the afternoon at Ogdensburg to the St. Lawrence County doctors, and in the evening to the Jefferson County men. Some doctors from Lewis County also attended. Each Watertown lecture was preceded by a social supper, when the lecturers formed the acquaintance with the doctors. The local physicians supplied cases for clinical demonstrations whenever the subject permitted.

## TUBERCULOSIS TEACHING IN SUFFOLK COUNTY

The first class in tuberculosis authorized by the Suffolk County Medical Society has held a two-hour session on every Wednesday afternoon of July in the Suffolk County Tuberculosis Sanatorium under the leadership of Dr E P Kolb, Superintendent of the Institution. The attendance has averaged six, which is the size of the classes that were originally planned. The subjects discussed at the classes have been as follows:

1 Historical—Types, Channels of Infection and Modes of Onset

2 Symptoms and Signs of Incipient Tuberculosis

3 Tuberculosis in Children—Incipient and Advanced

4 Common Complications of Tuberculosis—Laryngeal, Bone, Joint and Abdominal

5 Chronic Non-Tuberculosis Infections of the Lungs, Bronchiectasis, Emphysema, Bronchitis, Lung Abscess, etc

Clinical cases were shown at each lecture, and the modes of treatment were demonstrated.

Another class will be started in September, and the series will be continued until every physician in the County has had an opportunity to learn tuberculosis. Dr Kolb's course has a significance that is more than local. It is a careful laboratory experiment and demonstration of how to teach tuberculosis to average family doctors, simply, clearly, and attractively. F O

---

## SARATOGA COUNTY MEDICAL SOCIETY

A regular meeting of the Saratoga County Medical Society was held at Newman's Lake House, Saratoga Springs, on Tuesday, June 30th, 1925, with 27 members present and the President, Dr J R MacElroy, presiding.

The subject of Graduate Education was discussed at some length, and Dr J S Lawrence, Executive Officer of the State Medical Society, outlined the plans of the State Medical Society. The project was well received by the members, and the meeting appointed Dr Thomas Goodfellow, Saratoga Springs, Dr E J Callahan, Schuylerville, and Dr J R MacElroy, Jonesville, a committee to arrange clinical lectures and courses in instruction in cooperation with the State Society. It was decided to send a questionnaire to all the members of the County Society in order to ascertain their preferences as to subjects. It is

planned to begin a course of instruction about the first of October.

A committee on public health was appointed, consisting of Dr G S Towne, Saratoga Springs, Dr L A Parmenter, Corinth, and Dr William Van Doren, Mechanicsville.

A committee on medical economics was also appointed consisting of Drs Earl King and Miles Varney of Saratoga Springs, and Dr C J Higley, Ballston Spa.

The scientific program consisted of two numbers.

1 Bradley P Kirschberg, Ph G, Dean of the Schenectady Police School, described some of the newer toxicological problems.

2 Dr Ellis Kellert, Pathologist of the Ellis Hospital Laboratory, at Schenectady, spoke on the subject Differential Diagnosis between some Chemical and Bacterial Poisonings.

## CLINICAL MEETING, ORANGE COUNTY MEDICAL SOCIETY

The third monthly Clinical Meeting of the Orange County Medical Society, in co-operation with the Medical Society of the State of New York, was held on July 21st, in the Sullivan Street School House, in Port Jervis, with twenty-three doctors present. Dr. N. B. Van Etten, President of the Medical Society of the State of New York, was also present and received the familiar greetings of many of the doctors who knew him when his father practiced medicine in the city. Dr. Van Etten gave a ten-minute address on the service which the State Society can render to the local physicians. He emphasized the importance of closer affiliation with the State Medical Society and of Fellowship in the American Medical Association, the necessity of one hundred per cent membership in the Group Insurance plan of the State Society, and the value to all physicians of co-operation in the post-graduate medical education plan of the State Medical Society.

The scientific part of the meeting consisted of a clinic on general Pediatrics by Dr. Charles Hendee Smith, Clinical Professor of Diseases of Children in the College of Physicians and Surgeons, New York, and Director Children's Division, Bellevue Hospital, New York. He demonstrated his points upon cases which were brought to the meeting place by the physicians of the city about an hour previous to the clinic in order that they might be examined and classified without loss of time during the clinic.

The first three children were cases of mental deficiency, all due to mongolism of different degrees. The mental condition of these children was entirely the result of their physical state. They are often the last of several children or the first of a very young mother. Dr. Smith brought out the necessity of an accurate diagnosis in these cases. They are often mistaken for cretins, but thyroid and other glandular extracts are useless as is also any other form of medication. Special mental training helps the milder cases to some extent.

The next case was one of acute stomatitis which Dr. Smith said was infectious, and self limited. It was best treated with mild, soothing applications, and food which is not sweet, salt or sour, i. e., cereals and diluted milk. Its interest

is largely in the diagnosis, since it is often not appreciated that an inflammation of the mouth may be the cause of a fever. These children are often very sick.

The fifth case was a nine-months-old baby, poorly nourished. It was the only survivor of five children. Two former children had died from what was diagnosed as chronic diphtheria because of a persistent reddish discharge from their noses. This one also has a nasal discharge and general enlargement of the superficial lymph nodes.

The diagnosis was plainly lues, but a blood specimen of the parents had been reported negative, although the father has a perforated nasal septum.

Although the child needs a correct diet, treatment of the lues was also necessary before it would improve.

The next two cases had rickets in rather severe forms. Both were pale and white, and neither had been exposed to direct sunlight, although they were put out of doors every day "to get the air" on a porch under the trees.

Dr. Smith gave an interesting talk on the importance of sunlight in the prevention of rickets, and said that the exposure of the face, hands and feet to the direct sunlight for part of every day, would almost surely prevent a child from developing rickets, but the exposure must be to the direct sun and not through glass.

The last case was a child four years old, who was thin and weak, had no appetite, and could not be made to eat. Dr. Smith said that these children were in a chronic state of fatigue, and that the first essential was to treat the fatigue. The treatment outlined was that the child should be put to bed and kept there with its toys and playthings. The proper food should be brought to the child's bed without comment, and in half an hour should be removed, still without comment. The child will eat as it gets over its fatigue, and will get up and continue to eat when it is fully rested.

The series of clinics will be continued as a demonstration of the co-operation between the county societies and the State Medical Society through its Committee on Public Health and Education.

F O

tific Programs?—Dr G J Curry, of Flint, Secretary of the Genesee County Medical Society

4 Aids in Secretarial Work—Dr H L French, of Lansing, Secretary of the Ingham County Medical Society

5 Community Responsibility and the Work of the County Society—Dr D F Kudner, of Jackson, Secretary of the Jackson County Medical Society

6 Co-operation With County Medical Societies—Mr H G Smith, Executive Secretary of the State Medical Society

7 Round Table Discussions—Conducted by Dr Warnshuis

Each subject was presented briefly and concisely, and within five minutes, and then followed a general discussion. The topics centered around the specific major activities which are promoted by the State Medical Society. The talks might be divided into three groups of subjects

1 Inspirational, and the statement of fundamental ideals

2 The broad activities of the State Medical Society

3 The details of the execution of the plans by the State and County Medical Societies

Dr Warnshuis stated the four fundamental ideals of a County Medical Society to be

1 To enlist and interest all the eligible members of the profession in your county in the work of your County Society

2 To cause your Society to enhance the type of medical service in your community

3 To re-awaken the spirit of organized effort for the attainment of the mastery and honor of our profession

4 To beget professional fellowship

These are specific understandable ideals, and for the purpose of attaining them, Dr Warnshuis makes four specific suggestions which are the major activities of the State Society. These suggestions are as follows

1 Bring about better scientific programs for your regular meetings

2 Foster, inspire, and institute with the aid of selected members, an increasing number of public meetings for the education of the public in regard to scientific medicine

3 Adopt and develop a plan of periodic physical examinations

4 Join with and assume directing control of all public health work, clinics and hospitals in so far as medicine is involved. (This last suggestion embraces what we have called the practice of Civic Medicine—The Editor)

A study of the minutes of the Secretaries' Conference gave us the impression that the four

major means for carrying out the activities of the State Society were

1 The Journal of the Michigan State Medical Society

2 The field work of the Executive Secretary

3 The Joint Committee on Public Health Education

4 District conferences

The Joint Committee on Public Health Education was formed in 1922 on the initiative of the Michigan State Medical Society. The organizations which were represented on the Committee are the State Medical Society, the University of Michigan, the Detroit College of Medicine and Surgery, the State Department of Health, the State Dental Society, the Michigan Tuberculosis Association, the State Nurses' Association, the State Conference of Social Work, and the Wayne County (Detroit) Committee on Education

The object of the Joint Committee is to supply popular lectures on medical topics to lay organizations. The Committee has about 200 speakers listed. During the past year, the Committee arranged for 271 lectures, at which the average attendance was 289 persons

At least nine district conferences have been held. The May Journal, page 268, and the June Journal, page 330, carry brief accounts of two conferences which are called Post Graduate Conferences. The programs consisted of all day scientific and clinical sessions, broken at noon by a luncheon by a Rotary or other civic club, and an evening popular session under the auspices of a civic organization, such as a Parent-Teacher's Association. The account in the June Journal concludes

"The ninth Post-Graduate Conference has brought more proof to the fact that Post Graduate Conferences that are conducted by the State Society in co-operation with councilor districts, and County Societies are what the members of these Societies desire"

When we analyze the suggestions made by the county secretaries, we find a wealth of details

Regarding programs, we note the following plans which have been used

1 Teams of members to arrange programs

2 Exchange of speakers with other Societies, or one Society to put on a program for a neighboring Society

3 Clinical programs like those of a staff meeting of a hospital

4 Social activities—lunches and picnics

As aids to secretarial work we note

1 Getting committees to do the details of the secretary's work

2 Clerical assistance to attend to mailing and filing



# OUR NEIGHBORS



## STATE MEDICAL JOURNALS

Anyone who wishes to be broad minded, up to date, and efficient, must know what other people are doing in his line of work. We have had our hands full doing the necessary work that belongs to the editorial office, but now that the summer season has come when doctors prefer fishing to reading, we have an opportunity to study what our neighbors have to say about themselves.

There are thirty-one medical publications which are the organs of forty-one state medical societies. There are only seven state medical societies that have no published organs. We receive the *State Journals* through our exchange list, and have set ourselves to the pleasant task of interpreting the civic activities of the leaders of the several State Medical Societies as they are revealed in the *Journals*.

We are aware of the modesty of physicians generally, and realize that they usually do much more than they tell about. Yet their practice of civic medicine is done by groups as the doctors are associated in county, state, and national societies. We are especially interested in the work of medical groups, and in what they are doing both for themselves and also for the people generally. We can get this information from the statements of the objectives and ideals of the leaders as told in their society meetings, and from the records of their achievements as shown by their reports.

We are beginning what we hope will be a permanent feature of this *Journal* as we review the work of the Michigan State Medical Society, and give our impressions of the publication of a county medical society in Pennsylvania. F O

## THE CONFERENCE OF SECRETARIES OF THE COUNTY MEDICAL SOCIETIES OF MICHIGAN

The *Journal* of the Michigan State Medical Society is the official organ of the State Society and of its 56 constituent county societies. The present membership of the State Society is about 3,000 out of 4,500 physicians in the State. The form of organization of the State Society is almost exactly like that of the Medical Society of the State of New York. There are the House of Delegates, the Council, the Executive Committee, and the Executive Officer who, however, is a layman in Michigan.

The *Journal* is in reality the organ of the State Medical Society, and records and reflects its activities. Its editor is Dr. F. C. Warnshuis, of Grand Rapids, who is also Secretary of the State Society. Dr. Warnshuis is also speaker of the House of Delegates of the American Medical Association and, having seen him preside over the National body, we expected that his editorials and reported addresses would be concise and carry extremely definite suggestions—and we found them even so.

The Departments of the *Journal* cover the range of activities of the Society. That of *Editorial Comments* is in addition to the formal editorial pages, and carries running comments on the medical news of the month, such as one thoughtful doctor would make to another during a casual conversation. There is a department devoted to Society work and its planned activities. The meetings of the County Medical Societies

are reported in an interesting style, but an editorial urges that more reports be sent.

The June number of the *Journal* of the Michigan State Medical Society contains a 28-page stenographic report of a conference of the secretaries of the county medical societies which was held in Grand Rapids on April 22nd, and lasted from ten until five o'clock. We have read the report from end to end, and have made marginal notes to indicate the points of the speakers, and we have thereby gotten the spirit and the point of view of the leaders who are promoting the practice of civic medicine in the State of Michigan.

The Conference was attended by fifteen county secretaries, three councilors, and four high officers of the State Society, including President Clancy, who presided. The total attendance was twenty-two.

The subjects discussed included the major activities of the State and County Societies, and showed that the officers of the State Society have practical plans which can be put into operation throughout the State. The program was as follows:

- 1 Activities of County Societies—Dr. J. B. Jackson, Chairman of the Council
- 2 The Spirit of Modern Organized Effort—Dr. F. C. Warnshuis, Secretary of the State Society and Editor of its *Journal*
- 3 What Are Desirable Features of the Scien-



tific Programs?—Dr G J Curry, of Flint, Secretary of the Genesee County Medical Society

4 Aids in Secretarial Work—Dr H L French, of Lansing, Secretary of the Ingham County Medical Society

5 Community Responsibility and the Work of the County Society—Dr D F Kudner, of Jackson, Secretary of the Jackson County Medical Society

6 Co-operation With County Medical Societies—Mr H G Smith, Executive Secretary of the State Medical Society

7 Round Table Discussions—Conducted by Dr Warnshuis

Each subject was presented briefly and concisely, and within five minutes, and then followed a general discussion. The topics centered around the specific major activities which are promoted by the State Medical Society. The talks might be divided into three groups of subjects

1 Inspirational, and the statement of fundamental ideals

2 The broad activities of the State Medical Society

3 The details of the execution of the plans by the State and County Medical Societies

Dr Warnshuis stated the four fundamental ideals of a County Medical Society to be

1 To enlist and interest all the eligible members of the profession in your county in the work of your County Society

2 To cause your Society to enhance the type of medical service in your community

3 To re-awaken the spirit of organized effort for the attainment of the mastery and honor of our profession

4 To beget professional fellowship

These are specific understandable ideals, and for the purpose of attaining them, Dr Warnshuis makes four specific suggestions which are the major activities of the State Society. These suggestions are as follows

1 Bring about better scientific programs for your regular meetings

2 Foster, inspire, and institute with the aid of selected members, an increasing number of public meetings for the education of the public in regard to scientific medicine

3 Adopt and develop a plan of periodic physical examinations

4 Join with and assume directing control of all public health work clinics and hospitals in so far as medicine is involved. (This last suggestion embraces what we have called the practice of Civic Medicine—The Editor)

A study of the minutes of the Secretaries' Conference gave us the impression that the four

major means for carrying out the activities of the State Society were

1 The Journal of the Michigan State Medical Society

2 The field work of the Executive Secretary

3 The Joint Committee on Public Health Education

4 District conferences

The Joint Committee on Public Health Education was formed in 1922 on the initiative of the Michigan State Medical Society. The organizations which were represented on the Committee are the State Medical Society, the University of Michigan, the Detroit College of Medicine and Surgery, the State Department of Health, the State Dental Society, the Michigan Tuberculosis Association, the State Nurses' Association, the State Conference of Social Work, and the Wayne County (Detroit) Committee on Education

The object of the Joint Committee is to supply popular lectures on medical topics to lay organizations. The Committee has about 200 speakers listed. During the past year, the Committee arranged for 271 lectures, at which the average attendance was 289 persons

At least nine district conferences have been held. The May Journal, page 268, and the June Journal, page 330, carry brief accounts of two conferences which are called Post Graduate Conferences. The programs consisted of all day scientific and clinical sessions, broken at noon by a luncheon by a Rotary or other civic club, and an evening popular session under the auspices of a civic organization, such as a Parent-Teacher's Association. The account in the June Journal concludes

"The ninth Post-Graduate Conference has brought more proof to the fact that Post Graduate Conferences that are conducted by the State Society in co-operation with councilor districts, and County Societies are what the members of these Societies desire"

When we analyze the suggestions made by the county secretaries, we find a wealth of details

Regarding programs, we note the following plans which have been used

1 Teams of members to arrange programs

2 Exchange of speakers with other Societies, or one Society to put on a program for a neighboring Society

3 Clinical programs like those of a staff meeting of a hospital

4 Social activities—lunches and picnics

As aids to secretarial work, we note

1 Getting committees to do the details of the secretary's work

2 Clerical assistance to attend to mailing and filing

3 Use of the telephone to get members to the meetings

4 Send accounts of the meetings to local newspapers

We note the following suggestions for meeting the community responsibility of County Societies

1 Close co-operation with the local boards of health

2 Medical publicity to the people

3 Periodic health examinations

4 Medical legislation (We find little said on this subject)

5 Charitable activities, especially those in co-operation with lay organizations. There was a lengthy discussion regarding orthopedic clinics conducted by Rotary Clubs, and the consensus of opinion seemed to be that local doctors should direct the medical phases of the clinics, and the laymen the business part, both working in harmony

Mr H G Smith, Executive Secretary, said that his work was to co-ordinate the activities of the County Societies by three general methods

1 Visiting County Societies and making medical surveys of the counties

2 Arranging district conferences

3 Legislative work during the session of the Legislature

Dr Warnshuis demonstrated his ability as a presiding officer by his management of the round table discussions, and his definite summary of the points brought out. After the subject of new members had been discussed for some time, Dr Warnshuis said that he would expect each county secretary to send him a list of non-members whom the Society would be willing to accept, and that he would write each one a personal appeal to accept an invitation to join.

We feel that our study of the minutes of the Secretaries' Conference and of accounts of the activities of the State Society that are printed in the Journal, has aroused our deep interest in the work of the Michigan State Society, and a desire to make the personal acquaintance of the leaders who are doing original work in the practice of civic medicine in Michigan. F O

## PROGRAM TEAMS

The Journal of the Michigan State Medical Society for July, 1925, page 401, contains a description of a new plan for programs of county medical societies. It is called the "Team Program Plan," which means that a team of from two to five men shall prepare a program on a given subject, and shall develop all phases of it, and be prepared to go to a neighboring county society and present it.

The plan was the result of the request of some of the smaller county societies that they be given assistance in making up their programs. The first call for assistance came from Alpena County on the northeast corner of the lower peninsula, whose population is 17,000 and is diminishing. The county society that responded was that of Bay County at the head of Saginaw Bay which has a growing city of 47,000 population. Bay County sent a team of five men who put on a

demonstration, to the great satisfaction of the doctors of Alpena County.

This plan is worthy of consideration by the Committee on Public Health and Education of the Medical Society of the State of New York. It benefits both the giver and the receiver, and stimulates interest in both societies. It solves to a great extent the problem of how to develop local talent. It is easy to send a speaker who will pour information over an admiring audience of doctors, it is quite another feat to get those same doctors to tap the springs of wisdom in their own midst. If only an individual doctor assumes to teach the rest, he is likely to be opposed, but if a team of doctors is appointed to present a subject in the name of the Society, the personal element is absent, and the Society is praised.

F O

## MONTHLY BULLETIN OF THE MEDICAL SOCIETY OF LYCOMING COUNTY, PENNSYLVANIA

We confess to some degree of envy when we received the June number of the Medical Bulletin, the official publication of the Lycoming County Medical Society in Pennsylvania. We had met the Associate Editor at the A M A meeting in Atlantic City, and he had told us that

his County Society had been publishing a Monthly Bulletin for years. We found that the current number is Volume Fifteen.

We then looked up the statistics of Lycoming County and found that its area is 1,220 square miles, and its population 83,100, distributed in

the city of Williamsport, 36,198, in seven villages, 29,388, while 17,514 people live outside the cities and villages

The city doctors number 60, those in the villages, 32, while 7 practice in strictly rural communities. Ten live out of the county.

The Lycoming County Medical Society has 109 members. So much by way of statistics.

The Bulletin consists of fourteen pages of live reading matter, and an equal number of advertisements largely of local firms. There are 275 copies printed monthly at a cost of \$83, which is largely met by the advertisements.

One of the first articles is one with the title "Attendance." It gives the number of members who have attended the regular monthly meetings of the Society during the last six months, and the average is seventy-five. Think of that, ye members of county medical societies in New York State!

Now, we chronicle a more surprising thing. The Editor considers it noteworthy that eleven members had failed to attend any of the six meetings, and then he proceeds to give the names and addresses of those 11 non-attending members!

The Bulletin carries a five-page description of the May meeting of the Society, and gives the names of the 80 members and 50 guests who attended the meeting. The program consisted of clinical demonstrations of 35 cases in the Williamsport Hospital by Drs. Thomas A. Shallow, Demonstrator of Clinical Surgery of the Jefferson Medical College, and Dr. Ross V. Patterson, Dean of the College. When we read this account, we felt that the Medical Society of New York State has a fine example to emulate in its promotion of clinical programs for county societies.

We also note that the Medical Society is actively engaged in the practice of civic medicine, as the following resolution shows:

*"Whereas*, The Lycoming County Medical Society has been given official recognition in the charter of the Williamsport Hospital, and thereby has assumed a definite responsibility in its affairs, and

*"Whereas*, it has always been the purpose of this Society to encourage any move that will develop scientific medicine among its members and provide better care for the sick, and

*Whereas*, we believe the effort now being

made by the staff and physicians of the Williamsport Hospital, and the hospital management, having for its purpose meeting the requirements of the College of Surgeons and the State of Pennsylvania in the way of detailed study of cases and case records to be a move that will increase the value of the Hospital in this community, provide better care for the sick, and encourage a higher type of scientific medicine among physicians practicing in the hospital,

*"Therefore, Be it Resolved*, that this Society, now assembled in regular session, and fully recognizing and accepting our responsibility in this matter hereby give our unqualified endorsement to this effort, and pledge our entire support to it.

*"Further, Be it Resolved*, That we urge each and every member of this Society who may have work in the hospital to give his personal support to this plan by following to the letter the plan of the staff and hospital to establish higher working standards in the hospital, and

*"Therefore, Be It Resolved*, That we assure the Board of Managers of the Hospital that we, as a Society, have assumed our proper share of the responsibility in this move and will at all times support the Board of Managers in their efforts to have this plan stand on its merits and be entirely acceptable to the College of Surgeons and the Bureau of Licensure of the State of Pennsylvania, and in the enforcement of any and all proper rules and regulations adopted to effect the desired end.

*"Further, Be It Resolved*, That this resolution be entered upon the minutes of this meeting and that a copy be transmitted to the Board of Managers of the Williamsport Hospital.

"By unanimous action, the Board of Directors recommend to the Society the adoption of the resolutions."

There is also a notice that at its next meeting the Society will elect two members of the Board of Managers of the Hospital.

The Bulletin carries an article on vomiting, a page describing the A. M. A. meeting, several poems, a page of personals, some jokes, and a cross-word puzzle.

It does us good to learn about the Bulletin and its most gratifying feature is that it is published by a medical society of an up-state county containing only 109 doctors. This is indeed a challenge to the county medical societies of New York State.



# NEWS NOTES



## THE MEDICAL FIELD SERVICE SCHOOL AT CARLISLE

We have just returned from a two-weeks' course for Medical Reserve Officers of the Army in the Medical Field Service School at Carlisle Barracks, Pennsylvania. We were of 254 medical officers, ranking from full colonels to lieutenants. Of these 21 were from New York State, as follows:

Colonels S. J. Kopetzky (the officer of highest rank in the School) and Harlow Brooks, of New York; Lieutenant Colonels W. G. Noe, New York, and H. A. Steckel, Binghamton; Majors F. W. Allen, Ithaca, S. Block, C. F. Claasson and E. M. Sutliff, of Brooklyn; Carl Boetiger, Forest Hills; E. C. Joyce, P. Lehman, L. H. Cornwall, P. I. Lipsott, H. C. Saunders, and U. Pascole, of Manhattan; B. S. Harwood, New Brighton; F. Overton, Patchogue; and M. Schley, Buffalo; Captain W. J. McGrath, Sylvan Beach; and Lieutenants E. Donheiser and T. Rosenthal, Manhattan.

There were also 530 medical, dental and veterinary students belonging to the Reserve Officers' Training Camps maintained in the professional schools east of the Mississippi River. These were taking a six weeks' course under the same field conditions as the medical officers.

All the physicians and medical students lived in tents in an alfalfa field, and followed a field service routine in all respects. We marched to classes and to meals, and all were on an equality with no distinctions as to rank. We sat on the grass while we listened to demonstrations in the field, and we stood up and recited our lessons in the class rooms. We studied the modern organization of the Army and the methods of work of its Medical Department. Most of us had seen

active service in the World War, and we were gratified to find that the deficiencies and intricacies of the methods used in the war have been simplified and standardized. We were amazed at the knowledge of details shown by our instructors, and by the clarity of the "clinical" methods of instruction as they demonstrated litters, and ambulances, and hospital tents, and sanitary appliances. A sham battle was staged on the golf field in order that medical officers might visualize an actual battle, with the air service and chemical warfare service assisting the foot troops. Another day aid stations were established on an imaginary battle front five miles away from Camp, and a number of soldiers were "planted" over the field tagged as if for wounds. Medical students of the R. O. T. C. found the men, gave first aid treatment, and transported them to aid stations, collecting stations and ambulances, and finally entered them in the hospital, exactly as they would do in a battle. The physicians of the Reserve Corps went with the R. O. T. C. boys, while the instructors of the School explained all the steps of the process. The "Clinical" method was followed in every respect.

We helped to get out a school publication called *Caduceus*, which contained a roster, jokes, cartoons and personal references, which will help the officers to recall a very pleasant fortnight spent in camp.

The Medical Field Service School is an essential part of the preparedness program of the Army of the United States. It also supplies information which is of great value to any doctor in his civic duties, such as organizing and managing hospitals. (See page 864)

F. O.

## BRONX COUNTY MEDICAL SOCIETY

A regular meeting of the Bronx County Medical Society, held at Montefiore Hospital on June 17, was called to order at 9 P. M., the Second Vice-President, Dr. Goldberger, in the chair.

The following candidates were elected to membership: Abraham Louis Framer, Matthew S. Goldman, Benjamin Posinka, Lincoln M. Saulpaugh.

Dr. Podvin presented the following Report of the Building Committee:

The Committee has held several meetings within the past six weeks and considerable enthusiasm has developed in the plan of securing a permanent Home for the Bronx County Medical Society. Several plans have been advanced. One plan is

that we try to establish a Professional Building composed of the Medical Profession, the Legal Profession, the Dentists, and the Pharmacists. Another is that we erect a building for the use only of the members of our Society. The members of the Committee felt more favorable to the latter plan, and would only consider co-operating with other organizations when convinced that it would be impossible for the Society to build alone.

It was also decided, before we enter upon this very important venture, that we call a meeting of some of the prominent men in the Borough, outside of the medical profession, who have been interested in public affairs, in order to secure

their advice as to the best way to go about this project.

Before any definite action can be taken, it is necessary that we know whether or not the individual members of this Society are in favor of this project, and the only way we can find out is to ask them to contribute. Every member of the Comitia Minora and of the Building Committee has expressed a willingness to contribute to this fund. It was the intention of the Committee to place the matter before the members at this meeting, asking all members who will have been practicing medicine for at least five years in October, 1925, to pledge themselves to the donation of Fifty Dollars, payable in two installments, one half during 1925 and the other half in 1926, or the whole amount at one time, and all physicians practicing for less than five years to pledge themselves to the donation of Twenty-five Dollars, also payable in two installments. The Committee has decided to postpone action until the fall when it will be necessary to have the assurance of at least eighty or ninety per cent of the membership that it will co-operate in order that the project be carried on.

Dr Friedman, for the Committee on Public Health, reported that the Committee is working on various Periodic Health Examination Forms, and also requests additional names of doctors to volunteer for physical examinations.

The scientific session consisted of a clinical program arranged by Dr E M Boss and other members of the staff of the Montefiore Hospital, as follows:

1 Cases Illustrating Pain as the Initial Symptom of Various Nervous Disorders Walter M Kraus

2 Vascular Diseases of the Extremities, Illustrating Methods of Treatment Harold Neuhoof, Ira Cohen

3 Cases Illustrating Thoracic Operations in Pulmonary Tuberculosis Julius Gottesman, Jerome M Ziegler

4 Cases Illustrating Different Types of Hypertension Ernest M Boas

5 The Clinical Interpretation of Thoracic Radiograms (Lantern Slides) Maurice Fishberg

The meeting adjourned at 11 10 P M

I J LANDSMAN, Secretary

## SUFFOLK COUNTY MEDICAL SOCIETY

The regular semi-annual meeting of the Suffolk County Medical Society was held in the County Tuberculosis Sanatorium, Holtsville, on May 21, 1925, with President George H Schenck presiding, and 38 members present. The meeting was also attended by three visiting physicians, two lay officials, and five public health nurses.

Four new members were elected, and five members were accepted by transfer from other societies.

The following resolution was unanimously adopted:

*Resolved*, that the Legislative Committee of this Society be increased to five members, and that such Committee be instructed to interview the County Political Committees with a view of securing the nomination of candidates for election to the Legislature who will be guided in matters pertaining to public health and treatment of the sick by the Suffolk County Medical Society, and be it further

*Resolved*, that the members of this Society here present agree to use their influence in behalf of the candidates recommended by the Committee, and to vote in a non-partisan manner in case only one of the political parties will accede to the requests of the Legislative Committee of this Society.

The following is the membership of the Legislative Committee, as finally appointed:

Dr W H Ross, Brentwood, Chairman

Dr Guy H Turrell, Smithtown Branch

Dr J H Marshall, Southold

Dr George H Schenck, Southampton

Dr J S Ames, Babylon

A public health committee was appointed, consisting of Drs G H Turrell, David Edwards, and B P MacLean.

Dr John E Jennings, President of the Medical Society of the County of Kings, gave a ten-minute talk on Graduate Education, and outlined a plan by which the Graduate Education system of Brooklyn could be extended to Suffolk County as had already been done by the group constituting the South Side Clinical Society which centers about the South Side Hospital in Bay Shore (see this Journal, April 3, 1925, page 587, April 17, page 653, and the May issue, page 735).

Dr E P Kolb, Superintendent of the Tuberculosis Sanatorium, outlined a course of five clinical lessons on tuberculosis to be given to small groups of physicians who would agree to come to the sanatorium once a week. The plan was unanimously endorsed by the Society, and a class of eight was formed at once.

The Society discussed the matter of the appropriation of money by the State Society for the promotion of Graduate Education, and the following resolution was adopted:

*Resolved*, that this Society request the Council of the Medical Society of the State of New York to appropriate the sum of \$1,000 to each District

Branch to be used for the promotion of Graduate Education in the district

Milk problems in Suffolk County were scheduled for discussion during a ten-minute period, but the reports from several health officers showed such a widespread interest in the tuberculosis testing of cattle and the scoring of dairies that the discussion lasted an hour without a dull moment

A half-hour clinic on the twenty or more malnourished children in the Sanatorium was given by Dr E P Kolb, Superintendent, and Dr Frank H Richardson, Chairman of the Com-

mittee on Education of the Brooklyn Pediatric Society

The meeting consisted largely of animated informal discussions of topics connected with the practice of civic medicine. Several motions were carried thanking the several speakers, and at the end the Society adopted the following resolution of Dr W H Ross

*Resolved*, that the Society thanks the forward looking members who are waking up to the importance of the practice of public health

FRANK OVERTON, *Secretary*

### MEDICAL SOCIETY OF THE COUNTY OF ULSTER

The Medical Society of the County of Ulster held the April meeting at McCabe's restaurant

Communications were received from the Board of Managers of the Kingston City Hospital and the Kingston Academy of Medicine approving the Erie County resolutions on "Nurse Training"

On motion of Dr Norwood, the following resolutions were unanimously passed

"Resolved, That the Delegate of this Society to the State Society be and hereby is instructed to use every effort to secure action by the next House of Delegates looking toward the introduction by the State Legislative Committee of a bill embodying the Erie County resolutions on similar ideas regarding the training of nurses

"Resolved, That the Delegate be also instructed to work for the establishing in the State Society of a Standing Committee on Nurse Training,

whose duty it shall be to advise with the State Legislative Committee on all proposed legislation touching this question"

Dr Mary Gage-Day brought up the question of the Gorgas Memorial, and on motion of Dr Chandler, it was unanimously voted that the Medical Society of the County of Ulster give one hundred dollars (\$100.00) toward the memorial

Dr John J O'Leary gave a paper on "The Child and the Hospital" He emphasized the point that comparatively few children are cared for in hospitals. He also brought out the idea that so much of the meddling and interference by neighbors with the treatment would be done away with and the doctor would have the assurance that his directions would be intelligently carried out

MARY GAGE DAY,  
*Secretary Acting*

### MEDICAL SOCIETY OF THE COUNTY OF WASHINGTON

The Semi-Annual Meeting was held at Greenwich, May 26, 1925 Vice-President in the Chair

The Secretary presented the matter of the old Secretary's Book On motion, Dr Banker was authorized to select a suitable place to store the book and such other historic books as the society may possess

Dr Senftner from the State Department of Health, gave an exhaustive report on the use of antitoxin and toxin-antitoxin in the treatment and immunization of diphtheria

Following an adjournment for dinner, the afternoon meeting was called to order at 2 p m The President in the Chair

The Vice-President gave an address "On the

Diagnosis of Non-traumatic Acute Surgical Conditions of the Abdomen"

Miss Killrain asked for the opinion of the society on the proposition of extending the tuberculosis work to other branches of welfare work The President appointed Dr Davies Chairman of a committee to investigate the subject and report at the fall meeting

Drs Prescott, Rogers and Vickers gave a very thorough study of sixty cases of acute appendicitis as observed and treated in the Mary McClellan Hospital

Dr Morgan gave a very interesting paper upon the management of the tubercular patient as carried out in the Metropolitan Sanitarium at Mt McGregor, emphasizing the importance of rest



# THE DAILY PRESS



We started this Department of Daily Press in order to relay medical news items to our readers. We soon became interested in a study of the kind of items which the newspapers carried, and of the effect which the items have on popular thought and opinion. We recorded some of our observations and made suggestions as to how certain items could have been presented in a more effective form, so that the articles would carry more scientific information, and give the essential basis on which the information is founded.

Scientific information is likely to be cold and uninteresting, but yet a bit of it explains the reasons for certain actions taken by experts. If, for example, there is trouble over quarantine regulations, a statement as to how the disease spreads will illuminate and make plain the whole discussion. On the other hand, a scientific item on how the various diseases spread will be unprofitable, for no one will remember the details.

We have also studied the sources from which editors get their medical items.

A year or two ago the principal source was state-wide lay organizations which used the press for their propaganda, but for some months these organizations have made less use of the press. This is unfortunate, for one of the greatest values of lay organizations in public health is to educate the people regarding modern developments in medicine.

Local lay organizations are prolific sources of health items. Parent-teachers associations, tuberculosis committees, clinic organizations—all these do excellent work which is interesting to the people.

Official departments and boards of health are always sources of news. Court proceedings in health matters, and complaints of indignant citizens make spicy reading. Vital statistics and warnings of epidemics have less appeal. The official health authorities are making good use of newspaper space.

Professional health writers are also a source of items, especially of health columns. Many departments of health give out bulletins regularly which are widely used. They often lack force because they are propaganda rather than news. A vaccination article is usually mere propaganda, but it becomes vital news when a serious accident is ascribed to vaccination, or a smallpox outbreak develops.

The least used source of health items is the one from which we would naturally expect the greatest number of items to come. We refer to the doctors themselves. Last month

we found only eight clippings of articles that were supplied by doctors themselves, and this month we found only two or three. We believe that the ignorance of the public regarding medical matters is due very largely to the failure of the doctors to enlighten them through the most evident channels—the public press.

We ascribe the failure of doctors to give out health news to two causes:

1. A wrong interpretation of the principles of medical ethics.

2. A dislike to write composition.

Doctors complain loudly about the ignorance and indifference of the public toward medical topics. They make a correct diagnosis, but they do little in the way of treating the public to more information.

The day has passed when medical ethics prevent any doctor from giving out medical publicity items. The real reason why doctors do not give out medical items is that they just don't like the bother of writing them.

Two conditions are of extreme importance in effective medical publicity—1, timeliness, and 2, personality.

The great defect with most medical publicity is that it has no immediate practical application to the people. Departments of health send out columns of general information, but very little of it sticks, because no one is vitally interested in it. But let a diphtheria epidemic break out, and every person in the community is at once interested in antitoxin, Schick testing, and toxin-antitoxin immunization.

We believe that in every community there is always some medical topic in which the people are vitally interested. Therefore, it is wise for medical men to use these topics as subjects for publicity articles, and to write about them while they have a live interest.

The readiness of the people of a community to read medical articles may be compared to the fertility of a soil. When the soil of a community is freshly plowed and fertilized and watered, then is the time to plant the seed of medical truth and inspiration. Seed planted under such conditions will produce a crop a thousand times greater than that sowed broadcast without regard to the soil or season.

But the seed is of equal importance with the soil. Almost any medical topic is perfectly good, vigorous seed, but it lacks one little element to make it grow. That element is the personal name of some doctor who is known in

the community where the article will circulate. It is all very well to say "Truth is mighty and will prevail," and "We doctors can't use any newspaper tricks to get truth across to the public." The stubborn fact of the psychology of publicity is this **ALL NEWSPAPER PUBLICITY IS BUILT AROUND PERSONS**

Newspaper stories are mostly biographical. Someone gives a big party, and the reporter goes to great trouble to get a long list of names of those who were there. Why? Because the party itself is of small importance and interests few readers, but every reader looks through the list of those present, and will hail his friend the next day. "I see by the paper that you were at the swell party last night."

This same principal applies to medical publicity. For example, a county medical society has a meeting. This in itself arouses little or no interest. But the article gives the names of the doctors who were present, and everybody in the town wants to know what great thing has led his doctor to drop work to go to a meeting. The psychology is that the meeting must have been important if the doctors took the trouble to attend it, and when the people ask what it was all about, the reporter can tell them. The article as he prepares it will start out with about five lines telling what doctors were there, and then will follow fifty lines of a description of the meeting and the medical topics that were discussed. The presence of the doctor is the principal news item, and in relation to it the description of the work of the society is only secondary in the opinion of the editor and people.

We doctors may say that this is a foolish sort of psychology, nevertheless it is a scientific fact which doctors may do well to heed.

If medical publicity is to be accomplished, doctors must lend their names to the articles, and it is perfectly ethical for them to do so.

Now for a couple of concrete illustrations of what we mean.

The United States Army is the victim of unpreparedness which can be remedied by proper publicity. People do not know how many thousands of earnest peaceful men are attending army camps and army schools during this very Summer. If they did know, they would say "There must be a lot in prepared-

ness if Dr. Blank gives a month of his time in an army camp." The news that the doctor was in the camp is the strongest possible argument for preparedness, and a pacifist newspaper that would not mention preparedness will give half a column of space to the news of what the doctor did in the camp.

We were at the Army Field Service School at Carlisle, Pennsylvania, as we have reported on page 884 of this Journal, and we wanted to get a description of the camp printed in the Brooklyn Daily Eagle. We sent a description of the school to that newspaper and enclosed with it a list of the names of Long Island men who were there and a number of photographs of the school. The article promptly appeared with every name printed and a photograph of three doctors well known in Brooklyn and with only a few lines relating to the school. But the object of the article was well accomplished because the headlines featured the school. We presume some will be so unkind as to suggest that we sought publicity for ourselves, but no one has done so yet, and on the contrary many persons have commented on the school to which we went.

A second illustration. We attended a health officer class conducted by Dr. F. W. Sears in Watertown and lectured on the topics of medical publicity. In the afternoon we practiced what we preached and called on the reporters of the local newspapers and gave them a description of the course of instruction and of the interest shown by the doctors of Jefferson County. We have received clippings from four newspapers, all of which used the story because of the personal appeal of the doctors who attended the course.

The Committee on Public Health and Education may well consider the proposition that each county society shall have a committee on publicity whose duty it shall be primarily to send to every newspaper in the county an account of the meetings of the medical society, and, secondarily, to prepare and send out articles on live topics in which the doctors of the county are interested.

We believe that publicity efforts along this line will produce far better results than publicity along other lines. Effective health education cannot be dropped on a people from a central state authority. It must come from the doctors within the community. F. O.



# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL. 25, No 20

NEW YORK, N Y

SEPTEMBER, 1925

## PROSTATECTOMY \*

Emphasizing the Present Day Factors of Safety

By PARKER SYMS, M D,

NEW YORK CITY

THERE is no problem in surgery that demands a more careful exercise of judgment and sagacity than the care of men suffering from prostatic obstruction. These patients are old both in years and in physiology. They have more or less advanced arterio-sclerosis and nearly all of them have more or less impaired kidneys.

Prostatic obstruction, if long continued, will result in death.

When these patients consult us, they are nearly all in a condition of impaired health, the degree depending upon the length of time they have been subjected to prostatic obstruction.

Thus we are operating, for the saving of life, upon individuals who are already below par, so it behooves us to be familiar with and to employ every possible factor of safety known to modern science, not some of them but all of them.

In this paper, I mean to deal mainly with certain dangers to the patient, and with the means at our command, of recognizing these dangers and of combating them.

When a patient suspected of prostatic obstruction comes to us for advice and relief we should proceed with the utmost discretion. We may be able to determine at once that he is not a fit subject for operation, and that palliative measures are all that can be applied to him. On the other hand, we may find that though he is in no condition for operation at the time being, judicious treatment may render him fit for operation.

A carefully taken history is of the utmost importance. We must learn when his first symptoms of prostatism showed themselves, and we must trace the progress of the disease from that time to the present.

The prognosis will often depend upon the duration of the disease and also upon the type of symptoms which have been manifest.

By rectal examination, we should determine whether or not he has an enlarged prostate, and

whether his prostate appears to be cancerous or not.

A gently introduced catheter should inform us if he has residual urine, and if so how much. Of course, his urine must be chemically examined.

The cystoscope should not be employed at this stage of the proceeding.

Examination should be made to determine the condition of his circulatory apparatus, that is to say, the function of his heart and the condition of his arteries. Blood pressure is an important item.

A Wassermann test and other examinations should be made to exclude cases of bladder crisis due to tubercles.

An X-ray should be taken to determine the question of calculus.

The most important thing to determine is the state of the kidneys.

In my general surgical work, I never operate upon a patient of advanced years without carefully studying the kidney efficiency. I regard anything less than 20 per cent "phthalein" recovery as contraindicating the use of a general anesthetic.

Constant specific gravity of 1012 or below is indicative of kidney pathology.

As to the blood chemistry, we regard

**Blood Sugar** 140 mg per 100 c.c. as the highest normal. All above indicates diabetes as a surgical complication.

**Creatinin** Above 2 mg per 100 c.c. as suspicious, 3 mg per 100 c.c. or above, contraindicating the use of a general anesthetic.

**Urea Nitrogen** 18 mg per 100 c.c. as the high normal, 20 mg per 100 c.c. or above, pathological, contraindicating the use of a general anesthetic.

With our prosthetics, however I feel one can be a little more liberal in his interpretations because we do not employ a general anesthetic. In other words, sacral anesthesia has given us an entirely new opportunity.

While we feel that we must give absolute heed to the specific gravity, to the concentration test, to the blood chemistry and to the "phthalein" output, we believe that a patient who can improve from a low level to one a little higher, even though his condition be not ideal, may be classed as a safe risk.

Except for the employment of sacral anesthesia and the method of operating, which we feel is of the greatest importance, there is nothing that influences the safe conduct of one of these cases more than the pre-operative treatment. In other words, the study and preparation of the patient for operation.

We are particularly indebted to Hugh Young for his early recognition of and for his unfailing insistence upon the importance of this point. There can be no doubt that his wonderful results have been due to two factors, viz, the safety of the perineal route, and the preparation of the patient by methods he has so ably described.

They are not due to the personal equation of the operator, for Young himself says that he (the same operator), had unsatisfactory results as long as he followed the supra-pubic route.

Young emphasized the importance of gradual, not sudden decompression of the kidney pelvis. He accomplishes this by means of systematic and gradual catheterization, or by the employment of an indwelling catheter.

Personally, I feel that such catheter passed through the perineum is preferable to one passed through the urethra.

Without going into details of the mechanics and physiology of back pressure at this time, it is sufficient to state that residual urine, especially in increasing quantity, and obstruction at the bladder neck, resulting in frequent urination and retardation and straining, causes an abnormal amount of back pressure against which the kidneys have to work. Young has correctly interpreted this condition and has given us the proper means of coping with it.

It is this condition which has misled men to adopt the two stage operation as a routine. I have always maintained that a two stage operation should not be employed as a routine procedure. It should be reserved for those few cases where it is a necessity. Performed indiscriminately, it is a menace.

When preliminary drainage for decompression is a necessity and cannot be brought about by systematic catheterization, or accomplished by means of an indwelling catheter, the bladder should be drained by means of a perineal section and not by the supra-pubic route.

Experience has taught us that in cases which need decompression, sudden relief of pressure is often dangerous. With an indwelling catheter,

one can regulate the pressure. With drainage through the perineum, the same holds true, the bladder sphincter being intact. When the bladder is opened supra-pubically, there is no chance of restoring pressure if it is found desirable to do so.

As far as the sudden and unwise relief of back pressure is concerned, supra-pubic drainage subjects the patient to all the dangers of a one stage prostatectomy without preparatory treatment. How often has a patient succumbed to uremia owing to the sudden decompression? In these cases it should be gradual.

If one uses a retention catheter through a perineal urethrotomy, he can control it absolutely. Perineal drainage can be established by means of local anesthesia with practically no risk to the patient. The urethra can be opened on a lithotomy staff and a self-retaining catheter inserted, in one or two minutes. The back pressure can be reduced gradually and its effects carefully watched and controlled.

When, and if we feel the patient has reached his optimum and his condition is good enough for operation, it can be accomplished by simply enlarging the perineal wound and following out the proper procedures.

Young has also stressed the importance of administering large quantities of water.

Of course, the bowels should be thoroughly emptied and the patient's condition tested from time to time to see whether or not he has reached a state justifying operation.

#### *A further word concerning the cystoscope*

I do not wish to be thought lacking in appreciation of the cystoscope. I regard it as one of the most essential instruments of precision at our command. I have owned and employed the cystoscope from the earliest days of its perfection, but I do recognize and must call attention to the danger of its indiscriminate employment in cases of prostatic obstruction.

To pass a rigid, almost straight instrument through a tortuous, obstructed canal, into an infected bladder, is often a serious and dangerous procedure.

When there is occasion to use the cystoscope in cases of prostatic obstruction, I like to employ it at the time of operation, then, opening and draining the bladder will give one the greatest safety as far as infection is concerned. This is no theoretical objection on my part, but is based upon actual experiences of men of undoubted skill in the use of this valuable instrument.

So much for the examination and the preliminary care of the patient, let us now consider certain dangers which have attended prostatectomy in the past, and see what we have been able to do in the way of avoiding or combating them. In other words, let us further consider the factors of safety to the patient.

The most common causes of death have been uremia, pneumonia, embolism, hemorrhage and infection resulting in sepsis and in phlegmonous inflammation of the wound

The subject of *uremia* has really been covered in the preceding paragraphs relative to kidney deficiency, and the means employed to prevent and to correct it

Having eliminated those patients who cannot be rendered fit for operation, and having given careful attention and treatment to the others so that we shall be operating upon a class of patients who may be considered good, or at the worst, fair risks, will have gone a long way toward reducing the percentage of deaths from uremia, but there is no doubt that the administration of ether or any other general anesthetic to a patient with lowered kidney function is a menace. Thus the employment of sacral anesthesia is one of the greatest factors of safety as far as uremia is concerned

*Pneumonia* has stood prominently as a cause of death. It was largely due to the administration of a general anesthetic and to prolonged confinement in bed. Now we can expect it to be of infrequent occurrence, having done away with these two danger factors. We employ sacral anesthesia instead of a general anesthetic, and if we perform a median perineal prostatectomy we can expect to have the patient out of bed within 24 to 36 hours after operation

*Embolism* is a frequent complication of supra-pubic prostatectomy, and I am surprised to learn that Young has found it a frequent cause of death among his cases. As it has been of the rarest occurrence in my experience, I feel there must be some reason for this rarity in the method of operating. Of course, embolism depends upon injury to and infection of veins, resulting in thrombosis, the embolus coming from the clot. In supra-pubic prostatectomy, injury to the large venous plexus which lies *above* the prostate is unavoidable, and as the drainage must be uphill and incomplete, in an infected area, it is not surprising that embolus should occur rather frequently. Perhaps the methods of median perineal prostatectomy, where the wound is left open and inflammation practically never occurs, may account for the fact that embolus has been an almost unknown complication in my experience

*Hemorrhage* is and always has been a severe bugbear in connection with supra-pubic prostatectomy. The literature is full of methods and appliances which have been devised for its control. The large venous plexus lying *above* the upper part of the prostate is one reason for this complication of supra-pubic as distinguished from perineal prostatectomy. In perineal prostatectomy with a properly performed enucleation, hemorrhage is a complication not to be dreaded for it is practically not encountered. All that is

necessary is to avoid the artery of the bulb and to avoid lacerating and tearing the sheath which covers the prostate

*Infection, sepsis* and *phlegmonous inflammation* are, of course, more liable to occur in such an unsurgical wound as a supra-pubic prostatectomy results in, than in such a proper surgical wound as results from a perineal prostatectomy. Personally, I have had but one such case in my entire list

If what has been stated above is true, it will be seen that perineal prostatectomy performed under sacral anesthesia is the safest procedure we have at our command. Perineal prostatectomy is conceded to show a lower death rate than supra-pubic prostatectomy

(For details as to the administration of sacral anesthesia, see foot notes)

As to the comparative safety of sacral anesthesia, as compared with general anesthesia, there cannot be the slightest doubt. Sacral anesthesia is so thoroughly accredited and has been so fully described that I need not do more at this time than to emphasize its value and to urge its employment where it is applicable

The injection of a sufficient amount of a proper solution of novocain into the sacral canal will produce anesthesia of the perineal region, and will enable one to perform a perineal prostatectomy without pain to the patient. The amount injected should be between 30 and 40 c.c. of a 1¼ per cent solution of novocain. Personally, I believe we shall have full success with the caudal injection, which is much less complicated than the para-sacral. The latter can always be instituted if the anesthesia is not found to be perfect after a single injection has been made

The anesthesia should be perfect. Scholl and Meeker are correct when they claim as failures cases where a general anesthetic has to be supplemented

The anesthesia passes off slowly so that the first few hours are rendered comfortable. The patient is returned to bed in a good condition and able to eat a light meal

Our experience has led us to reduce the after treatment to the greatest simplicity. We used to do too much. Now we do very little

Formerly we irrigated a great deal, in our attempt to keep the bladder free of clots, but we have come to the conclusion that irrigation promotes oozing and we have less trouble if we do very little of it, so we scarcely irrigate the bladder. If the tube becomes clogged and there is difficulty in cleaning it, we remove it. I have done this an hour after the operation. At the time of operation we are careful to place the temporary suture so loosely that blood will not be dammed back into the bladder

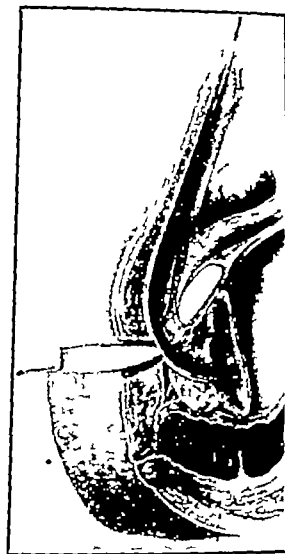
We used to feel that it was essential to pass steel sounds repeatedly with the idea of prevent-



1—Posterior surface of sacrum showing needle in hiatus sacralis



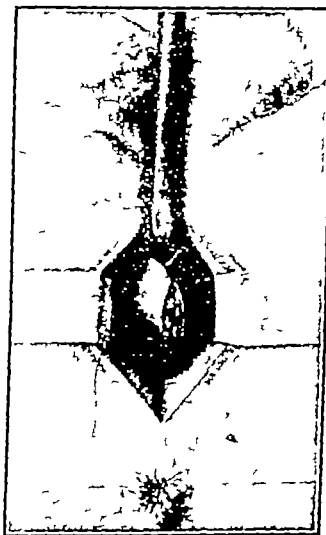
2—Showing simple median incision in perineum. There is no dissection and but a single sweep of the knife



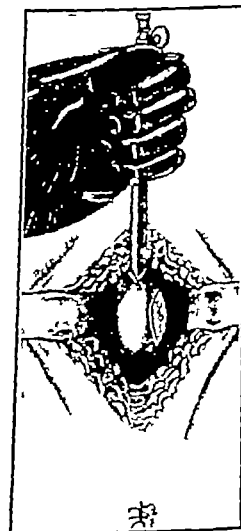
3—Knife entering the lithotomy staff and dividing the membranous urethra.



4—Showing Sims' rubber tractor within the bladder, pulling prostate toward the surface. (I am now using Young's tractor instead of my own.)



5—Showing Sims' tractor in situ. Incision in sheath of prostate is shown ready for enucleation



6—Showing Young's tractor in situ. Incision in sheath of prostate is shown, ready for enucleation

ing stricture We now feel that stricture never results from our operation, and all that is necessary is to pass a sound or silver catheter once through the urethra into the bladder, simply to be sure that the channel is open

It there be delay in the urine coming through the urethra, a sound may be passed into the bladder through the urethra on the sixth and seventh day

In a typical case, we remove the tube and most of the packing within 18 to 24 hours from the time of operation. If the patient is in fair condition he is then allowed out of bed. He is usually able to sit without much discomfort, and he is able to walk about. Usually his bladder condition will be satisfactory from the first. The remainder of the packing is removed on the second or third day, and but a light packing, if any, is replaced

After the gauze and tube are taken out, we irrigate through the penis, allowing the water to flow out of the wound. This should be done more or less frequently at first

The patient is usually able to hold his water and to go about under his own power within a few days. I have had most of my recent cases come to my office for treatment after the fifth or sixth day

The wound will usually be completely healed in the third week. Since we have stopped excessive packings and manipulations we have had no delay in the closure of these wounds

If the bladder needs treatment on account of established cystitis, I wash it with a 1-5000 solution of silver nitrate, passing my silver catheter through the urethra, not through the wound

*Epididymitis* we try to prevent by keeping the urethra clean and by keeping the testicles well elevated, at first with adhesive plaster and later with the suspensory bandage

*Final Results* A satisfactory result after prostatectomy will mean that we have a patient restored to comparatively good health. He

should be much improved in every way. As he has been relieved of residual urine and back pressure, of obstruction and difficult urination, his kidney functions should be much improved

The operation cannot be regarded as a success unless bladder function has been restored to a practically normal condition. The patient should be able to hold his urine, his bladder should have a good capacity, and he should be able to empty his bladder. He should not have residual urine. It has been claimed by some that the final function of the bladder will be better after a supra-pubic than after a perineal prostatectomy. I have no reason to believe this to be true. I have seen many more bad results following supra-pubic than perineal prostatectomy, though I have performed very few supra-pubic prostatectomies

I fully believe that the internal sphincter, which is a true sphincter, is the real bladder sphincter, that the external sphincter, so called, which, by the way, is not a sphincter, is but supplementary, but this is a question, the details of which I shall not go into at this time, for I hope to do this later

When I entered this field of surgery, in 1898, prostatectomy was of dubious worth, carrying with it such a high mortality that by some it was considered an unjustifiable procedure. Today, it has been elevated to one of the highest places in surgery

Improved methods of pre-operative care and preparation of the patient, sacral anesthesia and much improved operative technique, in both supra-pubic and perineal methods, have placed prostatectomy in the foremost ranks of surgical achievements, both as a means of prolonging and of saving life

#### BIBLIOGRAPHY

- 1 "Sacral Anesthesia, A Preliminary Report," *Medical Record*, June 14, 1919
- 2 "Sacral Anesthesia as Applied to Genito-Urinary Surgery," *International Jour of Surgery* June 1921
- 3 "Prostatectomy Under Sacral Anesthesia," *New York State Journal of Medicine*, September, 1924

### INHALATION VS REGIONAL ANESTHESIA FOR PROSTATECTOMY

By OSWALD SWINNEY LOWSLEY, A.B., M.D., F.A.C.S., and H. EARL ROGERS, A.B., M.D.

From the Department of Urology (James Buchanan Brady Foundation) of the New York Hospital  
NEW YORK CITY

THE question of prostatectomy has occupied the earnest attention of surgeons for many years. The introduction of ether and chloroform anesthesia opened the avenue of progress in this type of surgery as it did for all surgery. The next great advance was the gradual realization that the most important thing about a prostate operation was the preliminary drainage of the patient's bladder before the removal of the gland was accomplished. This procedure

still remains the most important part of any method of prostatic removal

Our experience teaches that suprapubic cystotomy after suitable preliminary decompression is by far the best method of pre-operative drainage. Its superiority lies in the fact that the drainage is complete, permits the oedema of the gland to be diminished, thereby lessening the extent of the hemorrhage at the time of operation.

Catheter drainage per urethram does not have the beneficial effect, and, in fact, there is just enough irritation caused by this foreign body

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse May 13 1925

lying in the prostatic urethra to lead one to believe that the patient absorbs a little toxin and does not reach the maximum of renal efficiency noted by the suction drainage through a suprapubic double draining tube as suggested by Kenyon and practiced in the New York Hospital

The last great step in the progress of surgery of the prostate is the introduction of regional anesthesia for its removal. This method, first originated by F Cathelin and Durant in 1902, who relieved sexual neuroses and incontinence of urine by epidural injections into the sacral canal, has been improved by many workers until now we are able to accomplish any type of prostatic operation by its use. The method in use has been described by the author and was popularized in this country by Labat

In order to be certain of results one must tabulate, unselected, consecutive cases and review the situation. This study is such a tabulation

The first 100 consecutive cases of prostatectomy under regional anesthesia are compared with the last 100 consecutive cases under inhalation anesthesia (gas-oxygen). Unfortunately the two series were not subjected to exactly the same conditions, as not all of the cases were cared for in the Department of Urology. We feel very strongly that the prostatic is much better off when cared for by doctors, nurses and orderlies who are experienced in their care and who are supplied with the proper food and appliances necessary for such attention

Those patients included in the series of prostatectomies performed under general anesthesia who were not treated in our department were cared for in private or special hospitals under such conditions that were as near like those prevailing in our department as could be arranged

#### FIRST SERIES

TABLE SHOWING 100 CONSECUTIVE PROSTATECTOMIES PERFORMED UNDER INHALATION ANESTHESIA\*

#### SECOND SERIES

TABLE SHOWING 100 CONSECUTIVE PROSTATECTOMIES PERFORMED UNDER REGIONAL

*Summary of Results*—By a review of the above tables it will be seen that in the first series the oldest patient was 85 years of age, the youngest 30—the average age 64.65 years—While the average in the second or regional anesthesia series was 65.25—the oldest being 82 years of age and the youngest 49

In the inhalation group there were

16—Two-stage suprapubic prostatectomies

8—One-stage suprapubic prostatectomies

38—Two-stage perineal prostatectomies

38—One-stage perineal prostatectomies

In the regional group there were

2—Two-stage suprapubic prostatectomies

0—One-stage suprapubic prostatectomies

98—Two-stage perineal prostatectomies

0—One-stage perineal prostatectomies

Sixty-eight per cent of the regional anesthetics were 100 per cent perfect, 2 received 98 per cent anesthesia, 12 received 95 per cent, 8 received 90 per cent, 6 received 85 per cent, and 4 received 75 per cent. This estimation is one made by the resident urologist and not by the anesthetist. The four very poorly anesthetized cases required less than one ounce of ether to make the operation possible. The rest listed as less than 100 per cent required even less. Those recorded as 98 per cent and 95 per cent complained but refused to smell ether, aromatic spirits of ammonia, essence of orange or other aromatic solutions

*Shock*—A study of the blood pressure in both series is most interesting. In the inhalation anesthesia the blood pressure is always considerably elevated. The extent of the rise varied from 30 mm -Hg to 90 mm -Hg during the anesthesia. Following operation there is always a drop below normal in the first series, almost all cases showed a fall below 100 mm -Hg. Ten required gum glucose or saline infusion in order to prevent shock, 23 definitely went into shock, one had a blood transfusion, one had a saline solution, 31 had unusual hemorrhage. In the regional series three cases went into profound shock after operation, two were given blood transfusion, the third case of shock died 18 hours after operation in spite of the most energetic methods of combating shock, including the administration of stimulants, gum glucose solution and other recognized procedures

*Complications Other Than Shock*—General anesthesia—calculi in posterior urethra, 1, slow convalescence, 1, uremia, 4, pneumonia, 2, myocarditis, 2, epididymitis, 4, infected wounds, 5, pulmonary emboli, 1, multiple abscess of kidneys, 1, diabetes, 1, faded away, 1, 76 of this series had no complications

Regional anesthesia complications were not so numerous, 87 cases had no complications whatever. Pulmonary embolus, 12th day post-operative, 1, hemorrhage relieved by gum glucose, 2, pyelitis, 2, Epididymitis, 2, calculus in bladder, 1, recto-urethral fistula, 1, cellulitis of scrotum, 13th day post-operative, 1, uremia, 1, phlebitis, 1

*Length of Stay in Hospital After Prostatectomy*—General anesthesia group, the longest post-operative stay in the hospital was 90 days, the shortest 10—average 33 days. The regional group shows an average post-operative stay of 22.7 days, the longest being 56 days, the shortest 10 days

*Mortality Record*—The death rate for the inhalation anesthetic group was 14 per cent, the causes of death were as follows

3 Died from hemorrhage and shock (2 one-day P O and one 16-day P O)

4 Died from pneumonia (one day, 3 days, 10 days and 19 days P O)

\* For Tables see pages 895 to 900

## PROSTATECTOMIES UNDER GENERAL ANESTHESIA

Name	Age	History Number	Discharge Date	Operation	Result Anesth	Shock, Mn B P—Post Oper Compl—Remarks	Days in Hospital After Operation	Result
1 S H	85	233211	1- 5-21	2 Stage P P		Extreme shock	1	DIED
2 C I	60	Card		2 Stage P P		Not noted	45	CURED
3 K G	30	243155	3-24-21	2 Stage P P		Not noted	10	CURED
4 J M	63	Card		2 Stage P P		Not noted	65	IMPROVED
5 J M	79	Card		2 Stage P P		Not noted	79	CURED
6 F T	53	Card		2 Stage P P		Not noted	30	CURED
7 F B	58	Card		2 Stage P P		Not noted	10	CURED
8 P O	81	235590	7-23-21	2 Stage P P		Fell 50 mm Developed calculus in Post urethra	44	CURED
9 G L	70	236152	7-25-21	2 Stage P P		Not noted Internal urethrotomy	39	CURED
10 C G	59	236474	8- 3-21	2 Stage P P		Not noted	24	CURED
11 D C	59	236540	7-21-21	2 Stage P P		Not noted	12	CURED
12 F I	58	236309	8-12-21	2 Stage P P		Profound shock—dropped 58 mm Glum glucose given	35	CURED
13 C G	72	236784	8-16-21	2 Stage P P		Shock—B P 100	21	CURED
14 J R	76	236967	9-12-21	2 Stage P P		Not noted—Pneumonia	15	DIED
15 F S	68	Card		2 Stage P P			20	CURED
16 M S	64	239597	1-28-22	2 Stage P P		Cardiac complications	12	CURED
17 S W	75	239437	3-12-22	2 Stage P P			51	CURED
18 E J	63	240177	3-22-22	2 Stage P P			18	CURED
19 A S	68	Card		2 Stage P P			20	CURED
20 A M	68	240883	5- 2-22	Perineal Prost		B P 90	28	CURED
21 S W	57	241048	6- 1-22	Perineal Prost		Blood pressure dropped to 65 Given Gum glucose	27	CURED
22 C C	70	241008	6-19-22	Perineal Prost		B P dropped 40 mm Given Gum glucose	38	CURED
23 J J	56	241215	5-20-22	1 Stage P P		B P dropped 30 mm Died in uremia 48 days P O Carcinoma		
24 M D	60	241045	6-17-22	1 Stage P P		Generally weak through his convalescence Carcinoma	43	DIED
25 D F	76	241651	6-23-22	1 Stage P P		No change	45	IMPROVED
26 D F	70	241903	6-24-22	1 Stage P P		Marked shock—Epididymitis	21	CURED
27 S T	67	242087	6-30-22	1 Stage P P			18	CURED
28 R P	69	242163	7- 7-22	1 Stage P P		Some drop in Blood Pressure	24	CURED
29 J C	62	242523	7-12-22	1 Stage P P		60 mm—Hemorrhage—Given Gum glucose	19	CURED
30 L M	59	Card		1 Stage P P		Shock	3	DIED
31 J F	51	243982	8-22-22	1 Stage P P		Moderate hemorrhage	24	CURED
32 T H	64	243968	10- 2-22	1 Stage P P		Some shock—Developed a chill 30 days Post Oper, died one hour later of "Chronic Myocarditis"		
33 J S	53	244001	10-10-22	1 Stage P P		Some shock—Carcinoma	30	DIED
34 F H	55	244702	12- 9-22	1 Stage P P		Moderate hemorrhage	18	IMPROVED
35 C M	59	245149	1- 1-23	1 Stage P P		Dropped to 60 mm B P Hemorrhage—Given Gum glucose	36	IMPROVED
36 S B	65	245910	1-31-23	1 Stage P P		Alarming shock—Serious hemorrhage—Gum glucose given	61	IMPROVED
37 A F	60	245094	4- 4-23	1 Stage P P			19	CURED
38 A S	70	246088	1-19-23	1 Stage P P		Moderate shock—Pulmonary emboli	77	CURED
39 N T	68	246458	3- 9-23	1 Stage P P			3	DIED
40 M R	62	246237	3- 4-23	1 Stage P P		Marked shock—Blood pressure dropped to 85 mm	38	CURED
							26	CURED

## UNDER GENERAL ANESTHESIA

## PROSTATECTOMIES UNDER GENERAL ANESTHESIA—Continued

Name	Age	History Number	Discharge Date	Operation	Result Anesth	Shock, Mn B P—Post Oper Compl—Remarks	Days in Hospital After Operation	Result
41 M J	54	246564	3-7-23	1 Stage P P	UNDER GENERAL ANESTHESIA	Minimum Blood Pressure 90	32	CURED
42 P M	50	237810	11-9-21	2 Stage suprapubic		Carcinoma	38	IMPROVED
43 A L	69	242488	7-26-22	2 Stage suprapubic		Mn Blood Pressure 110—Marked hemorrhage	34	CURED
44 J L	73	243100	3-14-21	2 Stage suprapubic		Extreme shock—Marked hemorrhage—Given Gum glucose Autopsy showed multiple kidney abscesses	16	CURED
45 J G	52	241410	5-3-22	2 Stage suprapubic		Epididymitis—Had an infected hydrocele on admission	16	DIED
46 J G	80	286817	9-20-21	2 Stage P P		Imperceptible pulse, cold and clammy—Grave shock—Gum glucose and stimulated during post-operative night	53	CURED
47 J G	72	250195	10-1-23	2 Stage P P		Severe shock—Stimulants and transfusion	41	CURED
48 B F	60	250913	11-9-23	2 Stage P P		Infected perineal wound Blood pressure 100	36	CURED
49 A D	56	250242	9-6-23	2 Stage P P		Blood pressure dropped to 90 mm Pulse 112	13	CURED
50 G P	67	253312	4-7-25	2 Stage P P		Hemorrhage	30	CURED
51 W R	62	247051	3-21-23	1 Stage suprapubic			19	CURED
52 D K	58	Card		1 Stage P P		Died of uremia 3 days P O	32	CURED
53 S S	58	Card		1 Stage P P		Pneumonia	3	CURED
54 R C	61	Card		Suprapubic Prost			10	DIED
55 M C	62	Card	1-26-21	1 Stage P P			26	CURED
56 J G	67	Card	2-6-20	1 Stage P P		Epididymitis	28	CURED
57 D W	63	Card		1 Stage P P			40	CURED
58 J S	42	Card	3-17-19	1 Stage P P			32	CURED
59 M L	64	Card		1 Stage P P			16	CURED
60 M M	77	Card		1 Stage P P			26	CURED
61 G T	80	Card	10-10-18	1 Stage P P			21	CURED
62 P L	76	Card	10-17-17	1 Stage P P		Slight shock	28	CURED
63 P M	60	Card	3-18-18	1 Stage P P			21	CURED
64 M P	67	Card	11-30-18	1 Stage P P			18	CURED
65 J D	28	Card	7-7-18	1 Stage P P			16	CURED
66 W M	64	Card	8-8-19	1 Stage P P			26	CURED
67 A L	59	Card	3-3-20	1 Stage P P			38	CURED
68 J H	45	Card	6-25-20	1 Stage P P	UNDER GENERAL ANESTHESIA	Carcinoma—Orderly pushed rectal tube through rectal wall 3rd day P O	24	IMPROVED
69 M B	58	Card	6-16-18	1 Stage P P		Carcinoma	28	IMPROVED
70 A G	60	Card		1 Stage P P		Diabetes	40	CURED
71 S M	70	Card	2-6-18	2 Stage P P		Died of uremia	32	DIED
72 A K	63	Card	10-18-18	2 Stage P P		No hemorrage but profound shock—Never seemed to recover from P O shock	72	DIED
73 J O	65	B Card	7-20-20	2 Stage suprapubic			40	IMPROVED
74 C M	69	B Card	3-21-19	2 Stage suprapubic		Carcinoma	32	IMPROVED
75 F M	60	Card	9-11-18	Suprapubic		Opened suprapubically	69	CURED
76 J R	83	B Card	2-24-19	Suprapubic		Cardiac collapse—Died	14	DIED
77 O B	60	B Card	6-12-17	Suprapubic		Slight shock	23	IMPROVED
78 T H	62	B Card	6-19-17	2 Stage suprapubic		Broken down suprapubic wound and epididymitis	45	CURED
79 R G	54	B Card	6-25-17	Subpubic Prost		Wound slow in healing	42	CURED



PROSTATECTOMIES UNDER GENERAL ANESTHESIA—Concluded

Name	Age	History Number	Discharge Date	Operation	Result Anesth	Shock, Mn B P—Post Oper Compl—Remarks	Days in Hospital After Operation	Result
80 F F	62	B Card	7-24-18	Suprapubic Prost	UNDER GENERAL ANESTHESIA	Wound slow in healing	51	CURED
81 R F	60	B Card	9-12-20	2 Stage supra Prost		Healed by granulation	47	IMPROVED
82 A E	60	B Card	9-12-20	2 Stage supra Prost		Healed by granulation	46	CURED
83 J S	52	B Card	8-1-18	1 Stage P P		Fistula	90	CURED
84 T S	70	B Card	2-12-18	1 Stage P P		Pleurisy	28	CURED
85 W M	51	B Card	3-28-18	1 Stage P P		P O Pneumonia	24	CURED
86 T F	62	B Card	9-25-19	2 Stage suprapubic		Hemorrhage (moderate)	43	CURED
87 M S	65	243155	11-1-21	2 Stage P P		Epididymitis	39	CURED
88 P B	64	B Card	12-16-20	2 Stage P P			42	CURED
89 C F	58	B Card	7-26-17	2 Stage suprapubic			28	CURED
90 S V	54	241048	5-1-22	2 Stage P P		Marked shock—Blood pressure dropped to 65 Given Gum glucose		CURED
91 G N	68	251711	1-4-24	2 Stage P P		Marked shock—Drop in B P	27	CURED
92 S B	65	231123	1-31-22	2 Stage P P		Marked shock	26	CURED
93 C G	72	249153	7-14-23	2 Stage P P		Marked shock—Died of shock—Gum glucose given	19	CURED
94 F H	55		12-9-23	2 Stage P P			1	DIED
95 C T	65	234029	2-28-21	2 Stage suprapubic		Marked hemorrhage	30	CURED
96 A S	68	240300	3-20-22	2 Stage P P		Marked hemorrhage	20	CURED
97 M S	64	239597	5-20-22	2 Stage P P		B P dropped to 100 Epididymitis	20	CURED
98 J M	55	234532	7-19-24	2 Stage P P			60	CURED
99 S W	75	239437	3-12-22	2 Stage P P			23	CURED
100 A W	61	235232	5-23-21	2 Stage P P		Profound shock—B P dropped to 90 mm Developed epididymitis—Given Gum glucose	49	CURED

GENERAL ANESTHESIA SUMMARY

Oldest Patient	85 Years	Average	64 65 Years	Number of Patients given Gum Glucose	14
Youngest Patient	30 Years			Number Had Unusual Hemorrhage	31
Longest Stay in Hospital—P O	90 Days		33 Days	Number Had Shock	23
Shortest Stay in Hospital—P O	10 Days	Average		Number of Deaths	14

## PROSTATECTOMIES UNDER REGIONAL ANESTHESIA

Name	Age	History Number	Discharge Date	Operation	Result Anesth	Shock, Mn B P—Post Oper Compl—Remarks	Days in Hospital After Operation	Result
1 F L	49	250956	10-26-23	2 Stage P P	100%	None	15	CURED
2 C L	62	254618	6-10-24	2 Stage P P	100%	80 This man was given Hyoscine and had Nar-cosis	17	CURED
3 P M	60	248966	6-2-23	2 Stage P P	100%	96	15	CURED
4 V M	71	249396	8-20-23	2 Stage P P	85%		22	CURED
5 H M	72	250583	11-13-23	2 Stage P P	95%	Fistula slow in closing patient left Hospital		
6 J M	71	249684	8-2-23	2 Stage P P	95%	Mn B P 100	56	CURED
7 B M	70	248338	6-8-23	2 Stage P P	100%	Mn B P 160	21	CURED
8 A M	65	255769	8-11-24	2 Stage P P	100%	Blood pressure normal	14	CURED
9 J L	64	254910	6-24-24	2 Stage P P	85%	Blood pressure normal	10	CURED
10 D M	66	254551	7-10-24	2 Stage P P	100%	Mn B P 117—Had Lobar Pneumonia following drainage	19	CURED
11 B M	62	255479	7-15-24	2 Stage P P	100%	Mn B P 119—Had four large vesical calculi	16	CURED
12 M M	69	253260	8-18-24	2 Stage P P	85%	Normal blood pressure	18	CURED
13 J M	64	254128	5-18-24	2 Stage P P	100%	Normal blood pressure	19	CURED
14 T M	67	258192	12-19-24	2 Stage P P	100%	Normal blood pressure	24	CURED
15 M M	54	250373	9-25-23	2 Stage P P	100%	Normal blood pressure	17	CURED
16 J M	57	251320	11-27-23	2 Stage P P	95%	Normal blood pressure	12	CURED
17 G M	62	247784	6-20-23	2 Stage P P	100%	Normal blood pressure	18	CURED
18 H N	70	248287	6-9-23	2 Stage P P	100%	Normal blood pressure	18	CURED
19 B P	57	255646	8-10-24	2 Stage P P	100%	Normal blood pressure	24	CURED
20 T Q	63	251532	12-26-23	2 Stage P P	100%	Normal blood pressure	11	CURED
21 H R	78	249482	6-2-23	2 Stage P P	100%	Had pyelitis	29	CURED
22 T R	64	247908	8-27-23	2 Stage P P	100%	Three stones in bladder—3x3x2 cm in diameter	28	CURED
23 W R	65	256228	9-16-23	2 Stage P P	100%	Blood pressure normal Had vesical calculi	20	CURED
24 A R	65	250880	11-6-23	2 Stage P P	100%	Had urethral stricture Internal urethrotomy done		
25 S D	60	246563	3-30-23	2 Stage P P	100%	Blood pressure normal	19	CURED
26 F J	69	253888	5-7-24	2 Stage P P	100%	Blood pressure normal	21	CURED
27 F A	68	253448	5-2-24	2 Stage P P	100%	Has been catheterized for 3 years—never voided normally during this time	22	CURED
28 W D	79	253292	8-20-24	2 Stage P P	90%	Developed fecal fistula	32	IMPROVED
29 S D	70	247567	5-11-23	2 Stage P P	100%	Developed calculi in bladder—Carcinoma	39	IMPROVED
30 R D	65	252464	1-31-24	2 Stage P P	95%	Blood pressure normal	24	CURED
31 H D	59	251826	12-12-23	2 Stage P P	90%	Mn B Pressure 100	27	CURED
32 J D	58	248248	5-26-23	2 Stage P P	95%	Mn Blood pressure 84 Saline given for low B P	16	CURED
33 M F	60	255973	9-4-24	2 Stage P P	100%	No drop in blood pressure	16	CURED
34 F F	55	255038	2-25-25	2 Stage P P	100%	No drop in blood pressure	15	CURED
35 P G	66	258764	2-25-25	2 Stage P P	100%	Mn Blood pressure 132	22	CURED
36 P G	65	257714	12-12-24	2 Stage P P	90%	No drop in blood pressure	27	CURED
37 W M	65	258340	1-19-25	2 Stage P P	100%	Blood pressure normal—Had internal urethrotomy	28	CURED
38 D G	62	255778	8-26-24	2 Stage P P	90%	No drop in B P Had 9 day attack of pneumonia between operations	17	CURED
39 J H	79	251828	1-12-24	2 Stage P P	100%	Marked hemorrhage—Given 350 cc of saline	27	CURED
40 E H	82	256342	10-10-24	2 Stage P P	100%	No drop in blood pressure	22	CURED
41 J H	75	250924	11-19-23	2 Stage P P	100%	No drop in blood pressure	35	CURED
						Mn Blood pressure 135	20	CURED

PROSTATECTOMIES UNDER REGIONAL ANESTHESIA—Continued

[illegible]

## PROSTATECTOMIES UNDER REGIONAL ANESTHESIA—Concluded

Name	Age	History Number	Discharge Date	Operation	Result Anesth	Shock, Mn. B P—Post. Oper Compl—Remarks	Days in Hospital After Operation	Result
77 D W	65	258565	1-19-25	2 Stage P P	100%	Mn B P 118	17	CURED
78 M W	63	247494	5-1-23	2 Stage P P	95%	Mn B P 100—The morning he was to be discharged he strained at stool and died of emboli	19	DIED
79 W W	69	258465	7-9-25	2 Stage P P	100%	Had emboli of lung 12th day P O Patient had extreme toxemia When brought into Hospital had 10% sugar in his urine	38	CURED
80 A V	78	253222	5-6-24	2 Stage P P	100%	No drop in blood pressure	21	CURED
81 J V	67	252088	1-24-24	Suprapubic P P	85%	Suprapubic prostatectomy	20	CURED
82 J K	61	259710	4-6-25	2 Stage P P	100%	No drop in blood pressure	23	CURED
83 F S	68	238413	1-30-22	2 Stage P P	100%	Hemorrhage small pack	20	CURED
84 H S	63	252268	2-8-24	2 Stage P P	100%	No drop in blood pressure	31	CURED
85 H V	68	258401	3-30-25	2 Stage P P	100%	No drop in blood pressure	25	CURED
86 M E	88	248388	4-24-23	2 Stage P P	75%	Mn B P 130—Was in uremia on admission	38	CURED
87 A F	69	234187	4-16-21	2 Stage P P	100%	Mn B P 100	55	CURED
88 J H	79	258051	1-20-25	2 Stage P P	75%	Hemorrhage—340 cc. gum glucose given and retention	21	IMPROVED
89 D B	77	254382	7-16-24	2 Stage P P	100%	Advanced carcinoma with hemorrhage and retention	48	ABSOLUTE CURED
90 W H	63	258724	2-25-25	2 Stage P P	100%	No drop in blood pressure Had hemaphysia and was in coma on admission	28	CURED
91 J S	75	259225	3-7-25	2 Stage P P	93%	Had fractured neck of humerus was in fracture bed	27	CURED
92 J S	74	254852	7-14-24	2 Stage P P	100%	No drop in blood pressure Developed epididymitis	14	CURED
93 A H	52	258392	2-16-25	2 Stage P P	100%	Also had multiple incisions in scrotum for abscessed epididymis	55	CURED
94 J D	67	248384	6-23-23	2 Stage P P	100%	Mn B P 108—Had pyelitis	44	CURED
95 W R	54	257620	12-2-24	2 Stage P P	100%	Blood pressure did not drop Carcinoma of the tongue	24	CURED
96 L B	71	259728	4-30-25	2 Stage P P	100%	No drop in blood pressure	30	CURED
97 J R	56	260462	6-8-25	2 Stage Suprapubic	100%	Blood pressure did not drop	22	CURED
98 W B	76	260372	5-7-25	2 Stage P P	100%	No drop in blood pressure Suprapubic prostatectomy	17	CURED
99 J F	64	259988	4-23-25	2 Stage P P	100%	Mn B P 116	28	CURED
100 H R	71	L B C	4-22-25	2 Stage P P	100%	Mn B P 110	21	CURED

## REGIONAL ANESTHESIA SUMMARY

Oldest Patient	82 Years	Average	65 25 Years	Number of Patients Given Gum Glucose	2
Youngest Patient	49 Years			Number Had Marked Hemorrhage	2
Longest Stay in Hospital—P O	56 Days	Average	22 7 Days	Number Had Shock	4
Shortest Stay in Hospital—P O				Number of Deaths	3

4 Died of uremia (one day, 3 days, 40 days and 43 days P O)

2 Died of myocarditis and cardiac failure (14 days and 30 days P O)

1 Died of pulmonary embolus (93 days P O)

Of the 14 deaths the last three are more or less accidental, although the operation must be considered as the cause of death. Three died as a direct result of the operation from hemorrhage and shock. Four died of pneumonia and four of uremia. The inhalation anesthesia can be accused of having a direct bearing in 11 of the deaths.

In the regional anesthetic group there were only three deaths, one from hemorrhage and shock (18 hours), one following infection and cellulitis, 13 days P O, one from pulmonary embolus, 19th day P O.

TABLE SHOWING COMPARISON BETWEEN THE TWO METHODS

	Average Age	Unusual Hemorrhage	Shock	Complications	Average Post Oper Day	Mortality
Inhalation Series	64.65	31	23	24	33	14
Regional Series	65.25	6	3	13	22.7	3

## THE PRESENT STATUS OF INSULIN THERAPY \*

By ELLIOTT P JOSLIN, M.D.

BOSTON, MASSACHUSETTS

**I**NSUFFICIENT Use of Insulin by the General Practitioner. The chief defect in the present status of insulin therapy is the lack of its use by the general practitioner. If he fully recognized what he could accomplish for his patients with insulin, he would not do without it. Insulin has metamorphosed my practice. It has made the care of the diabetic an ever-stimulating pleasure rather than a constant Puritanical duty. What insulin has done for one doctor it will do for any doctor who employs it after having learned the dosage and method of administration, and the relation it bears to the diet of the patient.

**Distribution of Doctors' Emergency Insulin.** So strong is the evidence that physicians would wish to use this new drug, insulin, if they had it and were accustomed to it that the Board of Health of the State of Massachusetts will distribute this month to each doctor in the State outside of Boston a bottle of Doctors' Emergency Insulin, which can be carried in the doctor's bag. This distribution has been made possible through the generous gift of your fellow citizen, Mr. John D. Rockefeller, Junior. It came about in this way. Some three years ago Mr. Rockefeller gave to individuals in various communities liberal sums of money to be used for the purchase of insulin for needy patients and for the instruction of doctors and nurses in its use. Fifteen thousand dollars was the sum assigned to Boston and, because unsolicited, was all the more welcome. Our saving New England propensities have made this sum last, although during this interval patients at five different hospitals in the city have been assisted by it. Boston doctors have benefited from it. But

one day it came to my attention that one of my diabetics in Newfoundland died, partly because the boat, carrying his insulin, was late. Then I heard that another patient in Caribou, Maine, was in extremis with erysipelas, and no insulin was to be bought in the town. Finally a doctor called me up early one morning, stating that he had been called the previous evening to a patient conscious and breathing a little heavily, but now in coma. He had no insulin the night before, could not get insulin, in fact had never given insulin, and at the moment was caring for another woman in active labor. Some hours later insulin was secured. The country doctor did the best he could, caring for the two patients living far apart, but as might be expected, the coma case died.

When these incidents were related to Dr. Kelley and Dr. Bigelow, of the State Board of Health, they eagerly accepted a gift of insulin for distribution under their supervision to physicians outside of Boston. I do not believe diabetic deaths or deaths from diabetic coma will cease in Massachusetts, but if such deaths occur it will not be because the first and therefore best dose of insulin is not available. Your Mr. Rockefeller has put a bottle of emergency insulin into the bag of every doctor outside of Boston in Massachusetts.

**What Insulin Has Accomplished.** It is very easy to say that insulin allows the diabetic patient to become efficient again—to teach, preach, work, play, and even grow and contribute to the support of his family—but such statements, though true, are generalities, and what is wanted by doctors who have used insulin little or not at all, are concrete facts. These are therefore submitted in the form of reports upon certain groups of diabetic pa-

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse, May 13, 1925.

tients acknowledged by all to be serious and by a few specific instances First let us take diabetic coma

*Evidence from Treatment of Diabetic Coma* Between January 1, 1923, and April 1, 1925, there have been treated at the New England Deaconess Hospital 33 cases of diabetic coma with two deaths from this complication During the preceding quarter century I have had but fifteen recoveries among patients already in or, perhaps better stated, less far advanced in coma A similar experience has just been published by Nellie B Foster, and many hospital physicians have lists of such cases But these hospital recoveries are not to the point Dr Shedd, of North Conway, New Hampshire, saved his case of coma, Dr Kilbourn, of Groton, Massachusetts, detected and saved his, and, best of all, old Dr Towle, of Dorchester, Massachusetts, who graduated 48 years ago from a New York medical school, saved his coma case, too When called to the unconscious girl, he recollected a diabetic, a doctor's widow, who lived hard by, begged from her a bottle of insulin, injected the whole of it, and when, to his astonishment, he saw it was doing his coma case good, secured the widow's last cruse and gave the whole of that, too, and then sent his patient to the Peter Bent Brigham Hospital, where Reginald Fitz finished the job

In your home city or town I daresay your patients, too, are talking about the coma case you likewise have saved However, if you have not had that pleasure, I warn you lest some young medical upstart or wise medical virgin arrive on the scene and enter into fame merely because of a bottle of insulin in his or her doctor's bag

*Evidence from the Treatment of Children* The children show what insulin will accomplish Formerly they died, now they live—for how long one cannot say, but the facts are these Prior to 1914 the duration of life of my 25 children with onset of diabetes under 10 years of age was 12 years In contrast are my first 16 cases of similar age to take insulin These have already lived not only three times as long but still are alive

*Pathological Evidence* This prolongation of life of diabetic children is of more significance than at first appears The first year of diabetes is the diabetic's danger zone Once passed, even under non-insulin treatment, he often lives for years A pathological explanation of this has recently been found in a third group of my cases Shields Warren and Howard Root, working under the guidance of Professor F B Mallory, have found some evidence, based upon 26 autopsies of my cases, that regeneration of the islands cells of the

pancreas takes place *pari passu* with the duration of the diabetes Their first article, dealing chiefly with the pathological aspect of the question, will be published in the July number of the Journal of Pathology, and a later article will correlate pathological with clinical findings If future work confirms their conclusions, we can feel that if we prolong the lives of our patients a few years we shall afford time for a certain amount of regeneration of the pancreas The Toronto case reported by Boyd and Robinson is perhaps the first and surely the most heartening in this connection, and is of especial importance because of the many investigators who attested the presence of regeneration in the tissue submitted for their opinion

*Specific Instances of Improvement with Insulin* A few specific instances to show why doctors cannot afford to neglect to use insulin Miss M, a nurse, Case No 1542, my first patient to take insulin, has employed it 34 months Her weight had fallen from 157 pounds to 74½ pounds, and for nine months she had not gone down a flight of stairs She now weighs 129 pounds and is earning her living Freddie G, Case No 1616, who was brought to the hospital on a cushion on October 4, 1922, after three years of diabetes, is now eleven years of age, has doubled his weight, and recently in one month grew an inch in height He seldom misses a day at the public school A girl, whose condition was formerly so deplorable and so tragic that I can't describe it, is now happy and attractive and for fun has become a teacher

*The Standard Diabetic Diet* The standard diet of a diabetic patient of moderate severity weighing 50 kilograms (110 pounds) is as follows

Food Grams	Carbohydrate Grams	Protein Grams	Fat Grams
5% Vegetables, 4 portions 600 grams or 20 ounces)	20	10	0
3 very small Oranges (300 grams), or			
3 medium sized Grape Fruit (600 grams)	30	0	0
Oatmeal, 1 saucerful (dry weight 30 grams, cooked weight 240 grams)	20	5	2
Uneda Biscuits, 2	10	1	1
Cream 20% butter fat, ½ pint (240 grams)	8	8	48
Eggs, 2	0	12	12
Bacon, 4 crisp strips (30 grams)	0	5	15
Butter, 3 portions (30 grams)	0	0	25
Meat, 1 small portion (60 grams)	0	16	10
	88	57	113
	4	4	9
	352	228	1017

Total Calories, 1,597

If the patient is not sugar free on this diet, it is easy to reduce the carbohydrate by 15 grams by halving the fruit, by another 10 grams by halving the oatmeal, by another 10 grams by omitting the Uneeda biscuits. Thus the carbohydrate becomes 53 grams, and below this quantity today we seldom ask our patients to go. If the carbohydrate is to be increased, remember a banana contains 20 grams, a shredded wheat biscuit 23 grams, and if your patient is so reliable that you can allow food as indefinite in size as potato or bread, remember that size for size potatoes are like bananas and toast like shredded wheat.

Younger and heavier patients need more protein, the little children even 3 grams per kilogram body weight, the very old, the very severe, the case complicated with Bright's disease, proportionately less. Fat is given for weight and efficiency. When the urine is sugar free and the protein is 1 gram per kilogram body weight, it is allowable to give 3 grams of fat for each 1 gram of carbohydrate, but if the protein is reduced to two-thirds of 1 gram per kilogram body weight, the fat may quadruple or quintuple the carbohydrate.

*Insulin Indications and Dosage* If a diabetic patient is not efficient, happy, and sugar free on a diabetic diet, he needs insulin. And did you ever think how much 5 units will do? It will allow at least 5 grams additional of carbohydrate, possibly 10 grams, but for our purposes let us say 5 grams. That means one Uneeda biscuit, but, to match the carbohydrate which it contains in fat, you can allow 15 grams, or one half ounce, of butter. These two foods are equivalent to 140 calories, nearly 10 per cent of the standard diet prescribed. Such calculations as these show how much a few units will do.

Small doses of insulin only are required by the majority of those diabetic patients who need insulin, besides diet, to keep sugar free and maintain strength. Few children, even after years of diabetes, demand over 15 or 20 units in 24 hours. None of my cases receives regularly over 60 units a day. As a rule the insulin is given twice daily, often once, less often three times, and very, very rarely four times. By testing four specimens of urine—namely, that of the morning, that of the afternoon, that of the evening, and that of the night—and comparing the results with the distribution of the carbohydrate in the diet and the dosage of insulin, one can soon arrive at the proper quantity of each to be administered. In the presence of the high metabolism of an infection or of exophthalmic goitre, during convalescence from operations, and during periods of abstinence from food, whether voluntary or involuntary, it is always the part of

caution to increase the frequency of giving insulin. Simultaneously the size of the dose should be changed up or down in accord with the result of the examination of an individual specimen of urine obtained at the time of each injection. Under these conditions insulin is given to offset the food derived from the metabolism and not from meals.

*Hypoglycemia Seldom Dangerous* An overdose of insulin seldom results in death. I do not recall 5 such having been reported in the United States either publicly or privately. A few units are dangerous in the course of diarrhoea and severe inanition, and once we had a noisy reaction in a feeble old man who was taking 100 grams carbohydrate. This occurred seven hours after the last of three meals, preceding the first of which the patient was given 5 units. It is unnecessary to speak of the treatment of a reaction. Of some 2,000 diabetic admissions it has been felt necessary to give glucose intravenously upon but three or four occasions. Others have recovered with the juice of an orange, one or two lumps of sugar or teaspoonsful of syrup.

The latency of the symptoms of a reaction, both in children and in adults who have used insulin long, deserves a word. Shortly before a meal they may feel a little weak and uncomfortable, yet not evince the symptoms characteristic of an insulin reaction, such as hunger, trembling, sweating, or even diplopia. An examination of the blood reveals an encouraging hypoglycemia, encouraging because it suggests a regeneration of the pancreas, an increased ability to burn carbohydrate. In years gone by we were on the watch for diabetics to grow worse, now we must be alert to detect their growing better.

*Abscesses* Abscesses do not result from the use of insulin save when preceded by extreme carelessness. To this statement I must make one exception—namely, that of a colored woman who developed an abscess in the hospital. Neglect of diet, very large doses of insulin, its administration constantly in the same site, and (Geyelin) the use of dilute rather than concentrated preparations, have been the causes.

*Omission of Insulin without Curtailment of Diet the Greatest Danger* The diabetic who takes insulin is walking on stilts. If he suddenly gives up the stilts, he is in grave danger of a rude fall unless he reduces his diet one-third or to that amount of food which he can tolerate without insulin. It is infinitely safer to give insulin than to withhold it.

*Coma and Rules for its Treatment* Overeating leads to diabetes, overeating makes the diabetes worse, overeating invariably precedes coma, though sometimes, as in

fever and in goitre, the overeating is endogenous in character—namely, of the body and not of extraneous food. Coma still is such a menace and can occur so easily in a careless diabetic taking insulin that our routine measures for the treatment of coma at the New England Deaconess Hospital may be of interest. These will appear this month in the second Boston number of the *Medical Clinics of North America* as a part of an article upon *Diabetic Coma and Its Treatment* written in association with Dr. Howard F. Root and Dr. Priscilla White.

*Rules for Treatment of Diabetic Coma in Force at the New England Deaconess Hospital April, 1925*  
*Duties of Nurse*  
*A. Preparations for Reception of Patient*  
 (1) A warm bed with blankets in place of sheets and at least four hot water bags.  
 (2) The necessary equipment in readiness at the bedside for catheterization, for a soapsuds enema, for gastric lavage, for subpectoral infusion of normal saline, for administration of caffeine and insulin.

*B. Care of Patient*  
 (1) Secure specimen of urine, by catheter if necessary. A specimen of urine is to be tested for sugar and di-acetic acid every hour until recovery. If a self-retaining catheter is to be left in the bladder, urotropin 10 grains should be given every four hours for three doses.  
 (2) Hourly records of the pulse and two-hourly records of the respiration rate and temperature are to be kept.  
 (3) Enema.

*Duties of Physician*  
*A. Examination of patient*

*B. Constant attendance until the crisis is passed*

*C. If diagnosis of coma is confirmed, write necessary orders for treatment with especial reference to (1) gastric lavage, (2) the method and rate of administration of liquids by mouth, rectum, or subcutaneously, (3) the diet, (4) caffeine, and (5) insulin.*

The purpose of gastric lavage is to prevent or relieve gastric dilatation.

Liquids by mouth must be given hot and at a rate not to exceed 100 cubic centimeters an hour. Liquids by rectum—salt solution, black coffee, or tap water—may be given every two hours for two doses and thereafter every four hours. If the patient is dry, unhesitatingly give salt solution subpectorally, except in the

presence of pulmonary rales, when it may be given under the skin of the thighs. If the intravenous route is preferred, give very slowly 250 to 500 c.c. of normal salt solution, and no more until at least an hour has elapsed. One c.c. of adrenalin from a sterile ampoule may be added to the salt solution when the systolic blood pressure is below 90.

The diet in the first 24 hours should not contain more than carbohydrate 50 grams, protein 25 grams, and fat 25 grams, unless warranted by unusual improvement of the patient. This is represented by oatmeal 30 grams dry weight, equivalent to 500 grams as thin gruel, orange juice 250 grams (the juice of two small oranges), the whites of 5 eggs, and medium cream 120 c.c. Broths, coffee, tea, cocoa shells, may be utilized as vehicles for the above.

Caffein sodium benzoate is injected subcutaneously, 5 grains every hour for four doses and thereafter as indicated.

The gravity of the coma is evidenced by the degree of stupor, the exhaustion of the patient as shown by a rectal temperature of 95° Fahrenheit or below, by circulatory collapse with blood pressure below 80 systolic, dry mucous membranes and skin, soft eyeballs, and by hemorrhagic vomitus or gastric contents. Air hunger, though slight but definite at first, increases to a maximum and toward the end gives way to shallow respiration.

The size of the first dose of insulin in coma depends upon the doctor's estimation of the probable number of hours the patient would live without insulin. If the patient's expectation of life is 24 hours, one would inject 20 units and repeat every hour until clinical improvement and sugar in the urine or blood is approaching normal. If the patient's expectation is 12 hours, one would inject 40 units and repeat the dose in the same manner, changing the quantity to 20 units as the state of the patient warrants. If the expectation is only 6 hours, one would inject 40 units every thirty minutes until improvement is manifest. Finally, in a case in extremis we should now give 40 units of insulin every fifteen minutes. No patient at the New England Deaconess Hospital should come within two hours of death from coma without having received at least 150 units of insulin in the preceding hour.



# EDITORIALS.

The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

Editor-in-Chief—ORRIN SAGE WIGHTMAN, M D,

New York

### COMMITTEE ON PUBLICATION

E ELIOT HARRIS, M D, *Chairman*

New York

WILLIAM H. ROSS, M D

Brentwood

Executive Editor—FRANK OVERTON, M D

Patchogue

DANIEL S DOUGHERTY, M D

New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

*President*—NATHAN B VAN ETEN, M D  
*First Vice President*—WILLIAM H ROSS, M D  
*Second Vice President*—FREDERICK H. FLAHERTY, M D  
*Speaker*—E. ELIOT HARRIS, M D  
*Vice Speaker*—GEORGE M. FISHER, M D  
*Secretary*—DANIEL S DOUGHERTY, M D  
*Assistant Secretary*—HOWARD GILLESPIE MYERS, M D  
*Treasurer*—CHARLES GORDON HEYD, M D  
*Assistant Treasurer*—JAMES PEDERSEN, M D

New York  
Brentwood  
Syracuse  
New York  
Utica  
New York  
New York  
New York  
New York

*COUNSEL*  
GEORGE W WHITESIDE, Esq 27 William St  
Telephone Broad 1744  
New York

*ATTORNEY*  
ROBERT OLIVER, Esq 27 William St  
New York

*EXECUTIVE OFFICER*  
JOSEPH S LAWRENCE, M D 51 Chapel Street, Albany

### SECTION OFFICERS

*Medicine*  
*Chairman*—L. WHITTINGTON GORHAM, M D  
*Secretary*—WARDNER D AYER, M D  
Albany  
Syracuse

*Surgery*  
*Chairman*—EDWARD S VAN DUYN, M D  
*Secretary*—GEORGE E. BEILBY, M D  
Syracuse  
Albany

*Obstetrics and Gynecology*  
*Chairman*—ALFRED C. BECK, M D  
*Secretary*—NATHAN P SEARS, M D  
Brooklyn  
Syracuse

*Pediatrics*  
*Chairman*—ROGER H. DENNETT, M D  
*Vice-Chairman*—ARTHUR W BENSON, M D  
*Secretary*—JOHN AIKMAN, M D  
New York  
Troy  
Rochester

*Eye, Ear, Nose and Throat*  
*Chairman*—EUGENE E. HINMAN, M D  
*Secretary*—JAMES W WHITE, M D  
Albany  
New York

*Public Health Hygiene and Sanitation*  
*Chairman*—ARTHUR D JAGUES, M D  
*Secretary*—LEO F SCHIFF, M D  
Lynbrook  
Plattsburg

*Neurology and Psychiatry*  
*Chairman*—CLARENCE O CHENEY, M D  
*Secretary*—THOMAS K. DAVIS, M D  
Utica  
New York

### CHAIRMAN, STANDING COMMITTEES

*Arrangements*—EDWARD R. CUNNIFFE, M D  
*Legislation*—HENRY L. K. SHAW, M D  
*Public Health and Medical Education*,  
CHARLES A. GORDON, M D  
*Scientific Work*—ANDREW MACFARLANE, M D  
*Medical Economics*—WILLIAM WARREN BRITT, M D

New York  
Albany  
Brooklyn  
Albany  
Tonawanda

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer) the ex President and the Councilors of the District Branches.

*First District*—JOHN A. CARD, M D  
*Second District*—JOSEPH S THOMAS, M D  
*Third District*—CHARLES P MCCABE, M D  
*Fourth District*—HORACE M. HICKS, M D  
*Fifth District*—NELSON O BROOKS, M D  
*Sixth District*—GEORGE H. FOX, M D  
*Seventh District*—WILLIAM I DEAN, M D  
*Eighth District*—HARRY R. TRICK, M D

Poughkeepsie  
Flushing  
Greenville  
Amsterdam  
Oneida  
Binghamton  
Rochester  
Buffalo

For a list of the officers of the county medical societies, see April 24th JOURNAL, advertising page v  
For list of District Branch Officers, Standing Committees and Special Committees, see July JOURNAL, advertising page xiii

## THE DISTRICT BRANCH MEETINGS

The months go by with a swish, and we are reminded of most agreeable experiences as we attended the meetings of the District Branches last Fall. We are anxious to repeat our visits to the Branches.

The District Branches are gold mines of usefulness whose riches have scarcely been touched. The theory on which they are founded is that of groups which have a common interest, and are readily accessible to one another. The present Districts do not meet those conditions.

The present District Branches comprise the old judicial districts, and some extend across the State, defying natural boundaries and routes of travel.

The Districts are also too large. We notice that other state societies make their Branches smaller. Michigan has 14 Branches divided according to congressional districts, Illinois has 9 District Branches.

The present House of Delegates has authorized the redistricting of the State. A wise method of forming the new districts is to give consideration to the natural grouping of the physicians, which are determined largely by geographical conditions. This is the plan that has been followed by the State Department of Health in the assignment of its fifteen District State Health Officers to their districts. If the District Branches were identical with the health officer districts, each branch president would find his work sufficient to occupy all the time he should be expected to give to it.

The District Branches which held the best meetings last Fall were those whose grouping was compact and according to natural routes of travel. Smaller districts, formed on these lines, will promote better Branch meetings, and a more effective system of advice and supervision for the county societies.

F O

## MEDICAL WRITINGS

The subject of graduate education has many phases. One of the oldest and most efficient means of educating physicians is that by means of articles in medical periodicals. Another is that of clinical demonstrations on actual cases. Either method is incomplete without the other—and an efficient system of graduate instruction in medicine will utilize both methods.

It is the peculiar work of the medical editor to choose articles which will enable physicians to practice clinical medicine in the ready manner that is exhibited by the expert demonstrator before his class. We believe that reports of actual teaching clinics are among the most useful and popular articles in our State Journal.

What is the mental attitude of a clinical teacher before his class? It is exactly the same as that of a physician in the presence of his patient whom he is seeing for the first time. On the one hand the teacher has a great number of items of knowledge classified, systematized, and filed away in his brain for ready use. This is the text book or medical article equipment of the physician—the tools with which he works. On the other hand there is a sick person on whom the physician will apply some items of his mental equipment.

The expert teacher does not use every bit of mental equipment that he happens to possess on every patient, any more than a modest surgeon lays out all his instruments for every operation. The teacher stands before his audience and thinks out loud. He reveals the mental processes by which he reaches a conclusion. Those processes may be brief and direct in certain cases, or lengthy and complicated in others, but in either event the teacher reveals the items of knowledge which he applies to the particular sick person, and also demonstrates how he uses those items.

The ideal clinical lecture will consist of two parts. First, there will be a general text book description of the condition to be demonstrated. This will give a picture of the ideal or standard case, which of course seldom exists.

Secondly, the teacher will point out the actual

picture which the sick person presents to his mind, and will compare that picture with the ideal or text book description of the sickness. This is the most practical method of teaching the practice of medicine.

What class of cases are most interesting to doctors? Physicians are most interested in the class which they see the most often—the common lesions of the heart, lungs, kidneys, and stomach. Advances in the methods of diagnosis and treatment are continually being made, and in the course of five years a general practitioner is likely to be behind the times in most subjects.

Dr. Gordon and his colleagues on the committee on Public Health and Medical Education, are planning to make medical study easy for the members of the State Society. The plan is to systematize instruction, so that a doctor can get a broad view of a medical subject with a minimum of effort. This means that articles of an elementary nature must be prepared, and that clinical teachers must be provided for classes of general practitioners.

There is a ready test for the popularity and practicality of a subject. We have made it our practice to attend as many clinical demonstrations as possible, and to take notes and make abstracts of the teachers' remarks. If the teacher was interesting and practical, we always have had impatient requests from his hearers to know when we are going to publish the abstract.

We believe that an elementary text book article on some common disease, ending with clinical reports of actual cases, is the most useful form of paper that we can publish.

We have now and then found most excellent clinical teachers who object to the publication of their remarks. The ground of their objection is usually that their remarks are too simple and incomplete for publication. Our reply is that if they interest an audience of listeners, they will also interest an audience of readers.

We have treated this same subject editorially on page 659 of our April 17 issue. F O

## MEDICAL PRACTICE ACT

The Special Committee of Seven appointed by the President on the authorization of the House of Delegates, to prepare a Medical Practice Act for introduction in the Legislature during the session of 1926, has held fortnightly meetings all

through the Summer, and has outlined a comprehensive bill. The magnitude of the task and the necessity of extensive investigations have precluded the completion of the work by September 1st, but a report in the near future is assured.

# LEGAL

By GEORGE W. WHITESIDE, Esq  
Counsel, Medical Society of the State of New York

## A TRIAL BY JURY SHALL REMAIN INVIOLETE FOREVER

*"Gentlemen of the Jury Take the case and do the fine fair thing with it You must not allow sympathy, you must not allow prejudice to influence you and I am sure you will not Whenever anybody has suffered pain we are bound to be sympathetic, but we are deciding a case on the law, not on sympathy, not on prejudice Take it and do the fine fair thing with it and thereby we will be vindicating that system of justice which we are so proud of and which, of course, really needs no vindication"*

Thus spoke the judge after three weeks of weary trial of three doctors as he committed to twelve men, good and true, the case for decision. Was the diagnosis based on a proper scientific examination? Was the operation which was performed justified? Were the doctors responsible for the infection appearing after the operation, for the long suffering and injury claimed by the plaintiff to have resulted therefrom? Were the doctors responsible for the disabilities suffered by the plaintiff some years later? Should they be condemned and heavy damages assessed against them? The pathologist, bacteriologist, the surgeon, the medical men on both sides of the case had given voluminous testimony and the time had come for the twelve laymen to say what they thought a negative culture, after twenty-four hours' incubation, signified, what the leucocyte count indicated, what story the various microscopic and chemical urine tests told, whence came the bacilli and bacteria in the plaintiff's urine, what diagnosis, operation and treatment they thought was proper in the case. These twelve jurors became the final judges of the scientific questions with which the most expert of specialists had struggled and were, by their decision, to determine whether the reputation for scientific knowledge, skill and care of these defendant doctors, built up by years of self sacrifice study and devotion to their profession, was to be destroyed by a decision that they were unfit, unqualified or careless in the treatment of the plaintiff. These jurors were men whose training, education and experience were all foreign to the practice of medicine. A grocer, a horticulturist, an architect, an engineer, a barber, an accountant, a bank clerk, a salesman, a small town merchant and several business men comprised the jury to whose tender mercies these important issues were committed. Whether the case be one for goods sold, debt, or one based on science, evolution or the

books of Genesis, a trial by jury "shall remain inviolate forever"

Had not these men at the beginning of the trial raised their right hands and sworn they would well and truly try the issue joined between the plaintiff and the defendants and a just verdict render according to the evidence, and had not the judge with patience and learning for about an hour and a half charged the jury, elucidating to them the facts of the case as given on both sides and the law to be applied to those facts, finally saying "that the right of the plaintiff to recover in this case necessarily depends upon medical evidence, that the plaintiff may not recover merely on the evidence of laymen—this is the law of this state, whatever it may be in other states—nor by the jurors considering because of their own knowledge or experience

In this connection the plaintiff claims that upon the credible medical and other evidence in this case he has established that the diagnosis and treatment of himself was not characterized by that skill and care which the law requires and that injury because of that resulted to him, he claims this upon evidence including the testimony of medical experts

The defendants, on the other hand, claim that on the whole case they exercised the care and skill required by law and further, that any result, even if not good, is not shown to be attributable or traceable to what they or any one or more of the defendants did, that what they or any one of them did is not shown to be a competent producing or proximate cause of the plaintiff's claimed injury"

The jury retires from the hot courtroom behind the closed door where the evidence is to be discussed. The principals in the tragedy await patiently and apprehensively for the knock on the door from within that signalizes that the jury have agreed. A half hour passes—time drags on until an hour has elapsed. Will disagreement of the jury make necessary a retrial for another three or four weeks of the whole case? The second hour passes. All that can be heard as the night wears on in the courtroom is the dim sound of voices from behind the closed door of the juryroom. Three hours—the question so vital to these doctors remains unanswered. Within the next quarter of an hour a rapping is heard. The whispers about the courtroom of those who have lingered are plainly heard, "they have agreed." Counsel studies the faces of the jury as they pass into the courtroom, hopeful that from the

expression of the eye he may glean some faint hope that his clients' fate has been justly decided. The court clerk who hundreds and hundreds of times during the past years has droned out the same question, rises and says, "Gentlemen of the jury, have you agreed upon a verdict?" responds the foreman, "We have." "How find you?" The foreman seems conscious that all eyes are boring into his trying to read the answer before his lips move—"We find a verdict in favor of—the defendants." Counsel on each side, who had waged bitter warfare for three weeks, marshalling against each other their scientific battalions, mowing down scientific fallacies and building up defenses of impregnable truth, who have summed up with all the scathing sarcasm and contempt that each command, exchange felicitations. The doctor defendants hardly realize that the strain is over and they have won as they slowly recover from the shuddering thought that science, under

the constitution, is ultimately at the mercy of the lay jury's verdict. The case is over. Counsel returns to his office to learn that other cases for other doctors are crowding their way up to the top of the calendar, ready to be sent out for trial. Then, again the drama in another case will be enacted for a day, two days or more, on a different stage with another cast, which will be in most respects a repetition of that upon which the final asbestos curtain was lowered the night before.

What will the next jury composed of salesmen, merchants, farmers, grocers, machinists, engineers, trolley car conductors, bank presidents, clerks, investment brokers and professors do with the case left to their decision, and the next, and the next? For Article 1 of the Constitution says, "*The trial by jury in all cases in which it has been heretofore used shall remain inviolate forever*"

### INJURED ANKLE—SUBSEQUENT INFECTION

In this action it was charged that the defendant as a physician, about the middle of December, was engaged to attend the plaintiff for an injury to her left foot and that he failed to render proper treatment and care for a period of about two weeks after his engagement. It was claimed that he applied a plaster cast to the ankle and foot at a time when the same was infected and that the infection was thereby increased and caused an abscess to form, resulting in the spread of the infection. That about two weeks thereafter he operated upon the ankle at which time he failed properly to cleanse, disinfect and drain the wound, with the result that the plaintiff's foot and ankle and leg up to the knee became poisoned and infected. That the plaintiff suffered for a period of ten weeks, during which time it was necessary for her to be under the care of another physician. That she was prevented from attending her employment and confined to bed for about eight weeks.

From the doctor's records it appeared that at the time he first attended the plaintiff he found that she had slipped and fallen, sustaining an injury to the left ankle. He prescribed an opium and lead wash. At this time no infection was discovered by the defendant. The patient was told to remain in bed and that the doctor would return in two days and for her to apply the prescription in the meantime. When he returned two days thereafter he found the patient in bed, examined the foot

and ankle and noted a subsidence of the swelling. There was no redness or infection in the region of the ankle at this time. The ankle was then strapped with adhesive tape and the patient was advised to remain in bed for three days and to advise the defendant physician at that time of the condition of the foot.

Nothing was heard from the patient by the doctor until ten days thereafter, when the patient was up and about and had failed to follow the instructions which had been given her. The plaintiff had also been going to her work daily. She complained of pain in the ankle and upon removal of the adhesive plaster the skin on the margin of the plaster was found infected. The wound was cleansed and an iodoform gauze drain placed in the wound, the ankle bandaged and the plaintiff advised to remain in bed. On the following day the doctor called, examined the foot, dressed the wound and rebandaged it. For three successive days he called daily, examining and dressing the foot each time, and the foot during this time showing improvement. At that time he advised the patient to come to his office upon the following day. Nothing further was heard from the patient until the institution of this action.

The matter finally came on for trial and at the close of the plaintiff's case was dismissed upon the merits by the trial court, thus favorably terminating the action in favor of the defendant physician.

## State Department of Health

### CASE OF TETANUS FROM AN UNUSUAL INJURY

According to a report, by the attending physician, Dr Joseph G Patiky, of Huntington, Long Island, the patient, a boy two years old, was playing in the yard of his home when he fell down and injured his eye. At that time, apparently, there was no foreign body in the eye. On the following day, when Dr Patiky first saw the case, the lids of the injured eye were markedly swollen, with a very free discharge of pus. The child was referred to an eye specialist the same day who was unable to open the lids sufficiently to see the eyeball. On the next day the swelling and discharge of pus had somewhat subsided and the child's mother while bathing the eye removed a piece of wood about one-half inch long and about the thickness of a match. Dr Patiky again examined the child and found the eyeball was uninjured, but observed a hole in the upper lid where the wood had been imbedded. At

this time infection no longer seemed to be present.

On the following day, three days after the date of injury, the patient developed slight twitching of his face and arm on the injured side. He was immediately given 10,000 units of tetanus antitoxin subcutaneously and intramuscularly and two hours later 20,000 units intraspinaly. The muscular twitching, however, became worse and in twenty-four hours the child had tetanic seizures of the entire body. Twenty thousand units of antitoxin were again administered intraspinaly and the same amount after twenty-four hours. In spite of the treatment the temperature reached 106.5 and the patient died a few hours later.

This case is deemed worthy of note because of the unusual type of injury and the very short incubation period.

### DEATH FROM AMOEBIC DYSENTERY COMPLICATED BY ABSCESS

Following a request of the Division of Communicable Diseases, a report was recently received from the Buffalo General Hospital, giving the history and findings in the case of a patient whose death was reported to be due to "amoebic abscess of liver and lung—parenchymatous degeneration of viscera."

According to the history received, this patient suffered with acute diarrhea lasting about two weeks, in September, 1924. It was noticed that there was blood in his stools throughout the attack. In November he developed shortness of breath upon exertion. His legs and ankles started to swell and he was admitted to the emergency hospital on November 2, where he remained until the middle of January. During this time he lost forty pounds. In December he was troubled with a cough and profuse yellow expectoration. He was admitted to the General Hospital on February 28. He had spasmodic coughing but apparently no pain. Breath sounds were diminished over bases, more so over the right base and axilla. Legs and ankles were oedematous. No

amoebae were found in several examinations of feces. X-ray examination indicated that there was an elevation of the right diaphragm, apparently produced by something crowding up from below, e. g., echinococcus or abscess. On March 11 the patient raised a large amount of dark brown sputum. It contained many pus cells. Clinically, there was evidence of considerable fluid in the right chest. Patient died on March 25.

Autopsy showed healed ulcers in the colon. Two large abscesses were found in the right lobe of the liver with perforation through the diaphragm into the adherent upper ('1') lobe of the right lung with the formation of an irregular multi-locular abscess occupying the greater half of the lobe, and showing perforation into the bronchus of the upper lobe. Also there was right-sided pleurisy, purulent bronchitis with numerous foci of lobular pneumonia, moderate swelling and softening of the spleen, degeneration of the heart muscle, liver and kidneys, oedema and anaemia of brain. Amoebae were isolated from specimens following autopsy.



ries, and the result is that the city of Watertown has milk of an unusually high standard

*Hospitals*—Jefferson County has three general hospitals and a County Tuberculosis Sanatorium, as follows

City Hospital, Watertown	100 beds
Mercy Hospital, Watertown	90 beds
General Hospital, Theresa	20 beds
County Tuberculosis, Watertown	50 beds
Total	260 beds

The county has 3.25 hospital beds for every thousand of population. The hospitals are usually full, and Mercy Hospital is adding 90 beds to its equipment. The village of Carthage, the southeastern corner of the county, is about to start its own hospital, and the local hospital Theresa takes care of emergency cases in the northern section of the county.

The City Hospital maintains a high standard, in accordance with that of the American College of Surgeons. It maintains an excellent laboratory and employs a history clerk. Both it and the Mercy Hospital conduct training schools for nurses.

*Clinics*—The outpatient care of the sick is done in clinics held in the Memorial Health Building in Watertown, which was built with funds left over from the War Chest. It provides space for clinics in pediatrics, pre-natal, tuberculosis, throat work and dentistry, and is the headquarters for the public health nurses and the Red Cross workers.

A venereal disease clinic is about to be established in the Mercy Hospital.

*Departments of Health*—The official public health work of Jefferson County is in charge of health officers who serve 35 districts. Each health officer outside of Watertown serves an average of about 2,200 people.

The health officers of Jefferson County are well equipped for their work. Seventy per cent of the health officers have taken special courses to fit themselves for their work (see this Journal, August, 1925, page 877).

Seventy-five per cent of the health officers are members of the County Society.

Forty-five per cent of the physicians outside of Watertown are health officers.

The tuberculosis work of Jefferson County centers in the County Sanatorium, which is located just outside of Watertown. There is also a Lay Tuberculosis Committee. The leaders in the County Medical Society are planning for an enlarged scope of tuberculosis activity of the county which shall include a full-time superintendent of the hospital, and teaching clinics for the instruction of the physicians of the county.

Jefferson County has no official public health laboratory, but emergency examinations of cul-

tures are made in the City Hospital of Watertown. The county has 10 public health nurses.

*Medical Publicity*—The Jefferson County Medical Society has a committee on publicity which has made serious attempts to do publicity work through the daily press. The newspapers are well disposed toward the physicians, and the two dailies of Watertown are willing to co-operate with the physicians. The publicity committee of the County Society plans to make publicity of the meetings and activities of the Society through the newspapers.

*Impressions*—The physicians of Jefferson County are united and progressive to an unusual degree. The success of their organizations is due to a considerable extent to the peculiarly favorable geographic conditions. The city of Watertown is the natural center of the county in nearly every respect, and the whole county medically and otherwise, is a suburb of the city. Added to this is a progressiveness and a spirit of co-operation on the part of the physicians of both the urban and the rural sections. The doctors of Jefferson County are setting an example for the rest of the State.

#### LEWIS COUNTY

Lewis County adjoins Jefferson on the east and south. Its medical conditions are largely dependent on those of Jefferson County. The physicians of Lewis County associate themselves closely with those of Jefferson County, and attend the meetings which are held in Watertown. This close association is due to geographic conditions.

Lewis County has an area of 1,270 square miles, and a population of 23,704, according to the 1920 census. The population is about 1,000 less than it was in 1850, and 7,000 less than in 1880, when the population was at its peak.

Lewis County occupies the broad valley of the Black River which flows north through the center of the county, and passes through Watertown. Travel is easy down the river valley, but is difficult over the mountains on the east and west.

The villages of Lewis County are located on the Black River. The largest is Lowville, with 3,127 population, which is increasing.

There are 20 doctors practicing in Lewis County, or one doctor to every 1,200 people. They are located in 11 centers, mostly along the river valley. The Lewis County Medical Society has 15 members, a large proportion of whom also attend the medical meetings in Watertown.

There are 10 health officers in Lewis County, all of whom are members of the County Society. Six of the health officers have taken special courses of instruction for health officers.

The physicians of Lewis County are progressive and active, and are interested in graduate medical education.



# DISTRICT BRANCHES



## DISTRICT BRANCHES

### ANNUAL MEETINGS FOR 1925

First District Branch—Wednesday, October 14, Poughkeepsie

Second District Branch—Tuesday, October 13, Hempstead

Third District Branch—Friday and Saturday, September 25 and 26, Haines Falls

Fourth District Branch—Thursday, October 8, Amsterdam

Fifth District Branch—Friday, October 9, Marcy

Sixth District Branch—Tuesday, October 6, Ithaca

Seventh District Branch—Thursday, September 24, Auburn

Eighth District Branch—Wednesday, October 7, Buffalo

## THIRD DISTRICT BRANCH

ANNUAL MEETING, TWILIGHT PARK, HAINES FALLS, FRIDAY AND SATURDAY, SEPTEMBER 25TH AND 26TH, 1925

The first day of the meeting will be devoted to the scientific and business sessions of the Branch

The second day of the meeting will be devoted to sports of various kinds

Special rates are offered by the management to those who wish to spend the week-end at the Park.

Special attractions will be provided for the ladies

Come early, stay late, bring your wives and sweethearts and enjoy yourself

### PROGRAM

Friday, September 25th, 1925

10 A M, Daylight Saving Time

Address of Welcome—Lyle B Honeyford, M D, President Greene County Medical Society

President's Address—Charles P McCabe, M D, Greenville, President Third District Branch

### SYMPOSIUM

Lesions of the Stomach

Diagnosis—Illustrated with lantern slides, Charles Gordon Heyd, M D, New York

Medical Treatment—Anthony Bassler, M D, New York City

Surgical Treatment—Charles H Peck, M D, New York City

Luncheon 1 30

Afternoon Session

### Business Session

Reports of the Chairmen of the Committees on Medical Education, Public Health, Nursing Situation, Membership, County Society Programs

Address—Nathan B Van Etten, M D, New York City, President, Medical Society of the State of New York

Address—Daniel S Dougherty, M D, New York City, Secretary, Medical Society of the State of New York

Address—The Functions of a District Branch, Joseph S Lawrence, M D, Executive Officer, Medical Society of the State of New York

Scientific Paper—Some Neurological Problems, Nelson K Fromm, M D, Albany

Address—Col George F Chandler, M D, Kingston, Member Committee on Graduate Medical Extension Instruction

Dinner, 6 30 P M

Evening Session 8 30 P M

Moving Picture—Lesions of the Stomach (Furnished by the Medical Society of the State of New York)

Dancing—9 30 P M

SATURDAY, SEPTEMBER 26, 1925

Saturday, September 26th, will be given over to sports of various kinds. The management of the hotel offers cups for the winners in the various events. Special arrangements have been made for the entertainment of the ladies



## FOURTH DISTRICT BRANCH

ANNUAL MEETING, AMSTERDAM, THURSDAY, OCTOBER 8, 1925

Address of Welcome—Horace M Hicks, M D ,  
President, Fourth District Branch

Address—Nathan B Van Etten M D , Presi-  
dent Medical Society of the State of New York

Address—Daniel S Dougherty, M D , Secre-  
tary, Medical Society of the State of New York

Address—Joseph S Lawrence, M D , Execu-  
tive Officer, Medical Society of the State of  
New York

"Details of How the Medical Society of the  
County of Montgomery Will Provide Post-  
Graduate Courses for the Members of the County  
Society," Charles Stover, M D , Amsterdam

"Details of the Use of the Improved Barton  
Obstetric Forceps," William E Caldwell, M D ,  
New York City

"Physiognomy and Its Relation to Diagnosis,"  
George Draper, M D , New York City

County Laboratory Exhibit of pathological  
specimens, including interesting slides Dr Dick-  
son of the laboratory will speak in regard to this  
demonstration

### EVENING SESSION

(Open to the Public)

Films on Tuberculosis, with local and outside  
speakers

## SEVENTH DISTRICT BRANCH

ANNUAL MEETING, AUBURN, THURSDAY, SEPTEMBER 24, 1925, AT 11 A M

"The Treatment of Tic Douloureux," Henry  
Ward Williams, M D , Rochester

"The Treatment of Scarlet Fever," Perry A  
Bly, M D , Rochester Municipal Hospital

"Cancer Control Education in Each County,"  
John M Swan, M D , Rochester

Luncheon

Election of Officers

"Infections of the Hand," Harry R Trick,  
M D , Buffalo

"Bonesetters, Chiropractors, et al," Edward  
T Wentworth, M D , Rochester

"Problems of the State Society" By the  
President and Secretary of the Medical Society  
of the State of New York

## EIGHTH DISTRICT BRANCH

ANNUAL MEETING BUFFALO CITY HOSPITAL, WEDNESDAY, OCTOBER 7, 1925

### Morning Session

Exposition of work in Periodic Health Exami-  
nations with presentation of various types of  
charts for carrying on the work and methods for  
getting the message to the public, under the di-  
rection of Dr W Warren Britt, Chairman Com-  
mittee on Medical Economics, assisted by a repre-  
sentative of the Metropolitan Life Insurance  
Company, and others

Address—Nathan B Van Etten, M D , Presi-  
dent, Medical Society of the State of New York

Address—Daniel S Dougherty, M D , Secre-  
tary, Medical Society State of New York

Address—Joseph S Lawrence, M D , Execu-  
tive Officer, Medical Society State of New York

Election of Officers

Luncheon, given by the Erie County Medical  
Society

### SCIENTIFIC PROGRAM

"The Differential Diagnosis of Pain in the

Right Lower Quadrant of the Abdomen,"  
Charles Goodell, M D , Jamestown

"The Surgery of the Handicapped Patient,"  
William D Johnson, M D , Batavia

"Some Solved and Unsolved Problems in Gall-  
Bladder Surgery," Edgar R McGuire, M D ,  
Buffalo

"The Acute Leukaemias," Nelson G Russell,  
M D , Buffalo

"A Resume of Recent Researches in Cancer,"  
Burton T Simpson, M D , Buffalo

Exhibit of X-Ray films during the meeting by  
C R Orr, M D , and Pathologic Specimens by  
W F Jacobs, M D , showing various diseases  
that were apparently caused by certain industries

6 30 P M Subscription Dinner

8 30 P M Evening Session open to the Public

Moving pictures showing the desirability of  
Periodic Health Examinations, as well as other  
subjects that may come up later



# DISTRICT BRANCHES



## DISTRICT BRANCHES

### ANNUAL MEETINGS FOR 1925

First District Branch—Wednesday, October 14, Poughkeepsie

Second District Branch—Tuesday, October 13, Hempstead

Third District Branch—Friday and Saturday, September 25 and 26, Haines Falls

Fourth District Branch—Thursday, October 8 Amsterdam

Fifth District Branch—Friday, October 9 Marcy

Sixth District Branch—Tuesday, October 6 Ithaca

Seventh District Branch—Thursday, September 24, Auburn

Eighth District Branch—Wednesday, October 7, Buffalo

## THIRD DISTRICT BRANCH

ANNUAL MEETING, TWILIGHT PARK, HAINES FALLS, FRIDAY AND SATURDAY, SEPTEMBER 25TH AND 26TH, 1925

The first day of the meeting will be devoted to the scientific and business sessions of the Branch

The second day of the meeting will be devoted to sports of various kinds

Special rates are offered by the management to those who wish to spend the week-end at the Park

Special attractions will be provided for the ladies

Come early, stay late, bring your wives and sweethearts and enjoy yourself

### PROGRAM

Friday, September 25th, 1925

10 A M, Daylight Saving Time

Address of Welcome—Lyle B Honeyford, M D, President Greene County Medical Society

President's Address—Charles P McCabe, M D, Greenville, President Third District Branch

### SYMPOSIUM

Lesions of the Stomach

Diagnosis—Illustrated with lantern slides, Charles Gordon Heyd, M D, New York

Medical Treatment—Anthony Bassler, M D, New York City

Surgical Treatment—Charles H Peck, M D, New York City

Luncheon at 1 30 P M

Afternoon Session, 2 30 P M

### Business Session

Reports of the Chairmen of the Committees on Medical Education, Public Health, Nursing Situation, Membership, County Society Programs

Address—Nathan B Van Etten, M D, New York City, President, Medical Society of the State of New York

Address—Daniel S Dougherty, M D, New York City, Secretary, Medical Society of the State of New York

Address—The Functions of a District Branch, Joseph S Lawrence, M D, Executive Officer, Medical Society of the State of New York

Scientific Paper—Some Neurological Problems, Nelson K Fromm, M D, Albany

Address—Col George F Chandler, M D, Kingston, Member Committee on Graduate Medical Extension Instruction

Dinner, 6 30 P M

Evening Session 8 30 P M

Moving Picture—Lesions of the Stomach (Furnished by the Medical Society of the State of New York)

Dancing—9 30 P M

SATURDAY, SEPTEMBER 26, 1925

Saturday, September 26th, will be given over to sports of various kinds. The management of the hotel offers cups for the winners in the various events. Special arrangements have been made for the entertainment of the ladies

## FOURTH DISTRICT BRANCH

ANNUAL MEETING, AMSTERDAM, THURSDAY, OCTOBER 8, 1925

Address of Welcome—Horace M. Hicks, M.D., President, Fourth District Branch

Address—Nathan B. Van Etten, M.D., President Medical Society of the State of New York

Address—Daniel S. Dougherty, M.D., Secretary, Medical Society of the State of New York

Address—Joseph S. Lawrence, M.D., Executive Officer, Medical Society of the State of New York.

"Details of How the Medical Society of the County of Montgomery Will Provide Post-Graduate Courses for the Members of the County Society," Charles Stover, M.D., Amsterdam

'Details of the Use of the Improved Barton Obstetric Forceps,' William E. Caldwell, M.D., New York City

'Physiognomy and Its Relation to Diagnosis,' George Draper, M.D., New York City

County Laboratory Exhibit of pathological specimens, including interesting slides. Dr. Dickson of the laboratory will speak in regard to this demonstration.

### EVENING SESSION

(Open to the Public)

Films on Tuberculosis, with local and outside speakers

---

## SEVENTH DISTRICT BRANCH

ANNUAL MEETING, AUBURN, THURSDAY, SEPTEMBER 24, 1925, AT 11 A.M.

"The Treatment of Tic Douloureux," Henry Ward Williams, M.D., Rochester

'The Treatment of Scarlet Fever,' Perry A. Bly, M.D., Rochester Municipal Hospital

"Cancer Control Education in Each County" John M. Swan, M.D., Rochester

Luncheon

Election of Officers

"Infections of the Hand," Harry R. Trick, M.D., Buffalo

"Bonesetters, Chiropractors, et al.," Edward T. Wentworth, M.D., Rochester

"Problems of the State Society" By the President and Secretary of the Medical Society of the State of New York

---

## EIGHTH DISTRICT BRANCH

ANNUAL MEETING, BUFFALO CITY HOSPITAL, WEDNESDAY, OCTOBER 7, 1925

### Morning Session

Exposition of work in Periodic Health Examinations with presentation of various types of charts for carrying on the work and methods for getting the message to the public, under the direction of Dr. W. Warren Britt, Chairman Committee on Medical Economics, assisted by a representative of the Metropolitan Life Insurance Company, and others

Address—Nathan B. Van Etten, M.D., President, Medical Society of the State of New York

Address—Daniel S. Dougherty, M.D., Secretary, Medical Society State of New York

Address—Joseph S. Lawrence, M.D., Executive Officer, Medical Society State of New York

Election of Officers

Luncheon, given by the Erie County Medical Society

Right Lower Quadrant of the Abdomen," Charles Goodell, M.D., Jamestown

"The Surgery of the Handicapped Patient," William D. Johnson, M.D., Batavia

"Some Solved and Unsolved Problems in Gall-Bladder Surgery," Edgar R. McGuire, M.D., Buffalo

"The Acute Leukaemias," Nelson G. Russell, M.D., Buffalo

"A Resume of Recent Researches in Cancer," Burton T. Simpson, M.D., Buffalo

Exhibit of X-Ray films during the meeting by C. R. Orr, M.D., and Pathologic Specimens by W. F. Jacobs, M.D., showing various diseases that were apparently caused by certain industries

6 30 P.M. Subscription Dinner

8 30 P.M. Evening Session open to the Public

Moving pictures showing the desirability of Periodic Health Examinations, as well as other subjects that may come up later

### SCIENTIFIC PROGRAM

"The Differential Diagnosis of Pain in the



# NEWS NOTES



## THE FLOATING HOSPITAL OF ST JOHN'S GUILD

We recently spent a pleasant day on the Floating Hospital of St John's Guild, whose headquarters are at 52 Vanderbilt Avenue, New York City, and observed the operation of one of New York City's most interesting institutions. We started from the foot of East 26th Street at 9 o'clock with 200 women, 680 children, and 88 babies on board, and sailed to Sandy Hook and back. The boat was filled to only half its capacity, for a slight collision, in which no one was hurt, had been magnified in the dailies, and many East Side mothers were afraid to go on the boat. Enterprising reporters had even been caught tying towels around the heads of the children and posing them for photographs of the "injured." Such are some of the difficulties with which the well-doers must contend in the busy city.

The Floating Hospital was organized in 1866 to provide a cool retreat for sick babies in the days when summer complaints were ascribed to the heat principally. The boat now carries a fully equipped hospital for 32 children, with two internes and a full equipment of nurses and dietitians. The beds contained 20 severely sick children on the day of our visit.

The boat also takes on board mothers and children without much restriction as to age, and none as to social condition. The doctors inspect the

children for head lice and other contagious conditions, as the passengers come aboard, and those who are found to be affected are isolated until they can be treated. Salt water baths are available for all, and milk and sandwiches are distributed. A supervisor of plays is employed, and half of the lower deck is the stage for games during the entire day.

The backs of the benches are provided with hammocks in which the babies swing and sleep under the eyes of their mothers, who often stretch themselves on the benches for a day of relaxation.

One of the newest and most interesting phases of the Floating Hospital was the educational work which is carried on by the Health Teacher, Miss Jessie Forshaw. We were particularly interested in the work of Miss Forshaw because we have tried to devise methods of teaching medical facts to laymen, and we believe that the Floating Hospital affords an effective means of reaching mothers. The talks are based on actual cases which she observes, the mothers are personally interested in what she says, and there is leisure time to absorb and discuss the teacher's words. We are printing Miss Forshaw's own description of her work.

F O

## HEALTH TEACHING ON THE FLOATING HOSPITAL

By JESSIE FORSHAW,

Health Teacher

The "Floating Hospital," which belongs to St John's Guild, a philanthropic organization, sails from New York piers daily throughout two months of the summer. It carries an average group of 600 children and 140 babies, and 260 mothers accompanying them. For the children, a recreational program is provided, to combine physical exercise with a certain amount of health education, with the mothers a direct program of instruction in matters of health is attempted by the health teacher.

Instead of lecturing formally to assembled groups, the aim of the health teacher is to effect a daily personal contact with each mother in a free and friendly manner. While doing this, opportunity is easily afforded for the observation of faulty or improper child hygiene. Such matters as physical defects, incorrect methods of feeding, the cultivation of improper habits, and so forth, are brought to light. The situation is exceptionally well adapted for such work, as the

mothers and children are on the boat for the whole day, while many take all the trips during the summer. Another factor which favors the health teacher is the relaxed and receptive mood of the mothers, due to their freedom from household worries. There are no distracting stimuli with which to contend, such as a pot burning dry, or a tub of clothes to be washed.

### A TYPICAL DAY

A description of a few of the observations made during the day will serve to illustrate the method of attack, and the kind of instruction which is given.

I find several two- or three-year-old children drinking from nursing bottles. This introduces a talk to their mothers about habit formation, and the effect of diet on the nutrition and general development of the child. Some mother, by way of defending herself, will say that her child is "skinny," has no appetite, and will not take any-

thing except from the bottle I take advantage of her admission that the bottle is the cause of the child's trouble, and explain in simple and intelligible language how its appetite may have been satisfied, whereas its nutritional needs have not. During this explanation the attention of fifteen or twenty other mothers has been attracted, and some of these have undoubtedly taken to themselves something of benefit from the instruction.

The mother in the next seat will ask me to look at her boy. He is "skinny," she says. Also that at school he was told he had tonsils, which she does not believe. And will I tell her? Yes, he has diseased tonsils. I show them to her—enlarged, cryptic, and marked with pus. I explain to her that this may be one of the reasons why her child is "skinny." I then equip her with a note to a tonsil clinic, and I feel certain that she will have the condition remedied. She will do this because she has been directly convinced that the child has diseased tonsils, and because I have taken the time to explain the possible effects of neglect. Often mothers in the seats near by have been listening, and there will be competition among them as they try to get my attention riveted on their children. Health teaching is thus immensely simplified. The attention of the mothers has been aroused. They want to know. The rest is easy.

I find a mother screeching at her child who is in a well defined temper tantrum. It takes some time to recall the mother to a reasoning state of mind, but after that a quiet little talk is in order, the child having been sent in the meantime to play with others. I try to impress upon those in that particular corner that motherhood is more than the mere feeding and clothing of a child. It is also the training of a child to make adjustments even to its own small environment. Mothers are much too prone to keep their young ones dependent, instead of encouraging resourcefulness in them.

The next problem may be the much hackneyed "pacifier" question. There is still much to be accomplished in this regard, in spite of the great good that health workers have already done. In this instance I choose a young mother to speak to, because I know I will get a better reaction from the surrounding group. One can say a great deal to a young mother, much that others will drink in without feeling that their "divine right of instinctive motherhood" has been slandered. Surprise creeps over their faces as I tell them that God intended babies to cry in reasonable amount, that it is thus they learn to gurgle and later to talk, and that they need the exercise of crying to encourage lung and abdominal development. It is like a new gospel to these women, and most of them find an unexpected relief in it.

In a seat not far away I find a boy of about

fourteen years of age huddled close to his mother. I ask why he does not play with the other boys, and soon discover that he is one whose personality requires careful handling if he is to be saved from succumbing to the dangers of adolescence. The necessary teaching in this case is hard to give the average layman, but something needs to be done. The most practical act is to take him to the playroom, and have the play directors help him mix with the other boys. The mother will refuse to let him go, pleading that "he is afraid," and this leads on to a discussion of healthy play, and the abuse of the instinct of fear. Frightening a child in order to secure obedience shows only poor management, and is a crime against him. Points to be stressed are the need of play and recreation, the danger of over-fatigue from too much activity, and the importance of a regular and reasonable bedtime.

Here is a mother who has her baby overdressed. This gives occasion for a much-needed talk on the proper clothing of the baby. During the summer months, especially, the poor things seem to suffer from a superabundance of motherly affection along this line.

In the midst of all this a mother is discovered giving her three-year-old a huge dill pickle, which the latter seems to relish immensely, clasping it much as one would a banana. Ten years from now medical science may discover that dill pickles contain some very necessary elements of nutrition, but for the present they are taboo. This violation of diet standards provides another opportunity to explain the importance of food for the growing child and also to suggest the kind of diet suitable to such a child, together with the need for attractive and regular preparation of meals.

I find a child with whooping cough, and try first to impress upon the mother that she has violated a moral responsibility by bringing her child in contact with others. I can then explain the modern conception of the communication of diseases, illustrating the principle with the concrete situation before me.

These instances show what can be done in the way of instructing women along health lines, and how it may be accomplished in the direct way. The repetition which occurs when different mothers require the same sort of information, and which would be avoided by the lecture method, is more than compensated for by the strength of the impression made through the direct personal talk. No one is allowed to think that the instruction is theoretical or academic. The audience has always a concrete case before it, and one which bears a close personal interest for at least one member of the group. In this way the "project method" is put into practice, and the positive results are indeed gratifying.

## LIVINGSTON COUNTY MEDICAL SOCIETY

A regular meeting of the Livingston County Medical Society was held at the Craig Colony, Sonyea, N Y, on May 5th, 1925. It has become an established custom for the Society to hold its regular spring meeting at this institution as guests of the Medical Superintendent, Dr William T Shanahan, and his staff.

Following an excellent luncheon at 1 P M, the Society was called to order by President Harold A Patterson. The scientific program preceded the business meeting and was as follows:

"The Treatment of Cardiac Decompensation," by Dr Edward W Jackson, Rochester. Dr Jackson's paper was a valuable one to the general practitioner, explaining as he did, the newer methods of treatment of cardiac conditions. The free discussions that followed emphasized the interest with which the members had listened to his presentation.

"The Evaluation of Symptoms," by Dr George Eckel, Buffalo. Dr Eckel's talk was of immense practical value. He took up some of the more common symptoms with a view of differential diagnosis and cited cases to illustrate the

various points made. He laid particular stress on the part played by focal infections in the production of vague symptomatology.

The Society was especially honored by the presence of the President of the Medical Society of the State of New York, Dr Owen E Jones, who next addressed the Society with an eloquent plea for "Preventive Medicine." Dr Joseph Lawrence, Executive Officer of the State Society, gave an outline of the work being carried on by the State Society and of its plans for the future. His talk convinced all present of the necessity for the increase in the State dues and the need for close co-operation between the State and County Societies.

The usual routine business session followed which included the reading of the minutes of the last meeting and reports of committees. The Society received the application of Dr Philip A. Palsano of Mt Morris and duly elected him to its membership. The matter of the revision of the fee bill was again voted to be laid on the table until next meeting. Twenty-three members and nine guests were present.

## KEUKA LAKE MEDICAL SOCIETY

The twenty-sixth annual meeting of the Lake Keuka Medical and Surgical Association was held on July 9th and 10th in the Keuka Hotel, Keuka, Steuben County. The Society combines science with pleasure, and its members and their wives get together on Keuka Lake for a two-day outing on the Thursday and Friday nearest the full moon of July.

The Association has no formal membership list, but about 250 physicians from most of the counties of Central New York come together spontaneously and elect a president and a secretary and pay two dollars apiece toward the expenses of the meeting. We received from Dr John A Hatch, of Penn Yan, Secretary of the organization, a program which announced the meeting as the "Snappiest Surgical and Meatiest Medical Meeting in New York State for 1925."

"Program Points," contained in the announcement are as follows:

Douglas P Arnold, M D, Buffalo Children's Hospital—"Diarrhea in Children," lantern slides

Oswald S Lowsley, M D, F A C S, Uro-

logist, New York City Hospital—"Regional Anesthesia in Kidney Surgery," lantern slides

Samuel Calvin Smith, M D, Cardiologist, Philadelphia—"Cardiac Irregularities"

Charles Gordon Heyd, M D, F A C S, Professor of Surgery, New York Post Graduate Hospital—"Differential Diagnosis of the Right Upper Abdomen"

Charles Franklin Hoover, M D, Professor in Medicine at Western Reserve, attending Lakeside Hospital, Cleveland

William Edgar Caldwell, M D, F A C S, Visiting Obstetrician, Sloan Maternity Hospital, New York City

Ethan Flagg Butler, M D, F A C S, Chest Surgeon, Packer Hospital Clinic, Sayre—"Lung Abscess," lantern slides

Homer L Samson, Roentgenologist, Saranac Lake—"X-Ray Diagnosis and Prognosis of Pulmonary Tuberculosis," lantern slides and films

The Keuka Lake Medical Association is a great educational and social force in Central New York, and we hope we may be able to attend its meeting next year and report it in full.

F O



# THE DAILY PRESS



## EDITORIAL EXPLANATION

We have tried an experiment. We took a week's clippings and gave them to a theological student and a medical student, each of whom had completed two years of professional training.

These two men read the clippings carefully, and each wrote his impressions without consulting the other. We are pleased to print their opinions, especially since they confirmed our own. F O

## A LAYMAN'S REVIEW

A great number of medical clippings from the daily press were recently put into my hands, and my lay opinion was asked as to their popular interest and value. The general purpose of these articles is not only to arouse the interest of the people, but also to educate them, not only to advertise medical activities throughout the State, but also to arouse a sympathetic interest in these activities, which will lead to a public benefit.

These clippings covering the month of July seemed to fail utterly in their main purpose—that of arousing interest. They seemed to be successful only in so far as they filled up newspaper space. A very large percentage failed even to interest.

We noted large striking headlines, such as, "Mayors of State Co-operating for Public's Health. Conference of Officials Has Secured United Action on Cities' Problems," under which is a full column containing practically nothing of public interest except perhaps a statistical and chronological history of the five preceding meetings, and absolutely nothing informative about the problems of health which confronted the city, which problems were advertised so glaringly in the headlines. Another large percentage dealt with statistics setting forth the increase of alcoholism and the decrease of infant mortality. These, though they have some news value, seem to have little that interests the general public, and certainly very little that bears on the health or education of the individual reader.

A large class of people seem to be affected by the popular advertisement. They turn for their authority to the wise sayings of our popular heroes. Henry Ford, it is claimed, set forth the novel idea, "The fate of the world lies in food." The article goes on to state "This is not the statement of a fanatic, but of one of the biggest business men of the world, and can be substantiated by uncontrovertible proof." The article then expounds at length upon the care we take of our animals and the small percentage of sicknesses in their life history, ending with the rhetorical appeals "Why should intelligent people eat simply to glorify a depraved appetite? Is it possible for man to improve upon God's plan?"

The author invites any who are interested to talk the matter over with him. Unless he is prefacing a series of articles, it seems to me that it would be helpful if he set forth in a simple way the fund of knowledge upon this subject or food which he proposes to talk about. As he is an official of the educational council of a lay organization, his authority would be a good one, and anything he might have to say in a less general way would be read with interest and benefit.

(EDITORIAL NOTE. The reviewer was deceived by this article, as its author seemed to intend every reader should be, for he represents a commercial organization.)

The greatest number of clippings show all the earmarks of coming through the unaided efforts of the reporter of that department of the paper. Most of them show an optimism and a hopefulness that is delightful and which undoubtedly go far to cheering up our day, but like the rest, they seem to be lacking in interest and effectiveness. Under the headline "Health Talks," it says "What are the purposes and aims of health education? To instruct children and youth so that they may conserve and improve their own health, to establish in them the habits and principles of living which throughout their school life, and in later years, will assure abundant vigor and vitality which provide the basis for the greatest possible happiness and service in personal, family and community life, to influence parents and other adults, through the health education program for children, to better habits and attitudes so that the school may become an effective agency for the promotion of the social aspects of health education in the family and community, as well as in the school itself, to improve the individual and community life of the future, to insure a better generation and a still better third generation, a healthier and better nation and race" (*Tarrytown News*, July 15). Many writers follow this hopeful editorial style under headings relating to public health, yet it is woefully lacking in anything of special interest or information.

We are impressed and interested by the numerous clippings relating to clinics of one sort or

another which, because of number of clippings and because of the many societies represented, we judge are being held frequently and generally. We are led to believe the public can be helped a great deal in this way, and that information in regard to this source of aid is much needed.

The article which interested me most related to scabies. It gave the history, symptoms, and cure of the disease in a simple, direct way. It had the professional tone of authority, and led me to feel that I was learning something which might at some time serve a purpose. Now, we have never had scabies, and do not know of any one that ever had scabies. In fact we are not sure we ever heard of it before, and so the interest we took in the article could hardly have been a personal one. The interest was due to the nature of the article. To many the newspaper is a primary source of certain kinds of information, and real

information is usually appreciated. Health is a subject in which the general public takes a real interest, because to most of us it represents a goal not quite attained. The people generally are able to take a far more intelligent interest in things medical than is credited to them by those who have had a professional training, if one can judge at all by these sample clippings. We believe that the people would understand and appreciate a greater number of items of a scientific nature.

Professional education through the press undoubtedly has a large field of opportunity, but its aims so hopefully set forth can only be realized when more professional time and interest is given to the press articles by those physicians who are able to write them.

ALBERT LEE KLAER, A B

### A MEDICAL STUDENT'S OPINION

The daily newspapers carry many articles in relation to health, and among the most conspicuous are the syndicated health talks. They are commonly a regular feature. The fact that these articles appear regularly and usually on a certain page, practically guarantees a host of readers. Therefore, they have much obvious potential value as a medium for educating the people on health matters. The popular style in which such articles are presented is commendable, but in reverting to conversational English, something of inaccuracy may develop. The deplorable thing concerning them is that they are often carelessly written. Not only can a medical student find inaccuracies in details, but he can also perceive instances where, due to carelessness of the author, the paragraphs lead one to an erroneous conclusion. These syndicated articles, unless of the best, can very easily result in detriment. The fact that these articles so often do not inspire the confidence of medical students leads one to doubt their value, for, if a medical student is unable to derive benefit from them, how many laymen are benefited by them?

The remaining health articles in the daily press appear purely because of their positive news value. They are the products of the reporter's sincere efforts and are intended to be what he believes is a readable news story. He must rely on his own fund of knowledge to supply the human interest to the bare skeleton of the story. Therefore an article describing a summer health camp receives very favorable publicity, due to the fact that most reporters can build up a good news story about almost any small incident from such a source. But given a similar amount of data on an orthopedic clinic, and the best attempts this reporter can produce are something like this sentence from an actual clipping: "One

hundred children were examined at these consultations, and 222 defects were found." The statistics were probably accurate, but as that was all the information that the reporter had at hand, he was unable to make a good news item. The fault lies with the doctor or health official who supplied such bare facts.

Too many reports of child welfare work, tuberculosis clinics, and free mental clinics, are written up merely as statistical statements, which cannot attract the attention nor compete for publicity with such sensational stories as a death from drinking liquor or the menace of a dead dog.

One would gain from the daily press the impression concerning free clinics that they are closed affairs in which the doctors and certain patients participated, despite the use of the word "free."

What interests a man concerning orthopedic clinics is where he may send his clubfooted office boy for advice. A worried mother wants to know to whom to go first with her problem—a mentally defective child. A medical student reads to learn the source and mode of transmission of the infection in a typhoid epidemic. All such items are the human interest points so often lacking in news articles which should have been supplied by the health officer, the health worker, and the doctor. Reporters cannot be expected to supply such information, but the doctor who knows the details should furnish them in order that these articles may afford the same news value as those about summer camps.

The daily newspaper should develop into a mighty health factor, if doctors supply reporters with detailed information concerning health matters, paying particular attention to points of human interest and educational value.

D E OVERTON, B.S





# BOOKS RECEIVED



Acknowledgment of all books received will be made in this column and this will be deemed by us a full equivalent to those sending them. A selection from this columns will be made for review, as dictated by their merits, or in the interest of our readers.

**ANAPHYLAXIS AND SENSITISATION** With Special Reference to the Skin and Its Diseases By R. CRANSTON Low, M.D., F.R.C.P. Lecturer, Diseases of the Skin, Edinburgh University 16 colored plates, 7 half-tone illustrations William Wood and Co, New York, 1925 Price, \$6.50

**THE INTERNATIONAL MEDICAL ANNUAL** A Year Book of Treatment and Practitioner's Index Forty-third year, 1925 William Wood and Co, New York Price, \$6.00

**AIDS TO PHYSIOLOGY** By JOHN TAIT, M.D., D.Sc., late Lecturer in Experimental Physiology, Edinburgh University, and R. A. KRAUSE, M.D., D.Sc. Second Edition William Wood and Co, New York, 1924 Price, \$1.50

**AN INTRODUCTION TO THE MIND IN HEALTH AND DISEASE.** For Students and General Practitioners Interested in Mental Work By WADDELOW SMITH F.R.C.S. (Eng.), Deputy Medical Superintendent of the City Mental Hospital, Nottingham William Wood and Co, New York, 1925 Price, \$4.00

**AIDS TO OBSTETRICS** By SAMUEL NALL, B.A., M.B., Cantab, M.R.C.P., Lond Revised by C. J. NEPEAN LONGRIDGE, M.D., Vict., F.R.C.S., Eng, M.R.C.P., London. Ninth Edition William Wood and Co, New York, 1925 Price, \$1.25

**A COMPANION TO MANUALS OF PRACTICAL ANATOMY** By E. B. JAMIESON, M.D., Senior Demonstrator and Lecturer on Anatomy, University of Edinburgh Second Edition William Wood and Co, New York. Price, \$5.00

**LUMBAR PUNCTURE, ITS ANATOMICAL AND PHYSIOLOGICAL RELATIONS** With an Appendix on Encephalography and Puncture of the Cisterna. By MARTIN PAPPENHEIM, M.D., Professor University of Vienna. Translated by GEORGE CAFFEY William Wood and Co, New York. 1925 Price \$5.00

**QUACK, THE PORTRAIT OF AN EXPERIMENTALIST** By ROBERT ELSON Small, Maynard and Co, Boston \$2.00 net

**COLDS, CAUSE, TREATMENT AND PREVENTION** By RUSSELL L. CECIL, M.D., Assistant Professor Clinical Medicine Cornell University Medical College D Appleton and Co New York, 1925 Price, \$1.00

**THE LIFE OF SIR WILLIAM OSLER.** By HARVEY CUSHING Two Volumes Oxford University Press, American Branch, 1925 Price, \$12.50

**HOW TO LIVE.** By PROF IRVING FISHER Yale University, and DR. EUGENE LYMAN FISK in Collaboration with the Hygiene Reference Board of the Life Extension Institute 12mo Cloth Illustrated. 541 pages \$2.00 net. Funk & Wagnalls Co, New York

**OLD AND NEW VIEWPOINTS IN PSYCHOLOGY** Some Interpretations and Applications of Psychological Principles By KNIGHT DUNLAP Professor of Experimental Psychology, Johns Hopkins University Baltimore The C V Mosby Co St. Louis \$1.50 net.

**RATS AND HOW TO DESTROY THEM** By MARK HOVELL, F.R.C.S., with introduction by S. L. BENSUSAN William Wood & Co, New York. Price, \$5.00

**SYMPTOMS OF VISCERAL DISEASE.** A Study of the Vegetative Nervous System in Its Relationship to Clinical Medicine. By FRANCIS MARION POTTEVGER, A.M. M.D., LL.D., F.A.C.P. Third Edition. Eighty-six Illustrations, Ten Color Plates The C V Mosby Co, 1925 Price \$6.50

**SOME FUNDAMENTAL CONSIDERATIONS IN THE TREATMENT OF EMPYEMA THORACIS** By EVARTS A. GRAHAM, A.B., M.D. Professor Surgery, Washington University School Medicine. Illustrated C V Mosby Co, 1925 Price, \$2.50

**PERSONAL AND COMMUNITY HEALTH** By CLAIRE ELSMERE TURNER, Associate Professor Biology and Public Health, Mass Institute Technology Illustrated. The C V Mosby Co, St. Louis, 1925 Price, \$2.50

**METHODS IN SURGERY** Used in the Surgical Divisions of Barnes Hospital, St. Louis Children's Hospital and Washington University Dispensary By GLOVER H. COPER, M.D. The C V Mosby Co, St. Louis, 1925 Price, \$3.00

**THE NORMAL DIET** A Simple Statement of the Fundamental Principles of Diet for the Mutual Use of Physicians and Patients By W. D. SANSMAN M.S., M.D., Director Potter Metabolic Clinic, Santa Barbara Cottage Hospital. Illustrated The C V Mosby Co, St. Louis, Mo., 1925 Price, \$1.50

**THE FAITH, THE FALSY, AND THE FAILURE OF CHRISTIAN SCIENCE.** By WOODBRIDGE RILEY Ph.D., FREDERICK W. PEABODY, LL.B., CHARLES E. HUMISTON, M.D., Sc.D. Fleming H. Revell Co, New York, 1925

**SURGICAL TREATMENT OF PULMONARY AND PLEURAL TUBERCULOSIS** By J. GRAVENSEN, M.D., Copenhagen, with a Foreword by S. Vere Pearson, M.D., M.R.C.P. Eighty-seven Illustrations (three in color) William Wood and Co, New York, 1925 Price, \$3.50

**THE CHEMISTRY OF THE BLOOD IN CLINICAL MEDICINE.** By O. L. V. DE WESSELOW, M.B. (Oxon) F.R.C.P. (London) William Wood and Co, New York, 1925 Price, \$4.50

**CANCER, POST-GRADUATE LECTURES** Delivered under the auspices of the Fellowship of Medicine. Edited by Herbert J. Paterson. Preface by Sir John Bland-Sutton LL.D., F.R.C.S. Illustrated. William Wood and Co, New York, 1925 Price \$4.00

**DIABETES, ITS TREATMENT BY INSULIN AND DIET** A Handbook for the Patient By ORLANDO H. PETTY, A.M., M.D. F.A.C.P., and WILLIAM H. STOVER, A.M., M.D. F.A.C.P. Illustrations and Tables F. A. Davis Co, Phila., Pa., 1925 Price \$1.50 net

**DISEASES OF THE EAR, NOSE AND THROAT** By HAROLD HAYS, M.A., M.D., F.A.C.S. 495 Half-Tone and Line Engravings 55 Full Page Plates F. A. Davis Co, Publishers, Phila., 1925 Price, \$10.00 net

**OPERATING ROOM PROCEDURE FOR NURSES AND INTERNES** By HENRY C. FALK M.D. with foreword by Eugene H. Pool M.D. With 275 Illustrations G. P. Putnam's Sons New York, 1925 Price, \$2.50



# BOOK REVIEWS



**PRECIS DE CLINIQUE SÉMIOLOGIQUE** (Diagnosis, Prognosis et Traitements) GASTON LYON, Ancien Chef de Clinique Médicale de la Faculté Masson et Cie, Editeurs, 120 Boulevard Saint-Germain, Paris 1924

In this volume an attempt has been made to unify the consideration of symptomatology, general pathology, therapeutics and diagnostic, and therapeutic technic. This method of exposition, which aims to present a subject as viewed from many angles at once, is to be commended. The lack of illustrations and the inadequate index are unfortunate features of the book.

HENRY M FEINBLATT

**OPERATIVE SURGERY** By J SHELTON HORSLEY M.D., F.A.C.S., Attending Surgeon, St. Elizabeth's Hospital, Richmond, Va With 666 Original Illustrations Second Edition The C V Mosby Company St Louis, 1924 Price, \$12.50

From the multitude of books brought out in recent months that of "Operative Surgery," by John S Horsley, is probably most deserving of consideration. The work covers the field of surgery viewed from the standpoint of the preservation of the physiologic function of the part under consideration and also the interpretation of the biologic processes that follows each operation. The operations described (the volume is limited to descriptions of the technique) are those which are accepted as the most logical for the lesions being discussed and are lucid in presentation. Explanations given for the choice of operations are clear as well as a fair criticism of those rejected. Of the later additions to surgery may be noted those of Lymphaticostomy for diffuse peritonitis and the late obstruction of the bowel. The operation for the innervation of the paralyzed muscle, Pylorotomy of Finney, Lobectomy as outlined by Graham, and the Intestinal Resection as practiced by Kerr, which lessens the likelihood of infection following the resection of the cecum. Thyroid surgery is reviewed and the advances noted. Frequent references are made to the work and results obtained at the Mayo Clinics. The opening chapter on Drainage is well worth careful consideration.

E W S

**INFECTION IMMUNITY AND INFLAMMATION** A Study of the Phenomena of Hypersensitiveness and Tolerance, and Their Relationship to the Clinical Study, Prophylaxis and Treatment of Disease. By FRASER B GURD, B.A., M.D. C.M., F.A.C.S., Montreal The C V Mosby Company, St. Louis 1924 Price, \$5.00

This volume is unusual, and at the same time interesting in that it presents an immunological subject from a surgeon's viewpoint. The author attempts to explain some of the complex phases of inflammation and infection in terms and manner which might be comprehensible to the practicing physician and surgeon. Details of technique are therefore purposely avoided and only general principles and theories discussed.

One of the fundamental hypotheses advanced by the author is that "anaphylaxis constitutes the first stage in the immunological reaction" and may be part of the physiological response of the body in inflammation and infection. That such a broad conception of anaphylaxis will meet with considerable opposition in immunological circles is inevitable.

To the immunological students who seek detail, or an unbiased presentation of all sides of the subject, this volume can be of little value. To the practitioner who seeks a casual and not too critical, glimpse into the subject, it may be of more service.

M W

**A CONTRIBUTION TO THE STUDY OF PERNICIOUS ANEMIA AND APLASTIC ANEMIA** By ARTHUR SHEARD, M.D. A Thesis presented for the degree of Doctor of Medicine in the University of Leeds, December, 1923. William Wood and Co., New York, 1924 Price, \$2.50

The volume is divided into three sections. The first dealing with Pernicious Anemia, the second with Aplastic Anemia, and the third devoted principally to case reports and analyses of cases.

In the first section, after an historical resume, the details of a series of fifteen cases of pernicious anemia are described. A clear definition is given conforming to the original one of Addison. The onset was slow and insidious in most of the cases with weakness the chief complaint in the majority. Other leading symptoms were pallor with definite yellow tint (fourteen cases), some degree of pyrexia (ten cases), prematurely gray and silky hair (eleven cases), glossitis and stomatitis (100 per cent of cases at sometime in the course of the disease). Undue smoothness of the tongue in irregular patches, on dorsum, denoting atrophy of the papillae, was found in most of the patients. Dyspeptic symptoms were found to have occurred in fourteen of the fifteen patients, principally vomiting, nausea, flatulence, abdominal pain and diarrhoea. Fourteen of the fifteen cases gave a history of dental caries or dental sepsis and all showed complete achlorhydria with a low total acidity. In four cases a palpable enlargement of the spleen was present. Other frequent symptoms were shortness of breath, palpitation, nervous disturbances, cardiac murmurs and persistently low blood pressure. In every patient normoblasts were observed some time or another, and megablasts in all save two cases. During the period of a definite remission it was rare to find even a single normoblast. The color index average was 1.126, but may fall below unity at some time in the course of the disease. A normal fragility of the red cells was found, proving a valuable feature in the differential diagnosis from hemolytic jaundice. Leucopenia was present in all but one patient, and a relative lymphocytosis in every patient. A yellow blood serum was always found, opposed to the nearly colorless blood serum of all other anemias.

Other features of the disease are analyzed in an interesting manner, and the subject of Aplastic Anemia is treated in detail. It is believed that the majority of cases of aplastic anemia bear no relation whatever to pernicious anemia.

A careful bibliography is appended. The book is well written, the cases carefully studied, and forms a valuable contribution to the study of the diseases of the blood.

W E McCOLLOM

**INTERNATIONAL CLINICS** By Leading Members of the Medical Profession throughout the World Volume I Thirty-fifth Series 1925 J B Lippincott Company, Philadelphia, 1925

The first two articles in this volume are written by L F Barker one dealing with Staphylococcus Septicemia and the other with the treatment of the Psychoneuroses. A section on Diagnosis and Treatment follows some of the subjects discussed being Group Medicine, Some Relationships of the Visceral Nervous System, Psoriasis, Surgical Diseases of Meckel's Diverticulum, and Exophthalmic Goitre in Children. In the last article a report of a girl, age nine years, is given where the result of treatment with tincture of iodine was very good. Sections on Mental Disturbances and Surgery follow. At the end of the book there is a review of the Progress of Medicine for 1924. This is comprehensive, covering about seventy-five pages.

As usual with this publication, the volume is a very interesting one.

W E McC

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 21

NEW YORK, N Y

OCTOBER, 1925

## PREVENTION IN PEDIATRIC PRACTICE\*

BY J H M KNOX, JR.,  
BALTIMORE MD

THE presentation before this distinguished body of a theme which is becoming current, if not trite, has for its excuse that although the importance of prevention is recognized in the medical literature of the day, its practice still lags far behind our knowledge, and it occupies in the routine day of the physician too small a proportion of his time and thought

It is estimated that there are approximately 1,500,000 cases of enteritis among the 5,000,000 of our infant population each year, that 700,000 instances of communicable diseases occur in early childhood, that there are today 15,000,000 school children presenting one or more remediable defects, and that 2,000,000 persons are infected for the first time with venereal disease annually in America

These and similar startling figures make it worth while for the doctor to consider if it is not essential that more of his individual effort, a greater proportion of his time and energy, should be devoted to applying such knowledge as he has to preventive work

"To make the unfit fit, is good" say Rankin, "but to make the fit fitter is even better"

Is it not true that at present most of the diseases occupying the attention of the medical profession have reached an advanced stage, few are treated in the early, and fewer still, in their predisposing stages? Treatment in anticipation, if possible, or threatened diseases, is *prevention*

The ideals of medicine, as distinguished from its practice, have always included the prophylaxis of disease and premature death, and the principles of medical ethics advise the members of the profession to take an active part in disease prevention in the interest of public welfare

The enormous task of controlling preventable maladies cannot be left to a small group of health officers, however competent. These indeed may be useful in organizing such social and professional machinery as is necessary to reduce

morbidity and mortality rates, but it the task is to be done in a large way, it must claim an appreciable part of the daily activities of all practitioners and they must function not only as expert diagnosticians and therapists, but also as hygienists. In their intrenched positions in their communities as trusted citizens and confidential family advisers, possessed of expert sanitary knowledge, the rank and file of the profession should accept the corresponding responsibilities and play a leading part in prevention if a successful public health program is to result

In speaking on this theme, the pediatrician has much to which he can point with pride, for much of his work, as it has developed, has been devoted to prevention, to keeping well children well. This is particularly true in his direction of the health of infants. He has encouraged parents to bring their well babies to his office at regular intervals. Through this method of early examination and advice, the pediatrician has demonstrated that not only the large proportion of time given to preventive medicine has been beneficial to the patient, and to the community, but also that it yields him satisfactory financial returns. It is possible, at least, in pediatrics to obtain from grateful parents a comfortable income derived in considerable measure from the guarding of well children

These statements may be pardoned in one who considers the care of children throughout their whole development—from the prenatal period through adolescence—not only the most interesting field of medicine but one which should contribute as much as any to the present welfare and future betterment of the race

The interest of the pediatrician in the welfare of the child should begin with a desire to improve the material with which he has to work. It is his evident duty to make the best physically, of the children under his care, whatever their handicaps may be, but surely no group of medical men are in better position to speak from firsthand knowledge of the many almost unsurmountable difficulties met with in dealing with the un-

\*Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse May 12 1925

fortunate human products which result from the mating of the unfit. The selection of parents with reference to the probable vigor, mental and physical, of their offspring may never be a possible achievement among men, but surely a more general movement to discourage the notoriously unfit, those below a minimum standard of mental development, those afflicted with disease which may be passed on to innocent children, a movement to prevent such classes as these from propagating their kind should be undertaken by the community and led by the medical profession. It would save untold misery and crime and in a few years would result in an enormous conservation of public funds if the moron and the criminal insane could be segregated during their reproductive years. Any individual, belonging to these groups, who, during this period improved sufficiently, could be released, but the method would greatly diminish the now constantly growing numbers of afflicted children who are at present crowding our public institutions or permitted to live without adequate restraint.

We are told that in Aosta, a district in northern Italy, for years there were many Cretins. They lived freely among the general population and their number was rapidly increasing. By law, in 1890, these unfortunate grown-up children were segregated. In 1910, after 20 years, a census of the district showed that there were only 3 Cretins remaining well past middle life. This seems to be a practical demonstration of the advantage which might be expected from the application of negative eugenics in the effort to improve the quality of our stock. There is also real danger to the maintenance of our racial standards because of the deliberate limiting of the number of their children by the more intelligent classes of the community. Ninety per cent of all women marry before the age of 40 years, whereas only 45 per cent of college women marry up to this age. Both our Puritan and Cavalier stocks are rapidly dying out. Men of science are producing about half as many children as their fathers. Whatever may be the causes of this change, whether love of personal comfort and luxury, additional brain activity, or the preaching of neo-malthusian doctrines, they do affect the quality of the pediatrician's material. Part of his duty would seem to be therefore to reduce the dross and improve the output.

It may be questioned, if the physical condition of a child is determined by heredity whether we have any responsibility in the matter at all. The truth is, however, that the average child rarely reaches the potentialities of its inheritance, and its failures are often those of environment. A relatively poor inheritance and a good environment may be better than the reverse. Twins with the same heredity differ widely from each other if their training and environment are dif-

ferent. Even Darwin held that "men differ less in capacity than in zeal and will."

It is our duty to improve the physical condition of each child by improving its environment, and this is, of course, most effectively done during the period of immaturity. It seems just as unintelligent for a physician, at least for a pediatrician, to be indifferent to the quality of the children that come under his charge as it would be for a tailor to be scrupulously careful of the fit of his garment but neglectful of the quality of his cloth. The quality of our race can be improved by

- 1 Weeding out the unfit
- 2 Discouraging voluntary infertility among the fit
- 3 Early and favorable marriages
- 4 Providing children with proper environment, food and training

Having kept congenial company thus far with the practical eugenicist on the trail of prevention leading to physical betterment, the pediatrician now joins company with the wide-awake obstetrician. Together they agree that the care of the infant begins at least 9 months before its birth and must be applied in his early period through adequate attention to the mother. We are learning that the great salvage of infant life that has been one of the most significant triumphs of preventive medicine of recent years has concerned almost exclusively the later three-quarters of the first year. The early infant death rate, that occurring in the first month, and which is nearly one-half of that of the first 12 months has been but little diminished. Moreover, the number of conceptions which are prematurely interrupted are at least 50 per cent of those which continue to term.

Every pediatrician is called to treat not a few infants born alive, it is true, but with too little vitality to continue the struggle even under favorable conditions. Some of them are syphilitic, others are ignorantly said to be suffering from congenital debility for want of a better term. Another group is made up of infants subject to convulsions, paralyzed or spastic from birth trauma and cerebral hemorrhage.

It has been conclusively shown that when the expectant mother is carefully examined early in her pregnancy and kept under competent observation through the whole period, and when her labor is skillfully conducted, not only is the maternal mortality from complications of child bearing greatly reduced, but also the neonatal death rate of the infant.

Sixteen thousand mothers (16,000) and more than one hundred thousand (100,000) infants are sacrificed each year in America, many of them because of the lack of these self-evident precautions. In rural Maryland more than one-half of the expectant women come under medical treatment only when labor has commenced—too late.

for any prenatal care. The conduct of the labor therefore which ought to be deliberately planned for, becomes an emergency operation.

It has been shown that many of the abortions voluntarily produced in the early months of pregnancy would be avoided if the anxious women could be sympathetically advised. At the Hopkins' clinic, the mortality of children born alive, of untreated syphilitic mothers, is 52 per cent, and that of children born of luetic but properly treated mothers, is but 7 per cent. The laity does not appreciate these facts. The responsibility of making them generally known rests largely upon the medical profession.

We now enter a high road in which the pediatrician is more familiar, namely, the care and the diet of the infant.

For years it has been the custom of many parents to put their young infants under the care of an experienced physician who directs the diet and controls the daily *regime*. Not a little of the present knowledge of nutrition has emerged from the laboratory or from the bedside practice of the pediatrician. He has long recognized the value of the calory and of the relative significance of protein, fats, carbohydrates, salts, and water, and recently has realized the importance of the vitamins. He has controlled and lengthened the intervals between feedings and has specified the needed amount of sleep, exercise, clothing, sunlight and fresh air. With his faithful lieutenant, the mother, and the experienced nurse, he has so controlled the whole environment of the baby as to bring it into the runabout period with a maximum of health and vigor. More than this, a large company of less fortunate infants born with a poor start, and suffering from malnutrition, have been added to the number saved and enabled to look forward to as healthy an older childhood as those who had continued well from birth. It is because infant care, such as has been briefly outlined, is becoming more general that the infant mortality rate has fallen so remarkably in recent years.

Unfortunately, however, as the period of infancy ceases and the runabout period begins the average parent feels that the time of danger is over and fails to realize that the older child should continue under the same kind of skilled medical oversight, and yet this so-called post-infant or pre-school period is recognized by the pediatrician as perhaps the most important of the whole life span. This is the age of rapid growth and development, physical and mental, it is the age when at present, at least, two-thirds of infectious diseases appear—it is the period when the great majority of preventable physical defects begin, it is the time also for habit and character formation, in short, a series of years of tremendous import to the whole future of

the individual, and one which should be guarded carefully and directed at every step.

The diet, the intervals of rest and recreation, the adjustment of the child to its home conditions, the protection from infectious disease, obtained by giving it an active immunity against those diseases of which we have specific sera or vaccines or by prevention of exposure to others through isolation and care. The use of supervised play in the development of self-control and team work, the development of proper health and mental habit, all these, and similar protective measures fall within the purview of the pediatrician cognizant of the results of laboratory investigation, and of the new work of the psychologists.

That the pre-school children throughout the country are as yet deprived of this prophylactic care is but too well known, and today troops of children are entering the lowest grade of our schools, public and private, mal-nutritive, unhappy or handicapped by physical defects which impair their health, retard their progress and more or less hobble them in the race of life. Is it not possible that the so-called common diseases of childhood, which so many parents now feel that it is just as well to have their children have and get them over with, are not so negligible as is supposed, but may leave scars or injury in the vital organs which in consequence fail to stand the strain of middle life?

The pediatrician who realizes the situation is often embarrassed in advising the return for observation and advice of older well children however much he appreciates the need. It is here that general public opinion and the testimony of parents whose runabout children have been helped will be of advantage.

The pediatrician is also interested in the health of the child at school though he is firmly convinced that the large amount of attention to the health of children of school age would be rendered unnecessary of the pre-school period were lived under competent medical direction.

The daily gathering of large groups of children in close contact in school buildings is at once a danger and an opportunity—a danger because conditions are present for the rapid spread of infection unless adequate precautions are taken, and an opportunity because of the facility by which health group instruction can be carried out.

Whether or not the health of school children is a primary responsibility of the school commissioners or the health department, whether these children shall be called school children or children of school age, is still debatable, but in any case, all matters pertaining to the health of children in schools should be directed by a physician interested and skilled in this field of work. He should pass on the construction of

the building, the air space, ventilation, lighting, wash room and toilet facilities, the type of desks and seats, blackboards and lockers, the school lunches, and other arrangements that have to do with the hygiene of the school life. Competent medical authority should supervise the instruction in health given to all grades and advise as to school hours, rest periods, and the recreation of the children. In co-operation with the teacher, the nurse or physician should arrange for the daily inspection and occasional examination of the children and direct the precautions to be taken to prevent the spread of communicable disease, and with the family physician advise as to the care of the malnourished or otherwise physically handicapped child.

Until the public becomes more thoroughly aroused concerning the neglect of the runabout, it is doubly important that school children should be kept as free as possible from unnecessary disease, relieved of bodily encumbrances and made physically fit as early as may be in their scholastic careers. With all this the pediatrician is much concerned.

The same kind of medical oversight should be provided for boys and girls under sixteen years of age in industry. The exploitation of child life in the last century in factory work

is one of the dark blots in our civilization. Our own country deserves much reproach for the neglect of its working children. Mental development may be checked, growth stunted and disease contracted because of the unhealthful conditions under which many young children are allowed to labor. In securing improvement in these matters, in preventing a child too young or otherwise unfit from undertaking hard labor, in bettering the sanitary conditions of factory life, in obtaining for each adolescent sufficient hours for sleep and adequate food, in all that concerns the health of the child, the children's doctor should be vitally interested.

These remarks need not be extended to indicate the enormous field in preventive medicine open to the pediatrician or to the physician whose practice concerns children. It is no less a task than to secure for every child in the land its unalienable birthright, fit and healthy parents, and the opportunity to pass its years of growth and development in a suitable environment as free as possible from preventable defect and disease.

I believe that this field in prevention offers the pediatrician satisfactory financial returns, but even more than that, the satisfaction of having "done his bit" in bettering the succeeding generation.

## MENTAL HYGIENE OF THE CHILD AND ITS RELATION TO MEDICINE\*

BY D. A. THOM, M.D.,

BOSTON, MASS.

**P**EDIATRICS and child psychology are mutually dependent one upon the other. The pediatrician who fails to take into account the mental as well as the physical welfare of the child is no more efficient or less responsible than the psychiatrist who endeavors to interpret all the ills of mankind in terms of mental conflicts. The body and the mind rarely if ever operate independently one of the other. The cause of a bodily condition or mental ill health may be either predominately physical or psychological, that is, organic or functional, but rarely does it ever remain long so well defined.

Vomiting in a child often has its origin in imitation, worry, fear, but if it persists over a very long period of time physical manifestations will soon develop. The child may be subjected to an acute infection or an accident which ordinarily goes on to an uninterrupted recovery, but under certain undesirable home conditions an atmosphere of sickness is built up around the child incapacitating him for a normal healthy adjustment to life long beyond the usual convalescing period.

A little girl eight years of age was seen first by the family physician because she was under weight, tired easily, extremely irritable, and was considered by the family as an extremely difficult feeding problem. She was finicky about the types of food she would consider at all, and then would play about with her food sometimes for an hour and a half during meals, the problem of taking food always being more marked in the morning, the mother stating that she got so worked up and upset about the child's taking breakfast that five mornings a week, at least, the mother would lose her own breakfast. (This being an indication of the emotional instability of the mother.) The child was coaxed, teased, bribed, and punished with little or no effect. It took nothing more than a careful inquiry into the home situation to be fully convinced that the child was utilizing the meal hour as a time to attract attention, and was enjoying the fact that her undesirable habits of eating were keeping her in the limelight.

After explaining the child's motives to the mother, and getting the family's co-operation, improvement took place immediately. The exploitation of symptoms which well may have had some physical cause which long since have

\* Read at the Annual Meeting of the Medical Society of the State of New York, at Syracuse, May 12, 1925.

been removed, is not at all uncommon. The following case is a good example.

A child, six years old, went through a severe attack of whooping cough which lasted from May until September. During this period she had severe paroxysms of coughing which were occasionally followed by a moderate amount of rigidity in the extremities, and an apparent loss of consciousness. For several months after the child had been thoroughly examined at the Children's Hospital and a competent pediatrician had stated she was free from the original infection she would frequently have spells which the mother described as follows: the child would start coughing and fall to the ground, become stiff, her eyes would close and it seems that she knew nothing of what was going on about her. It was found, upon investigation, that these spells invariably occurred under emotional stress and strain, or when there was an impending punishment by one of the parents; in fact, they were utilized to get the child out of any difficult situation.

The mother was extremely worried and oversolicitous and whenever there seemed to be the slightest evidence that the child was about to have a spell the environmental situation was adjusted to her liking. This invariably aborted an attack. It seemed quite obvious that here again we were dealing with a psychological situation rather than a physical one, and enlightening the mother as to the motive of the attacks and assuring her there would be no danger in ignoring them, relieving her worry and anxiety and eliminating her over-solicitous attitude toward the child, this annoying and rather difficult situation was completely alleviated in two weeks.

In the foregoing cases the physical symptoms were sufficiently annoying and inconveniencing to the parents to make them seek medical assistance, but unfortunately all too frequently the problems of the child are of such a nature that they do not present themselves in a very spectacular way, in fact they tend to minimize the necessity of parental supervision.

Shyness, jealousy, fears, day dreaming, feelings of inferiority or perhaps the mental conflicts find expression in tempers, destructiveness, cruelty, lying, stealing or truancy, and here again it is often met as a disciplinary problem and measures are instituted to squelch the rebellion. Threats, attempts to frighten or beat the child in submission does nothing more than exaggerate and perpetuate the mental conflict.

The rod is about as useful in trying to cure diphtheria as it is in altering the conduct which is activated by motives unconscious to the child.

The general practitioner or pediatrician who neglects to take into consideration the mental side of the child's life is failing to utilize a very important instrument not only in dealing with un-

desirable habits such as enuresis, feeding problems, poor sleeping habits, night terrors, persistent fears, personality deviations, such as shyness, jealousy, pugnacity, delinquent trends as lying, stealing, truancy, but also the frequent personality changes and conduct problems that follow physical disease and accidents.

E. J. was a lad, seven years of age, who was sent to the Out Patient Clinic of the Psychopathic Hospital because of a marked personality change which followed a head injury. The patient had been in the hospital for a period of three weeks, seriously ill with a question at that time of a fractured skull. However X-rays and neurological examinations failed to reveal any evidence of an organic brain lesion. The patient was sent home, in bed for four weeks, during which period he became very irritable, extremely selfish, sullen, resentful, and when he got up and out with the other boys began to have fits of temper and soon became either ignored by the group or picked upon by them. He was nicknamed "empty head."

Legal proceedings were about to begin when the mother brought the patient to the clinic. One found that after the illness the entire family's attitude changed and the household began to revolve around the patient, everything was his to accept or reject. For the first time he found himself in the limelight. The other children, of which there were six in the home, were all impressed by the fact that their brother had been seriously ill and that he must be catered to and he soon found that his selfish, domineering ways began to get him things in the household especially that the other children were denied.

Although we could not be positive in this particular case that the personality change was due to the altered environmental situation, it seemed more than likely that it was the case, and the treatment was instituted along these lines, that is, instructing the parents as to the best way of managing this altered personality. In less than a month the child was his old happy, cheerful, unselfish self, competing and co-operating with the gang in a perfectly normal manner.

Mental hygiene is that branch of preventative medicine which has to do with the preservation of mental health. We are very apt to dodge the issue of poor mental health unless the patient is already deluded, hallucinated or intellectually deteriorated, this fact is brought out by the long duration of the symptoms of mental illness before the average individual will seek medical assistance, and the long time intervenes between seeking assistance and following the advice given. Mental illness, like physical illness, exists in all degrees from the earliest symptoms of poor adaptation to the problems of every-day life to final and complete mental delapidation of a frank psychosis. Some of the less severe forms of

mental illness (commonly called psychoneurosis or just nerves) are frequently more incapacitating than the definite psychoses. But the prognosis is far more encouraging, in fact, if recognized early and treated intelligently a large per cent make complete recoveries. There seems to be a direct relationship between the duration of the symptoms and the success of the therapy. And in a general way much more can be accomplished in the younger patients than in the older ones. It therefore seems but reasonable to expect better results in dealing with children whose dormant mental characteristics are still very plastic, whose reactions to their environment are not colored by experience and education.

If mental hygiene is to be of real service to the world at large it must be practiced in the home, school, on playgrounds, in gymnasiums and in our general relationships one with another.

I would take this opportunity of stressing the importance of painstaking and detailed history in every case where there is a conduct problem and in those cases which do not respond to the usual therapeutic measures which are applied on the physiological level. The general practitioner and pediatrician will frequently find the answer to many a baffling symptom or syndrome in some obvious environmental situation. It may be the child is caught between clashing personalities in his own home, he may be finding a refuge in illness from his failure in school or on the playground. Perhaps his mother is the type who refuses to allow him to grow up or his father is a stern, rigid, forbidding disciplinarian, who is starving the youngster's emotional life. Not infrequently we find some physical illness has placed the child in such a desirable position in the family group, made him in the center of the

stage, so to speak, that the child will cling tenaciously to the symptoms long after the physical cause has been removed. (It is not unusual to find the soldier developing a *neurosis* while he was recovering from a wound.) The attitude of the parents and physician toward the illness or incapacity of the child is tremendously important. We must remember suggestibility and imitation are two of the most dormant characteristics in the child life so that one must not develop an atmosphere which suggests illness or create motives for the exploitation of symptoms.

The point I started to emphasize was that if the physician would investigate the family history and general environmental situations with more care he would find very frequently the underlying cause or causes of many of the undesirable habits, personality deviations and moral twists seen in children. In many instances the necessary therapeutic measures would thus be perfectly obvious.

There are, however, a sufficiently large number of cases which need more than a painstaking history, a careful analysis of the whole family problems must be undertaken, it's a long, time-consuming task which will tax the skill and patience of those best fitted by training and experience to do the job. Here is where the psychiatrist and psychologist and social worker render valuable assistance.

The mental health of the child just as the physical health is in a very large degree in the hands of the general practitioner, and not the specialist, and in assuming the responsibility he should utilize as one of his important instruments the knowledge which has gradually been collected under the subject of mental hygiene.

## MENTAL HYGIENE OF THE CHILD AND ITS RELATION TO THE DEVELOPMENT OF CHARACTER\*

BY IRA S. WILE, M.D.,  
NEW YORK CITY

**C**HARACTER is the combination of qualities distinguishing a person. In a more specific sense it is applied to a man's strongly marked traits, especially those distinctive qualities dependent upon conscious choice.

Mental hygiene may be partly interpreted as those principles of human guidance which favor normal mental functioning. It involves a composite application of psycho-prophylaxis and psycho-therapeutics. It is not to be regarded as related only to mental defectives, epileptics, neurotics and the psychotic. It is obvious that, under the broad definition, men-

tal hygiene possesses definite values in relation to the development of character which, expressed in conduct, evidences mental function. Its purpose is constructive, protective guidance into normal social living, which alone is conducive to the highest character.

Every physical phenomenon has a psychic effect, and every psychic factor involves some physical response. Children respond to internal reactions of their physical organization, and are likewise influenced by persons, objects, and circumstances. The combination of their physical and psychic reactions enters into and fosters the development of their traits and helps determine their respective qualities and

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse, May 12, 1925.



quantity for making adaptations. Character may be regarded as the integrated responses of an individual as manifest in behavior.

The basis of character development lies in the establishment of habits and mental hygiene is concerned with habit formation. A knowledge of habitual reactions, in a sense, serves as the basis for the predictability of conduct under varying circumstances. Mental hygiene is involved in securing responsiveness or inhibitions, both of which may be regarded as measures of character.

Mental growth of children is conditioned by their anatomical and physiological variations. Unfortunately the direct relations between physiological processes and mental function are not known. It is necessary, however, to view character development in terms of mental function as related to the various factors conditioning it.

Inasmuch as character is a generic term, it is possible to refer to various sides of character as though they were units. It is unsound, however, to accept any specific quality or trait as though it were representative of character as a whole, even though for a time, it may appear to dominate mental activity. Character possesses components arising from every element of structure and function. Hence, mental hygiene must take cognizance of those elements of well being which ordinarily would be deemed purely physical. It is apparent that congenital endocrine disturbances, such as cretinism, are significant in altering the mental functions of a child, and thus interfere with the potentials of character development. A club foot, equally congenital, may indirectly handicap intellectual function, but its limitations upon activity indicate its possibilities for handicapping normal mental growth. Mental hygiene, therefore, is as much concerned with the correction of special deformity as it is in the supplying of a needed endocrine substance in order to provide a fuller opportunity for normal self-expression. Ophthalmia neonatorum, or any other form of blindness, calls for personal adjustment physically and mentally, and, therefore, is within the field of mental hygiene. Various disease sequelae, such as deafness and arthritis, hamper physical activity, limit intellectual effort, and may interfere severely with moral judgment and rational social behavior. Enuresis, whether functional or organic, calls for habit training, physiologic readjustment and adaptations to life that concern those responsible for the training of children. Constipation, regardless of its causation, produces effects which militate against health, and more particularly so, because of the current fetishes with reference to the importance of evacuations. The establishment of correct habits for the excretory functions are

mentally hygienic as well as physically hygienic. The student of childhood is constantly impressed by the effects of malnutrition and fatigue upon the mental attitudes and capacity for intellectual effort, as well as by their influences upon daily behavior. Many instances of pseudo mental deficiency, irritability, stubbornness, tantrums, moroseness and insolence are merely manifestations of under-nutrition, lack of sleep, or over work. Numerous infections of chronic type, as sleeping sickness, impair normal living and seriously affect character. It is thus apparent that mental hygiene requires a direct attack upon the physical elements of well being in so far as they constitute factors in mental function. A marked strabismus may be a greater factor in determining character traits than mental dullness. Any physical handicap, which produces limitation in physical function, is accompanied by psychic effects that may influence character disadvantageously. The physical basis of mental hygiene is of tremendous importance.

Intellectual power is significant but it is not necessarily dominant for the development of the finest traits of character. During the earlier days of intelligence tests, the discovery of feeble-mindedness was deemed a sufficient explanation for almost any type of misconduct. This viewpoint is hardly tenable. In order to guide childhood it is necessary to learn the intellectual potentials of a child so as to create a rational program for its guidance. This holds equally true for the supernormal children as well as for those who are mentally subnormal. It is necessary to ascertain the special abilities or disabilities of children regardless of their intelligence levels, in order to promote their mental welfare. Temperament may carry some implication concerning the quality of intelligence but it does not indicate the level of intelligence. There is a vast distinction between the ability to form moral judgments and moral behavior. Intellectual levels cannot be regarded as measures of character though they are important in suggesting methods essential and useful for the guidance of character.

The mental defectives, particularly the moron and the borderline types, present special problems to the mental hygienist, but, relatively, the character difficulties they present, are no more numerous than those found among children of the highest intellectual capacity. The inculcation of habits of right living, in the broader sense, calls for early acquaintanceship with mental capacity, as differentiated from mental traits. Frequently inherent traits and attitudes may account for failure in intellectual achievement. More commonly intellectual limitations help to account for the exhibition of mental traits, irrespective of the intellectual levels. The mental hygienist seeks to secure the proper adjustment of mental

effort and mental capacity, so as to provide for the maximum of satisfying achievement. To secure an adjustment of this type, it is insufficient to depend merely upon the determination of intelligence levels. The routine determination of mental age of children is valuable but insufficient, from the standpoint of mental hygiene, to make provision for the adjustments required for the evolution of desirable traits of character. The child with an intelligent quotient of one hundred and sixty or above may present the same character traits as those exhibited by a child with an intelligence quotient of sixty or seventy. In both instances similar basic thwartings and limitations may be responsible for the undesirable manifestations of behavior. The underlying desires for success, power, independence, and dominance, may be activating each of them, but the methods for satisfying these desires vary greatly because of their respective intellectual potentials. It is necessary, therefore, for the mental hygienist to recognize the values of intelligence tests in terms of the definite information they supply. They are not to be regarded, however, as the explanation of conduct, whether favorable or unfavorable. Obviously the intellectual components of character are important, but for the most part, they are not diagnostic nor completely explanatory of character. They reveal certain qualities of mental function but they do not yield information concerning some of the most vital characteristics requisite for social life. They cast little light upon initiative, leadership, inventiveness, kindness, sympathy, courtesy, obedience, or rectitude. They give insight into powers of memory, association, comprehension, reasoning and judgment, all of which are factors in securing adaptations to social life. To a great extent it is out of these adaptations that character emerges. Complete intellectual adjustment in itself does not guarantee moral behavior. It is essential, nevertheless, for the mental hygienist to recognize the value of intellectual adjustments as a factor in child guidance.

The interplay of physical and intellectual factors is recognized but they are especially bound up with the emotional life of children. An appreciation of the emotional contents of children's minds is essential because they are the most vital motivating forces in activity. Character growth is dependent upon the guidance of the emotions. Habitual emotional reactions tend to become fixed and crystallized into attitudes and sentiments which constantly affect personal adjustment. The tyrannic selfishness exhibited in anorexia nervosa merits early attention so as to forestall later neurosis or hysteria. The hygienist seeks to overcome the thwartings of desire and to present opportunities for the reasonable expression of emotional life through opportunities for self-satisfaction. The pleasure and pain

must be weighed in terms of the balance of self-assertion and self-submission. It is imperative to recognize the emotional elements bound up in the self-preserving ego instinct, the emotional qualities surrounding the herd instinct, and the forceful strivings attached to the sex instinct. It is equally important to appreciate the planes of conduct which are normal at various ages of individual development. The child is for many years bound up in himself, and his judgments and activities are unrelated to the welfare of others. A considerable degree of training is required to bring about the emotional controls, essential for deriving pleasure from experiences involving the welfare of human beings other than himself. The interpretation of rage, temper, pugnacity, shyness, lying, stealing, demands an analysis of the emotional content entering into such behavior.

Emotions are states of tension having their origins in conscious and subconscious living, they constitute the dynamics of character. It is obvious that the conscious life of the child is not the sole determiner of character. The subconscious motivation also is important in moulding it. The mental hygienist is obliged to analyze the emotions and emotional conflicts in order to suggest the sublimation of numerous impulses which arise in part from the physical status of the child, his intellectual potentials and his conflicts with the world in which he lives. Shame, slowness, stubbornness, defiance, peevishness, stolidity, indolence, may arise from the thwarting of self-assertive trends, whose needs must be determined.

The mental conflicts arising from the clashing of desires must be ascertained and eliminated. Character attributes have their basis in the instinctive and emotional life, and cannot be modified without an investigation and appreciation of them. Continued conflicts even before repression, profoundly affect mental function.

The early recognition of neurotic and hysterical trends is the basis for stabilizing emotional activity which is so essential for an equilibrium of mental function.

The social phases of character indicate the value of an understanding of the social forces acting upon child life. The child in isolation is a useless being and his qualities are of little concern. The child in relation to his environment evidences attitudes which are largely determined by the interaction of the social forces upon his innate potentials. Were the mental hygienist to focus all his attention upon the child, his service would be limited. Only by seeking out the social influences affecting child success and happiness can he be an intelligent guide and counsellor. One need but suggest the effects of poverty, alcoholism, ignorance, parental indifference, neglect and misunderstanding, desertion and divorce,

secular schooling and religious education, to appreciate the multitude of forces that enter into the child's world. To attempt to guide character development without endeavoring to create a favorable environment for the growth of desirable habits and attitudes is irrational.

Character does not arise wholly from innate internal patterns. The impingement of the world upon the child helps to determine the attitude of the child towards the world. The mental hygienist is deeply concerned with environment, with familial background, home conditions, methods of schooling, companionships, recreational opportunities, vocational aptitudes and interests, and with the personalities most constantly and frequently in contact with the child. Successful living is dependent upon free adaptation to life and the ability to make adjustments essential for health, comfort, and happiness. One does not disregard the exhibition of character traits similar to those found in other members of the same family, but there cannot be an assumption that these traits are inherited and unchangeable. Such a fatalistic point of view precludes an intelligent approach to the problems of character formation. If one assumes incorrigibility, mental hygiene would be useless.

The mental hygienist directs his attention towards the main requisite for bringing about normal mental function as the basis of rational character development. With an appreciation of the physiological and psychological constitution of the child, with an insight into his emotional relationships, he seeks to develop a definite plan for life guidance, with the child as the center of

activity. Around the individual child, however, are groups of elements radiating toward him. The child is viewed as an individual, but more completely in relation to his world of institutions, laws, and opportunities. Definite programs for adaptation and readjustment are developed. By nature children are imitative and suggestible, egocentric but reasoning, and hence, guidance in development becomes possible. The early recognition of desirable and undesirable character trends supplies a real opportunity for intelligent assistance in the art of living.

The mental hygienist is not merely a character analyst, his main function is synthesis, based upon his analysis. His aim is to promote a sense of security, a feeling of self-satisfaction and a consciousness of expansion for more complete living. He attempts, through an adjustment of the environment, to bring about a conscious willingness to accept personal limitations and to make adaptations in consonance with the realities of life. Conscious choice is not to be disregarded even though a high degree of motivation arises from subconscious interests and strivings. The soundest character development is dependent upon the conscious choice of traits that are personally satisfying. Character evolved from conscious selection of traits is established upon firmer foundations than that arising from coercion, over-direction and compulsive over-solicitude. Mental hygiene finds its greatest service in interpreting the world to the child and the child to its world, thus liberating and guiding the dynamic forces bound up in the development of character.

## THE SURGICAL ASPECT OF THE NASAL GANGLION\*

By SIMON L. RUSKIN, M.D.,

NEW YORK CITY

THE surgical aspect of the nasal ganglion has hitherto received but little attention in comparison with its importance. Although cocaineization of the ganglion intranasally by superficial application has been employed especially for the submucous resection of the septum, nevertheless, for radical sinus work the anesthesia of the ganglion by direct injection has seldom been used. This seems strange when one considers that the ganglion is one of the main centres for innervation of the nose and throat and can be blocked with one-half of a cubic centimeter of 2 per cent novocaine. The reason for this apparent neglect of such a useful measure lies in the fact that the nasal method of approach to the ganglion quite often presents technical difficulties that make the injection more bothersome than the diffuse cocaineization of the nasal mucous membrane.

In the February issue of the *Laryngoscope* I have described the injection of the nasal ganglion through the posterior palatine canal. Through this route one can inject the nasal ganglion almost with the same ease as an ordinary subcutaneous injection. This route is independent of any intranasal condition, has a direct and easy approach through the mouth, is in constant relationship to the ganglion and has practically no danger of hemorrhage. In addition, the same route brings the needle in close relationship to the maxillary division of the trigeminal nerve so that the injection of the ganglion and the maxillary nerve can be done simultaneously, thus securing a very extensive region of anesthesia in a quick, easy manner. I have recently had the pleasure of demonstrating to Dr. Greenfield Sluder this

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse May 13, 1925.

method of injection on the cadaver, and of showing him several unusual types of cases where the ganglion was successfully injected through this new route

On reading the article written by Silverman, the dental surgeon, in the A. M. A. describing the injection of the maxillary nerve, through the posterior palatine canal it occurred to me that I could reach the nasal ganglion through the same route. In attempting the injection, on anatomical material, I found that the ganglion could easily be reached in this way, and on clinical trial was gratified to see the thoroughness of the effect.

To fully realize the value of this injection, one must consider the extensive distribution of the nasal ganglion. The ganglion has four main groups of branches, an internal or nasal group, a descending or palatine group, a posterior group and an anterior or orbital group. The internal or nasal group sends a number of branches, the largest of which is the nasopalatine nerve through the sphenopalatine foramen to pass medially across the lower part of the anterior wall of the sphenoid to the septum, thus supplying the major portion of the septum. From the same group also arise branches to the middle and superior turbinates, superior meatus, sphenoid sinus and posterior ethmoidal cells. The nasopalatine nerve, passing as it does, obliquely across the septum in a groove in the vomer and septal cartilage and through the anterior palatine foramen where the nerves of each side meet and form a small plexus, reaches the roof of the mouth, and supplies, in addition to the septum, the anterior portion of the hard palate and incisor teeth.

The descending or palatine group of branches from the sphenopalatine ganglion comprise three large nerves, the anterior, middle and posterior palatine. These three branches associated with the posterior inferior nasal nerve descend almost vertically from the sphenomaxillary fossa into the pterygopalatine or posterior palatine canal. The posterior inferior nasal nerve leaves the canal through a small perforation to be distributed to the posterior two-thirds of the inferior turbinate and inferior and middle meatus. The nerve runs along the superior margin of the turbinate. The anterior palatine, which is the largest branch, emerges at the posterior palatine foramen to be distributed anteriorly over the roof of the mouth and medial side of the gums. The middle palatine nerve leaves the pterygopalatine canal to enter a small accessory palatine canal and emerge on the small pyramidal process of the palate bone to be distributed to the soft palate, uvula, upper two-thirds of the faucial tonsil and pillars. The posterior palatine nerve also leaves through a small accessory palatine canal and is distributed to the

same area. In addition to sensory fibres, this nerve also contains motor fibres supplying the levator palati muscle.

The posterior group also sends several branches to the extreme superior part of the nasal cavity, nasal septum, sphenoid sinus and a pharyngeal branch to the nasopharynx, superior part of pharyngeal wall and medial part of Eustachian tube.

The anterior or orbital group consists of a number of small branches which leave the ganglion passing upward and anteriorly through the inferior orbital fissure supplying sensation to the periosteum lining the orbit, and some branches passing into the posterior ethmoidal cells.

Arnold and Longet describe some branches passing upwards to be distributed to the neurilemma of the optic nerve. Bock and Valentine have observed a branch from the ganglion to the sixth nerve. Tiedman found a branch from the sphenopalatine to the ciliary ganglion. Luschka describes two or three branches, sphenothmoidal ascending to the superior portion of the internal orbital wall, passing through the posterior ethmoidal foramen and entering the brain case.

The nasal ganglion together with the maxillary nerve, both of which can be anesthetized at the same time, supply the integument of the cheek, forehead of the temple, the lower eyelid, the side of the nose and upper lips, most of the lining membrane of the nose, and the mucus membrane of the upper part of the pharynx, of the antrum, and posterior ethmoid cells, the soft palate, upper two-thirds of the tonsil, the uvula, and the glandular and mucus structure of the roof of the mouth. The mere recital of this distribution is enough indication of the value of this route of injection.

This injection has proven of value in tonsillectomy where an injection of half a c.c. of novocaine into each ganglion supplemented by 1 c.c. of novocaine at the base of each tonsil for the glossopharyngeal plexus has given total anesthesia. Although block anesthesia of the middle and posterior palatine nerves at their emergence from the accessory palatine canal has been practiced, nevertheless, I have been unable to find references to the injection of the ganglion directly for tonsillectomy.

In radical antrum operations the injection of the ganglion and maxillary nerve, by the new route has given a complete anesthesia.

For radical ethmoid and sphenoid surgery the ganglion has given extensive anesthesia. One must, of course, remember that the anterior and posterior ethmoidal nerves are not affected by the ganglion injection.

For the submucous resection of the septum the usual block anesthesia is sufficient, but in cases where the deflection is very great, mak-

ing the posterior part inaccessible, the ganglion injection by the posterior palatine canal is very useful

The injection also has a wide range of usefulness in oral surgery for the removal of neoplasms of the upper jaw and mouth

The technique of the injection is very simple after the regional anatomy has been mastered. The sphenopalatine ganglion is usually described as situated in the sphenomaxillary fossa midway between the anterior border of the sphenoid bone and the posterior border of the maxillary bone and 5 to 6 mm beneath the second division of the fifth nerve as it bridges the pterygopalatine fossa. In dissections I have found the ganglion to lie rather close to the sphenoid, separated from the periosteum by a thin layer of fascia. The ganglion is hung a few millimeters below the maxillary nerve and appears to be slung between the maxillary nerve laterally and the Vidian nerve medially. Anterior to the ganglion is the fairly large sphenopalatine artery and a sheath of fascia surrounding it. The fascia surrounding the ganglion is quite distinct and can be seen extending down into the posterior palatine canal to about the level of the inferior turbinate. Laterally the fascia encircles the

maxillary nerve, forming a sort of diaphragm. Thus fluid injected into the ganglion region can diffuse up to the retro orbital structures, causing a temporary amblyopia or transient abducent paralysis. The ganglion lies in close proximity to the sphenopalatine foramen. Above, the ganglion is covered by the under surface of the sphenoid and orbital process of the palate bone, behind by the pterygoid process and greater wings of the sphenoid, anteriorly by the maxillary sinus, and laterally, and inferiorly by the sphenomaxillary fossa.

Injection of the ganglion was formerly done by one of two routes, either through the nose, as suggested by Sluder, or through the mouth, passing the needle lateral to the last molar tooth and behind the tuberosity of the maxilla into the sphenomaxillary fossa. This latter route is the one generally used by the dental surgeons. The posterior palatine route which I suggest for the nasal ganglion differs from the above routes in that the needle is guided through the posterior palatine foramen into the posterior palatine canal at the top of which sits the nasal ganglion. The nasal ganglion sends the palatine nerves almost vertically down into the posterior palatine canal. By sending the needle upwards in the same direction one is guided like in a grooved

director exactly to the ganglion.

To enter the canal one first locates the posterior palatine foramen. This opening is usually round, quite large and as seen in the illustration lies opposite the second or third molar tooth. One palpates the edge of the hard palate posteriorly and inserts the needle one-half a centimeter anteriorly and about three-quarters of a centimeter medial to the teeth. In edentulous mouths one is of course guided more by palpation of the hard palate. In these cases, however, the posterior palatine foramen is larger than usual, thus making it relatively easy. The posterior palatine foramen varies in its position, sometimes opposite the third molar tooth, at other times opposite the second, or it may be oval in shape and quite close to the alveolar process. One is therefore obliged occasionally to probe with the needle to locate the opening. Another guide to the foramen is an occasional dimple in the mucus membrane of the palate in this region. This dimple is sometimes paler or redder than the surrounding area.



Frontal Sinus

Ant. Ethmoid

Uncinate Process

Bulla Ethmoidalis

Hiatus Semilunaris

Sphenoid

Maxillary Nerve

Nasal Ganglion

Vidian Nerve

Posterior Palatine

Canal & Pal. Nerves

Post. Palatine Foramen

men

Dissection shows  
Posterior half of  
Inferior turbinate  
Middle and Superior  
Turbinates removed,  
Sphenoid and Ethmoid  
dissected to expose  
Nasal Ganglion.

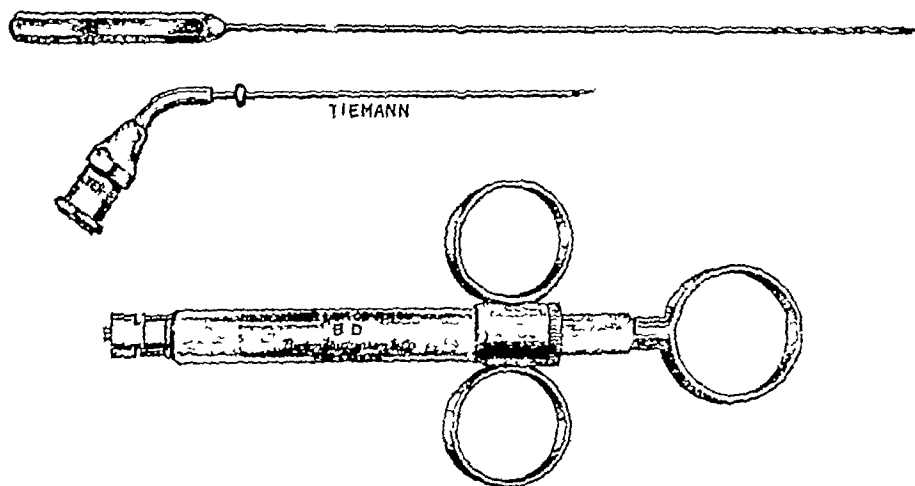
Needle in Posterior Palatine Canal for  
Injection of Sphenopalatine Ganglion

For the injection of the ganglion I employ a 22 gauge platinum or flexible steel needle, 4.5 cms long, mounted on a syringe at about a 45 degree angle. With the patient in the lying position and head extended, the posterior palatine canal which is almost vertical in the sitting position is brought almost horizontal. In this position I have found injection easiest, although it can be done in the sitting position. After the posterior palatine foramen is located the needle is inserted through it into the posterior palatine canal for a distance of 3.0 to 4 cms. This brings the needle point into the ganglion and opposite the sphenopalatine foramen. For the injection of the maxillary nerve simultaneously with the ganglion the needle is carried in 4.5 cms. There are several points to be remembered in this injection. The needle point must be directed in a line towards the inner canthus of the eye rather than towards the pharynx as one is strongly tempted to do. The mouth must be opened as wide as possible to permit the entrance of the needle in the proper direction. With some patients it is advisable to use a

avoided to prevent its breaking. It is also advisable never to bury the needle to the hilt, to avoid difficulty in extracting the fragment should the needle break. This accident is not more frequent in this injection than in injections elsewhere.

The injection should be done with strict asepsis. The roof of the mouth is painted with half strength iodine and the tongue kept depressed to avoid contaminating the area or the needle. For anaesthesia 2 per cent novocaine is preferred, 1 cc usually sufficing. For neuralgia injections either 10 minims 70 per cent alcohol or 5 per cent phenol in alcohol is used.

Up to the present time I have seen no untoward complications. There has been no case of severe hemorrhage following the injection. Should a vessel be punctured the pressure of the surrounding tissue would probably produce hemostasis. There is, however, a little bleeding from the palate for a few moments following the extraction of the needle. Occasionally one may observe a transient amblyopia or abducent paralysis, but this wears off in



mouth gag. The tongue should be kept depressed to avoid its contaminating the needle. If the canal has been entered the needle will slide in for almost its full length, otherwise it will enter the palate for only one to two cms. If one goes behind the posterior edge of the hard palate the needle slides in easily, but instead of being in the canal it has merely perforated through the soft palate and the fluid runs into the pharynx, or appears mixed with blood in the nose. If the needle was placed through the soft palate more laterally it will slide along under the mucus membrane of the lateral wall of the nose and the fluid will be deposited in the vicinity of the sphenopalatine foramen. In such event, anaesthesia of the ganglion would occur by infiltration. At all times leverage on the needle must be

a few hours. One case complained of some burning sensation and pain on movement of the eyeball for several weeks following the alcohol injection. In some cases I observed a swelling of the cheek on the side injected, associated with a moderate amount of tenderness.

In conclusion, I wish to point out again that injection of the nasal ganglion is a valuable aid in securing anaesthesia for nose and throat work, and that the ganglion can be easily approached through the posterior palatine canal. In addition this route of injection has a wide range of usefulness in cases of nasal ganglion neuralgias.

The accompanying cuts show the syringe used for the injection and also a fine nasal ganglion applicator for local applications in the nose.

## THE NEWSPAPER AS AN AID IN PUBLIC HEALTH WORK \*

By LEO F SCHIFF, M.D

PLATTSBURG N Y

**P**UBLIC health, being the health of the public, is therefore, a matter of utmost concern to the public themselves, and not merely a series of official acts. There is no better way of keeping the public acquainted with the health conditions in their community and to enlist their support than through the public news agency—the newspaper. My topic of today concerns itself particularly with the local (community) aspect of public health publicity work, and more particularly to that of the smaller communities. The State Department of Health and many other public health and charitable organizations, have been using the newspapers, moving pictures, and other means of publicity for several years in furthering great health movements and in educating the public in a general way. I am speaking particularly of the way in which the public health agencies of a small community may interest their local public in their own welfare from day to day and with reference to the varying conditions as they arise.

The newspaper's business is to print the news. The staff of the papers are constantly on the lookout for news, and they are glad to receive and print whatever comes to them as news. They receive a great deal of material sent out by the large health agencies and societies of various sorts, including some which is propagated to further movements which are not always of real benefit to the public, but rather propaganda of a non-representative group of fanatics or in some cases of various cults and sects. The editor and reporter are busy men and cannot take time to sift the wheat from the chaff. Whatever looks, at first glance, to be news is grist for their mill, and goes to the press room. A great many newspapers are buying syndicated health items, which tell us what to eat, what to wear, how to breathe, how to exercise and so on. None of the material described above gives the public the kind of information to which I am particularly referring in this paper, that is, what is going on in regard to the public health of their own community at the present day.

Quoting from my own experience, the easiest way to handle this situation is for the Health Officer to conduct his own column for which the daily papers are usually glad to grant him all the space he wants, and to supply the material for this column himself from the items of his daily routine and such other matters as

may come to him from time to time. It is far better to control the work in this way than to give it to the reporter or editor in abstract for their expansion into a news item. Even the routine of the Health Officer's work can be made interesting to the public if properly presented. Statistical reports of the deaths, births, and communicable diseases have their place in these columns, but should always be supplemented by other items of more human interest.

I started this work in Plattsburgh shortly after assuming the position of Health Officer, with the idea that the community should realize at all times that its water supply, its milk supply, and to some extent its food supply, was being looked after by the Board of Health and being kept up to a certain standard, believing, for instance, that an occasional statement throughout the year that the water examinations were satisfactory would gradually carry weight so that if it became necessary at any time during the summer to advise the boiling of drinking water, as a prophylactic against a possible epidemic, that it would be less liable to cause panic than the old way of completely ignoring such a factor as the water supply until it was necessary to publish a notice advising the public to boil their water. Under the latter circumstances the most usual thing was that a rumor would start that there had been several cases of typhoid and often times a number of deaths. Of course, sensation is always welcomed by the newspapers, balanced on the other hand by the fear of disturbing business conditions in the community. This latter was the condition met with recently in some of our communities when it was desired to make a frank statement in regard to smallpox.

A few examples of the sources of the copy for a local public health column are. Complaints received, constructive work going on, the application of general movements being advertised at the time, such as Child Welfare Week, to local conditions, or the utilization of startling news items, like the Nome episode, as an object lesson. In our publicity work in Plattsburgh, we have endeavored to keep away from the general news items, tuberculosis, cancer prevention, etc, except in so far as we could make a local application of them. We have not attempted to compete with the boiler plate, health news, or the State Department's publicity work. Practically all of our articles have been either in reference to some particular local condition or when of a

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse, May 13 1925

general character, written purely from the public health point of view. Thus, in an article on tonsillitis, the prevention and particularly the means of preventing its spread to others were stressed and the matter of treatment taken up only in a very general way with the advice to consult one's family physician.

A few specimen topics of articles in the Plattsburgh papers under the auspices of the Board of Health follow

Toxin-antitoxin Work

Clean-Up Week

Garbage Disposal

Milk Inspection, followed by advice on the proper care of milk in the household after delivery

A series on the commoner contagious diseases and reporting to the Health Officer in cases where no physician is employed

The occurrence of a case of typhoid fever on a dairy farm near Plattsburgh, commend-

ing the owner for promptly reporting the case himself, and stopping the sale of his milk.

The putting of kerosene in milk bottles by householders

A series on Rickets, pointing out the activities of the Child Welfare Clinic

A series on the activities of the State Department of Health

In addition to using the column allotted for us, we have at times written editorials and at other times suggested material for editorials to be written up by the newspaper staff, all of which has been done with a great spirit of cooperation by the newspaper men. I feel that today, as a result of a little over a year's effort along these lines, that the people of Plattsburgh appreciate what their Board of Health is trying to do and are ready to cooperate at all times, further, that they have acquired a feeling of confidence in the Board which may be of great value to us, should an emergency arise or epidemic threaten.

## Deaths

BUTSCH, JOHN LOUIS, Buffalo, Johns Hopkins, 1912, Fellow American Medical Association, Fellow American College of Surgeons, Buffalo Academy of Medicine, Buffalo Surgical Society, Member State Society, Associate Physician Millard Fillmore Hospital. Died September 6, 1925

FLYNN, JOHN JOSEPH, Brooklyn, Fordham University, 1913, Member State Society, Yonkers Academy of Medicine, Alumni Association St Mary's Hospital, Attending Obstetrician St Joseph's Hospital. Died September 1, 1925

GORHAM, GEORGE ELMER, Albany, Hahnemann Medical College, Chicago, 1874, Member State Society, Consulting Physician Memorial Hospital. Died July 31, 1925

HETZEL, FREDERICK CRAFT, Tompkinsville, Long Island College Hospital, 1919, Fellow American Medical Association, Member State Society, Alumni Association Woman's Hospital, Junior Attending Surgeon Staten Island Hospital. Died August 8, 1925

HOLTON, DAVID CRISPIN, Miami, Fla., Bellevue Medical College, 1886, Member State Society. Died August 11, 1925

MORRISON, DAVID ALEXANDER, Buffalo, Iowa, 1882, Member State Society, Buffalo Academy of Medicine, Consulting Physician Deaconess Hospital. Died August 17, 1925

POMEROY, RALPH H., Brooklyn, Long Island College Hospital, 1889, Fellow American Medical Association, Fellow American College of

Surgeons, American Gynecological Society, Brooklyn Gynecological and Brooklyn Pathological Societies, Member State Society, New York Obstetrical Society, Attending Gynecologist and Obstetrician Brooklyn Hospital, Consulting Obstetrician Kings County, St John's and Methodist Episcopal Hospitals. Died August 22, 1925

PRATT, JOHN RICHMOND, Manchester, Jefferson, Phila., 1851, Member State Society. Died September 14, 1925

PRESLEY, EARL WARREN, Great Kills, University and Bellevue, 1912, Fellow American Medical Association, Member State Society, Assistant Visiting Physician Sea View Hospital, Attending Physician Richmond Memorial Hospital. Died September 15, 1925

SKIFF, GEORGE E., Warsaw, Buffalo, 1920, Member State Society. Died August 9, 1925

SORNBERGER, SAMUEL J., Cortland, Physicians and Surgeons, Chicago, 1894, Fellow American Medical Association, Member State Society, Syracuse Academy of Medicine, Surgeon Cortland Hospital. Died August 10, 1925

VAN WACK, DAVID B., Arlington, Bellevue Medical College, 1889, Member State Society. Died August 19, 1925

VIRDONE, PAOLO, Brooklyn, Naples, 1899, Fellow American Medical Association, Fellow American College of Surgeons, Member State Society, Assistant Surgeon Wyckoff Heights Hospital. Died September 7, 1925



# EDITORIALS

The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

Editor-in-Chief—ORRIN SAGE WIGHTMAN, M.D.,  
New York  
Executive Editor—FRANK OVERTON, M.D.  
Patchogue

COMMITTEE ON PUBLICATION  
E. ELIOT HARRIS, M.D., Chairman  
WILLIAM H. ROSS, M.D.  
DANIEL S DOUGHERTY, M.D.  
New York  
Brentwood  
New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

President—NATHAN B VAN ETEN, M.D.  
First Vice President—WILLIAM H ROSS M D  
Second Vice President—FREDERICK H FLAHERTY, M.D.  
Speaker—E. ELIOT HARRIS, M.D.  
Vice Speaker—GEORGE M FISHER, M.D.  
Secretary—DANIEL S DOUGHERTY, M.D.  
Assistant Secretary—HOWARD GILLESPIE MYERS, M.D.  
Treasurer—CHARLES GORDON HEYD M.D.  
Assistant Treasurer—JAMES PEDERSEN M.D.

New York  
Brentwood  
Syracuse  
New York  
Utica  
New York  
New York  
New York

### CHAIRMAN, STANDING COMMITTEES

Arrangements—EDWARD R CUNIFFE M.D.  
Legislation—HENRY L. K. SHAW, M.D.  
Public Health and Medical Education  
CHARLES A. GORDON, M.D., Brooklyn  
Scientific Work—ANDREW MACFARLANE, M.D.  
Medical Economics—WILLIAM WARREN BRITT, M.D. Tonawanda

New York  
Albany

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex President and the Councilors of the District Branches.

First District—JOHN A. CARD, M.D.  
Second District—JOSEPH S THOMAS M.D.  
Third District—CHARLES P McCABE M.D.  
Fourth District—HORACE M. HICKS M.D.  
Fifth District—NELSON O BROOKS M.D.  
Sixth District—GEORGE H. FOX, M.D.  
Seventh District—WILLIAM I DEAN, M.D.  
Eighth District—HARRY R. TRICK M.D.

Poughkeepsie  
Flushing  
Greenville  
Amsterdam  
Oneida  
Binghamton  
Rochester  
Buffalo

COUNSEL  
GEORGE W. WHITESIDE, Esq. 27 William St.  
Telephone, Broad 1744  
New York

ATTORNEY  
ROBERT OLIVER, Esq. 27 William St.  
New York

EXECUTIVE OFFICER  
JOSEPH S. LAWRENCE, M.D. 51 Chapel Street, Albany

### SECTION OFFICERS

Medicine  
Chairman—L. WHITTINGTON GORHAM M.D.  
Secretary—WARDNER D. AYER, M.D.  
Albany  
Syracuse

Surgery  
Chairman—EDWARD S. VAN DUYN M.D.  
Secretary—GEORGE E. BEILBY, M.D.  
Syracuse  
Albany

Obstetrics and Gynecology  
Chairman—ALFRED C. BECK, M.D.  
Secretary—NATHAN P. SEARS, M.D.  
Brooklyn  
Syracuse

Pediatrics  
Chairman—ROGER H. DENNETT M.D.  
Vice Chairman—ARTHUR W. BENSON, M.D.  
Secretary—JOHN ATKMAN M.D.  
New York  
Troy  
Rochester

Eye Ear Nose and Throat  
Chairman—EUGENE E. HINMAN M.D.  
Secretary—JAMES W. WHITE M.D.  
Albany  
New York

Public Health, Hygiene and Sanitation  
Chairman—ARTHUR D. JAGUES, M.D.  
Secretary—LEO F. SCHIFF M.D.  
Lynbrook  
Plattsburg

Neurology and Psychiatry  
Chairman—CLARENCE O. CHENEY, M.D.  
Secretary—THOMAS E. DAVIS M.D.  
Utica  
New York

For a list of the officers of the county medical societies, see April 24th JOURNAL, advertising page v  
For list of District Branch Officers, Standing Committees and Special Committees, see July JOURNAL, advertising page xxiii

## EVIDENCES OF MEDICAL PROGRESS

Progress in the practice of medicine in New York State has been continuous although without spectacular featuring. It has been so gradual and slow that a busy practitioner who does not inform himself of what his confreres are doing may continue in the successful practice of methods of a quarter century ago without being deeply affected by the progress. But if that same practitioner should attend a third or fourth year class in a medical school or the rounds of a large hospital service with the chief, he would find that he must pass many milestones of progress before he reaches the standards of the up-to-date practice of medicine. The observant doctor can appreciate the progress of medicine in the community from year to year.

In what does progress in medicine consist?

One standard of measurement is the amount of new discoveries in a given time.

The discovery of new basic principles and the development of their application to patients constitute the science of the practice of medicine. Progress in medical science is the result of patient research by a limited number of gifted investigators in endowed laboratories, and a few clinical observers who record the histories of their cases with great care and truthfulness. All medical progress depends on these few who work along original lines. Their reports are recorded in special journals such as the Archives of Internal Medicine. These original workers set the ideals whose infiltration into the consciousness of general practitioners takes months or years.

While the science of medicine is made by a

few research workers, the standard of the art of medicine, or the practical use to which facts of scientific medicine is put, is the average practice of the doctors of a community. The sea of medical knowledge may advance in waves or in a swelling tide. Some doctors ride the foremost crest of every incoming wave that beats on the shore of ignorance, and when the wave breaks, they fall back with the receding undertow, but soon bob up on the crest of the next medical fad.

Medicine also advances like a rising tide, and we can measure its progress by the extent to which it reaches the great mass of general practitioners. A reliable test of the art of medicine in any community is the knowledge and skill that is shown by a representative number of doctors chosen at random. Suppose we choose the treatment of diabetes as the test. How many doctors can give insulin intelligently? How many can interpret the chemical findings which are the sure guides in the art of giving insulin? The tide of knowledge in the treatment of diabetes is rising but it has by no means reached all practitioners of medicine. Unmistakable evi-

dences of the rising of the tide of medical progress are seen everywhere in New York State. The State Medical Society has adopted graduate education as one of its major activities and the response of the county medical societies has been commendable. The membership of the State Society is composed principally of general practitioners of medicine and it is the family doctor on whom falls the burden of diagnosing and treating most diseases which fall upon suffering humanity. He wishes to know the short cuts in the practice of the medical art, how to examine a patient, and to know the outstanding diagnostic points of a sickness, and the approved methods of its treatment. He can make little or no use of fine points of pathology, or the history of a disease—he wants to know how to recognize it and cure it.

This is the kind of information which the Committee on Public Health and Medical Education will try to bring within the reach of the members of the county societies throughout the State. The fact that it is offered to the doctors is itself evidence of substantial progress in medicine.

## GRADUATE EDUCATION PLANS OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

Graduate education is making progress. That the State is ready for it, there is no doubt. Here and there of course we find skepticism and listlessness, and the inertia which so many of us enjoy, but everywhere there is a fine spirit of helpfulness.

The Committee on Public Health and Medical Education and the Special Committee on Graduate Education have met in Albany and New York, and are organized and functioning as a Joint Committee.

Surveys have been made and reports are constantly coming in from all the Districts of the State. Our immense amount of correspondence and a steady accumulation of information has resulted in the development of a comprehensive state-wide file which grows more valuable day by day.

Questionnaires have been sent to every county in the State. (See page 941.) The Committee tried to reach the County Committee on Medical Education or Public Health, where there was one, or the secretary of the County Society. Returns have been slowly coming in, but the questionnaires have invariably been carefully filled out.

A sub-committee is considering the whole question of graded courses. They are not as yet ready to report.

The State Department of Health is actively cooperating with its committees and has already provided speakers for meetings arranged

by the committees and county societies. Requests for the lectures in obstetrics and pediatrics are coming in so rapidly that there is some danger that we will be unable to meet the demand without severely taxing the resources of the State Department of Health. Already Chemung, Franklin, Rensselaer, Jefferson and St. Lawrence, Steuben, Allegany, Wyoming, Orleans, Wayne, Delaware and Washington have said that they are ready for these courses.

The great medical schools of the State are interested and willing to help. They have ready assets in their corps of teachers, some of whom at least will be willing to lend their services to the cause. This would be a great help. The same principles are involved in teaching clinical medicine in the field, as in giving instruction in the laboratory sciences. Good teachers are always active workers and so we hope they will enlist.

The Committee hopes for the loyal support of the entire profession. Everyone must help. The State is ready for graduate education. The task however is a tremendous one. The State is large, courses must be arranged, and willing workers assigned to counties, often far removed and perhaps difficult of access. The weather and the season of the year must be considered. Much money will be needed, and more than anything else, time. Time and cooperation will make everything possible.

C A G



# LEGAL



By GEORGE W. WHITESIDE, Esq.  
Counsel, Medical Society of the State of New York

## LUMBAR PUNCTURE—PARALYSIS—DEATH

The plaintiff's decedent, a man of about forty years of age, called upon the defendant for the performance of a lumbar puncture, which was done at the doctor's office, and about 28 c c of clear fluid withdrawn. A local cocaine anaesthesia was used. In the performance of the puncture a small trocar was inserted into the spinal canal and the fluid withdrawn, no difficulty being experienced in entering the spinal canal and there being no bleeding. Upon the day following the puncture there was no evidence of infection at the site of the puncture, no temperature nor inflammatory condition observed. The patient lived about twenty miles from the doctor's office and after the puncture traveled to his home. The puncture was performed at about one o'clock p. m. At five o'clock of the following morning, seventeen hours after the puncture, the patient had evidences of paralysis. Under the microscope no blood was observed in the spinal fluid. Very shortly after the completion of the puncture the patient complained of severe pain in his left leg and required the administration of an opiate. On the day following the performance of the puncture the doctor saw the patient at his home, at which time there was a complete paralysis of both legs without sensory disturbances. There was also a retention of urine. The defendant advised hospital care for the patient and was to receive word from the patient's wife in this connection. Upon the second day following the puncture he communicated with the patient's home and was advised that he had been removed to a hospital under the care of another physician. The defendant communicated with the physician who was then treating the patient and was advised by said physician that about a year previously he had had the patient under his care for a condition which he believed to be paresis, and that the patient had suffered a complete mental breakdown, became unmanageable and required institutional care. The defendant was also told by the physician then attending the patient had been previously treated by this physician for syphilis, both intravenously and intraspinally. Nine days after the spinal puncture the defendant, in consultation with another physi-

cian, saw the patient at the hospital, at which time it was found that he had a complete paralysis of the lower extremities without sensory disturbances. The patient was apparently quite ill with some type of infection. Upon examination of the chest the presence of rales and crepitant breathing in the left lung were discovered. Six days after this visit by the defendant to the patient, the patient died. An autopsy was performed upon the patient and the then attending physician advised the defendant that the findings upon the autopsy were that the cause of death was pulmonary embolus, that there was also phlebitis of the left leg, cystitis and brain syphilis, that there were no signs of injury or inflammation to the spinal cord, which was removed at the time of autopsy. The pathologist who performed the autopsy was of the opinion that the patient suffered a softening of the spinal cord as a result of his long-standing syphilis of the nervous system.

In an action to recover against the physician who performed the lumbar puncture for the death of the patient due to his alleged negligence in the performance of the puncture, it was charged that the defendant was negligent and careless in performing the lumbar puncture, causing a paralysis to the patient, from which he died fifteen days later. It was claimed that the negligence of the defendant consisted in his failure to await the result of a lumbar test before injecting into the spine of the patient certain harmful fluids and in that he made the spinal puncture at a point too high on the spine and contrary to the proper practice, that he also made the puncture too deep, and that as a result of the defendant's negligence the plaintiff suffered from transverse myelitis, cystitis, phlebitis and pulmonary embolus, causing the paralysis and subsequent death.

This action remained upon the trial calendar for some time. When about to be reached for trial, the plaintiff being unable to establish the allegations of negligence contained in her complaint, and being unable to prove that any act of the defendant was the competent producing cause of the death of the patient, a discontinuance was had of the action, thus favorably determining it in favor of the defendant doctor.

## CONTRACTION OF LEG DUE TO BURN

In this action, brought on behalf of a boy about three years of age, it was charged that one of the defendants in the month of February was engaged to attend him and to cure and heal certain burns on the body of the infant, and the second physician employed later that the physicians were careless and negligent in their treatment causing a contraction of the skin on the burned area which resulted in a shortening of the right leg of the infant causing him to walk with a limp.

On February 13, one of the defendants received an emergency call to attend the infant who had received burns when his clothes caught fire playing around a bonfire on the street. On examination it was found that about three-quarters of the abdomen was burned and a part of the right thigh, also burns on the neck and on both hands and arms. The burns were of a third degree nature. The abdominal burn extended from a little below the umbilicus to about eight inches on the thigh and involving the muscles. Carron oil and a sterile dressing were applied and the child ordered to bed. The physician advised the removal of the patient to the hospital which the parents refused to do. Proper instructions were given by the physician to the parents as to the care and attention to be given to the child. In the evening of the same day he again visited the patient at which time the child had a temperature of 105 which was caused by the burns. The child was also suffering physical disturbances. A sedative was prescribed. Upon the following morning, on removing the dressings the physician found that the tissues on part of the thigh and abdomen were becoming black, indicating death of the tissue. The burned area was also covered with a number of blisters which were opened with sterile scissors. Part of the dead tissue was likewise removed and the burns again dressed with sterile dressings. The physician continued to make daily visits to the child, examining and dressing the wound each time. The burned tissue continued to necrose which was removed with sterile instruments. The child was also given bicarbonate of sodium baths by the physician and wet dressings of bicarbonate of soda applied. Proper medication was prescribed to reduce the temperature which still remained high. The child was seen daily until March 23rd. After granulation started the use of carron oil was discontinued. The necrosis of the tissue did not cease until about the middle of April. The granulation did not begin to take place on the abdomen or thigh until about four weeks after the injury. To stimulate the granulation the physician used extracts of bismuth, zinc and a bland ointment. The necrosis of the thigh extended through the skin, fascia down to and

involving the thigh flexures. The necrosis ceased and the process of granulation continued until this physician was discharged from the case on March 23rd. To prevent the formation of a large mass of granulated tissue the physician had curetted the excess granulated tissue.

The father of the child frequently interfered with the care given by the physician and remonstrated with him for his procedure and the necessary curetting of the necrosed or excess granulated tissue. The father was frequently advised to remove the child to the hospital where better care could be given him and skin graft, splints and other treatment could be resorted to, also that the healing process would probably cause a contraction and impairment of the function of the leg. The father responded that he would not remove the child to the hospital and did not care what the result was so long as the child would live. At the time this physician was discharged from the case there had been no contraction of the leg.

On April 1st the father called at the physician's office, paid the bill and told the physician that the child was getting along all right and if further medical care was needed the father would call him. On April 4th the father called at the physician's office for treatment for himself. At that time this physician advised the father that he was going abroad and suggested the name of another physician in the event further treatment was needed for the child.

On April 5th the second physician was called to the patient's home by the first physician to assist him in treating the father. At that time he removed the dressing from the child and observed that the tissue was granulating. On April 7th the second physician visited the child, removed the dressings, washed the granulating tissue with bicarbonate of soda and applied silver nitrate along the edges to stimulate granulation. The child was seen by this physician for about two weeks, at first every day and later on about every other day. On each visit the granulated tissue was washed, disinfected and silver nitrate applied as necessary. At the time the second physician stopped calling upon the child the spot had been reduced from the size of a silver dollar to about the size of a quarter. The second physician was likewise discharged from further treatment of the child, the father telling the physician that he did not believe further treatment was necessary.

The plaintiff not proceeding with the prosecution of the action, a motion was made to dismiss the same for lack of prosecution, which motion was granted terminating the action in favor of both physicians.



# State Department of Health



## STEPS TAKEN TOWARD BETTER FACTORY WATER SUPPLIES IN NIAGARA FALLS

In investigating a case of typhoid fever at Niagara Falls recently, Dr. Edward Clark, district state health officer, discovered that the patient had drunk water at a manufacturing establishment where she was employed. This water came from Niagara River and was filtered at the plant, but no further purification treatment was applied. Dr. Clark took up the matter with the local health officer, Dr. E. E. Gillick, who sent a circular letter to each of the manufacturing establishments in the city which used raw water for commercial purposes. This letter

pointed out the responsibility of such establishments where this type of supply is used. The circular recommended that every employee should be notified of the danger, either by talks or lectures in the factory or by adequate printed notices conspicuously posted.

Following these measures, the company where the patient was employed has taken steps to have a pure water supply provided at certain taps where the filtered drinking water has hitherto been available.

## A NEW TYPE OF PUBLIC HEALTH EDUCATION

The following paragraph is an excerpt from an article entitled "A New Public Health Service," which appeared in the May 7 issue of the Boston Medical and Surgical Journal.

The Massachusetts General Hospital has taken a step that is perhaps unique for a general hospital by instituting a real campaign for the education of the public along health lines. This

health source consists of the periodical publication in the daily press of complete and authoritative articles by members of the staff dealing with matters of general and common interest. These articles appear and will continue for a time to appear, weekly in prominent Boston newspapers. Five have already been published, dealing with body mechanics, hay fever and asthma, varicose veins, basal metabolism and rickets.

## ITINERANT DIPHTHERIA CARRIER A PROBABLE SOURCE OF THREE CASES

According to a communication received from a district state health officer following his investigation of the death of a child from diphtheria, the family in which the child lived had been visited some time previously by a man who was discovered to be a diphtheria carrier. The report states that this man was unquestionably the

source of two other cases which occurred shortly after he had visited their families.

This man broke quarantine and was later traced to Castleton, Vermont, where he was again quarantined. He escaped a second time, and his whereabouts are now unknown.

## PHYSICIAN CALLED LATE—CHILD DIES

A recent report on a death from diphtheria of a nine-year old girl, received by the Division of Communicable Diseases, indicates that a physician was not called until two weeks after the child was taken ill.

Although the disease involved the pharynx, tonsils, nose and naso-pharynx, and the physician tried to impress the family with the serious-

ness of the case, the child was not kept in bed until the last twenty-four hours.

In this case the parents were doubly negligent—in their failure to call a physician until so late that antitoxin could be of no avail, and in allowing the child to be up and about, contrary to the physician's instructions.

## GLENS FALLS AMERICAN LEGION WANTS TUBERCULOSIS CLINIC

The American Legion of Glens Falls is taking an interest in public health. The organization has appointed a civic affairs committee of which Dr. Morris Maslon is chairman. This committee

has already notified the board of health, common council and Mayor that in their opinion a tuberculosis clinic should be held in the city at regular intervals.



# GRADUATE EDUCATION



## JOINT MEETING OF COMMITTEE ON PUBLIC HEALTH AND MEDICAL EDUCATION AND THE SPECIAL COMMITTEE ON GRADUATE MEDICAL EDUCATION

A joint meeting of the Committee on Public Health and Medical Education and the Special Committee on Graduate Medical Education, was held on the evening of August 21st, in Albany. There were present Dr. Charles A. Gordon, Chairman, and Doctors Jennings, Weiskotten, Madill, Tinker, Friedman, Johnson, MacFarlane, MacDonald and Chandler. The Executive Officer and the Executive Editor were also present by invitation.

The meeting lasted over three hours, and was characterized by earnestness and efficiency, as it developed through the three stages of the collection of evidence, a general discussion of conditions and definite decision.

The first third of the meeting was devoted to reports from each District Branch regarding the attitude of the members of the County Medical Societies toward Graduate Education.

Dr. Friedman, of the First District Branch, reported that the Orange County Medical Society had already instituted monthly meetings with clinical programs, and that the other counties were deeply interested in Graduate Medical Education, and were ready to undertake courses.

Dr. F. D. Jennings, of the Second District, outlined the extensive Graduate Education work of Kings County, and the course in Pediatrics in Suffolk County, and described the plans for giving the course in other counties of the Second District.

Dr. Chandler, of the Third District, said that he found the sentiment entirely favorable toward Graduate Education, and that the doctors wanted instruction in the practice of general medicine rather than the specialties.

Dr. MacDonald, of the Fourth District Branch, said that his District was the farthest removed from medical centers, and that his colleagues wanted instruction in pathology and other groundwork subjects, that Graduate Education would benefit his section more than any other section of the State, and that October was a good month for classes. Dr. Madill described the courses in Obstetrics that had been developed in St. Lawrence and Jefferson Counties (see the August, 1925, issue of this Journal, page 876). Dr. Madill said the courses gave the doctors something that they could use in their everyday practice.

Dr. Weiskotten, of the Fifth District Branch, said that in the large towns where abundant hospital facilities were available, the doctors asked

for intensive instruction in a small number of subjects, while in small places the doctors asked for fundamental instruction in several subjects. But first of all, he found that the doctors wanted to meet good teachers. He found that the most enthusiasm for Graduate work existed among doctors remote from hospitals.

Dr. Tinker, of the Sixth District Branch, gave a detailed report of the attitude of the doctors in each county of his District, and said that the sentiment was in favor of Graduate Education. He suggested the advisability of the smaller counties combining with adjoining counties in the courses.

Dr. W. D. Johnson, of the Eighth District Branch, said that he had made quiet visits to several counties, and was carefully investigating the attitude of the doctors in his District. He suggested the use of the hospitals for teaching, and the promotion of joint meetings among the smaller counties.

The Chairman explained the relation of the State Department of Health to the Graduate Education plan of the State Medical Society and the system of Regional Consultants in Pediatrics and Obstetrics, and how the consultants would be available for teaching. The Chairman also mentioned other agencies which might co-operate with the State Medical Society.

The reports of the members of the Committee mentioned all the various forms of Graduate Education which had been already started, many of which are described on page 875 of the August Journal.

The members of the Committee then entered into a lengthy discussion of the general principles involved in the Graduate Education plan of the State Medical Society, and yet each speaker was brief and clear. Dr. MacFarlane outlined some of the courses which had been carried out by the Albany Medical School, and presented arguments in favor of courses that required intensive study. He spoke of his experiences in his work of last year.

Dr. MacFarlane also discussed the question of payment to the lecturers and instructors, and presented arguments that payment would be good for both the lecturer and the listeners, for what one got for nothing was not likely to be appreciated.

The doctor also suggested that the Committee prepare syllabi on a few subjects and offer them to County Societies. The syllabi should be on

clinical subjects and illustrated with cases supplied by members of the County Society and worked up in full as to histories and laboratory tests

There was considerable discussion on the points brought up by Dr MacFarlane

Dr Jennings said that his experience in Brooklyn had shown that the more fundamental the lecture the more popular will be the course, as is shown by the crowds of doctors attending the five o'clock lectures of the Medical Society of the County of Kings. Doctors need instruction in the art of practicing medicine. He said that older doctors would take the courses as readily as the younger ones, for the need is general. Medicine is growing so fast that only through continuous education can men keep up their work and get their patients well.

Dr Weiskotten discussed the obstetrical courses given the Jefferson and St Lawrence counties, and thought that similar courses in other counties would be valuable. The desirability of publishing the lectures in the Journal was discussed, and some thought that if they were published, some doctors might be satisfied to read them and would not go to hear the speaker.

The discussion centered principally around the question as to the extent of the instruction to be given. Some speakers thought it should be intensive and others thought it should be confined to fundamental subjects—and the proponents of each plan conceded the desir-

ability of carrying out the other scheme as well as their own.

The third part of the meeting was directed by the Chairman who suggested that the Committee go on record with definite actions on some of the subjects that were discussed. Resolutions were formally passed along the following lines:

1 The State Committee shall work through the County societies and district branches, and no course shall be given or offered except through one of these organizations.

2 The courses in Pediatrics and Obstetrics that have been proven successful shall be offered to the county societies as courses already available.

3 The Chairman was authorized to arrange for such clinical lectures as the Orange County Medical Society may request in continuation of the course already in operation.

4 The moving picture films on tuberculosis and gastric ulcer shall be offered to the District branches for use in their annual meeting.

5 The Chairman shall appoint a sub-committee to prepare short courses, and shall find out from the medical schools whether they would be willing to help or not.

The meeting of the committee was highly practical and definite procedures were formulated and standards set.

CHARLES A GORDON

*Chairman, Committee on Public and  
Medical Education*

## QUESTIONNAIRE ON GRADUATE EDUCATION

Dr Charles A Gordon, Chairman of the Committee on Public Health and Education, has sent the following questionnaire to every county society addressed to the secretary, or to the chairman of either the Committee on Public Health or on Education. (See editorial page 936)

### THE QUESTIONNAIRE

1 What is your County Society doing in the line of graduate medical teaching?

2 Has your Society a committee on "Graduate Medical Education"? If so, who is chairman?

3 Has your Society any plans, tentative or otherwise, with regard to graduate teaching?

4 What facilities exist in your county to conduct extension courses such as meeting places for lectures, lantern, motion picture machine, hospitals, etc.?

5 Are there geographical divisions in your county which make it difficult to assemble at a central place or which would make it necessary in any plan to provide for your Society in geographical groups? If so, what are they?

6 What in your opinion would be attractive to your members in graduate teaching?

7 Has your Society a Public Health Committee? Who is chairman?

8 How many physicians in your county? How many are members of the County Society? Are most of them in public practice? Under average conditions what would be the best months in the year for extension work? How often and at what time of day would lectures or clinics be best held?

9 Are there any medical societies of importance, special or otherwise, in your county aside from the County Society?

10 Have you any suggestions or queries with respect to graduate teaching or public health activities which you wish to submit to the committee?

11 Are there in your membership physicians who are able and would be willing to take teaching assignments? If so, please list them.

12 Should physicians of the County who are not members of the Medical Society of the State or New York be included?



# MEDICAL ECONOMICS



The revised By-Laws of the Medical Society of the State of New York in Section 56, says

"The Committee on Medical Economics shall consist of five members including the chairman. It shall keep informed on all matters affecting the economic status of physicians and shall investigate and report on such matters as it deems necessary."

Rather a large program for five new men but your Committee has been selected with the idea of geological distribution, willingness to work, and understanding of the problems to be studied, and consists of

Dr William Warren Britt, Tonawanda,  
Chairman

Dr Charles O Boswell, Rochester

Dr Nelson K Fromm, Albany

Dr Henry B Doust, Syracuse

Dr Arthur S Chittenden, Binghamton

Economics may be defined as the science that treats of the development of material resources or the production, preservation and distribution of wealth and of the means and methods of living well, for the state, the family and individual. It covers the field of man's activities in making a living and particularly the relations of people in organized society, where in one way or another they cooperate in their labors and share in the results. The study of economics is for the purpose of understanding these complex relations, discovering the general rules or principles upon which people naturally act in them, and thus involving a system of order and cooperation in business, social life and public affairs.

The principles of economics are based upon and tested by experience. They are an interpretation of the experience of society. Many economic questions have been in controversy for a long time and will remain unsettled for a long time because the conditions to which they relate are continually changing, but there are certain principles upon which writers who are entitled to be regarded as authorities are in accord and concerning which all who wish to be well prepared for the responsibilities of every day life and of good citizenship should be informed.

Your Committee, on looking over the vast quantity of questions affecting the economic status of physicians, decided to send a questionnaire to the president of each county society. Many counties do not have a chairman

of Medical Economics but it is the hope of your Committee that each county will soon arrange to have some one appointed to this position.

The following questions are submitted

The Nursing Problem

Workmen's Compensation

Harrison Narcotic Administration

Distribution of Rural Practitioner

Industrial Medicine

Periodic Health Examination

Free Dispensary Practice

What Other Question?

and each one asked to number these in the order of importance from the standpoint of his county, also to submit any question he considered of importance.

Replies were received from thirty-seven counties, of which eighteen gave the Nursing Problem as of first importance. As a special Committee was appointed by the president of the Medical Society of the State of New York to consider this question we will not consider it here.

The question receiving the next highest number of first votes was the question of Periodic Health Examination. This question your Committee feels is an important one and it is our hope that through the combined efforts of all the counties we may devise a standard blank that will be adopted by all.

The remaining questions, arranged according to their importance as revealed by the replies received, are as follows:

Workmen's Compensation

Distribution of Rural Practitioners

Harrison Narcotic Administration

Industrial Medicine

Free Dispensary Practice

Other questions submitted by different counties were

Compulsory Vaccination

Chiropractic and Cult Question

Medical Ethics

State or County Aid for General Hospital in Rural Communities

Cooperation of Rural Physicians for Better Diagnostic Methods

This will indicate the lines along which we will work. We need the help of every physician who has anything to say along these lines and invite your correspondence.

W WARREN BRITT  
Chairman, Committee on  
Medical Economics





# MEDICAL SURVEY



## MEDICAL SURVEY NO 15—CATTARAUGUS COUNTY

**EDITOR'S NOTE** The information contained in this Survey was supplied principally by Dr James A Taggart, President of the County Medical Society and Dr Myron E Fisher, Secretary, Dr John J Mahoney, District State Health Officer, and Dr S A Douglass, County Health Officer

**Statistics**—Cattaraugus County is next to the most western of the southern tier of counties of New York State It has an area of 1,343 square miles It is approximately square, and its surface is rolling Farming is the dominating industry, but much oil is produced in the southern part of the county Its population was 71,323 in 1920, and is slowly growing It contains two cities, Olean, population 20,506, in the southeastern section, and Salamanca, population 9,276 south of the center of the county It contains 16 incorporated villages of which only seven have populations of over 1,000 apiece The largest village is Franklinville with 2,015 population

The distribution of population in Cattaraugus County is as follows

In cities	29,782
In 16 incorporated villages	15,374
In strictly rural sections	26,167
	<hr/> 71,323

The population of the county is fairly evenly distributed over the whole county, except in the Indian Reservation and State Park which together occupy about two hundred miles of waste land in the south central part, south of the Alleghany River The city of Salamanca is located in the Indian Reservation, and the people pay rent to the Indians

Good roads reach to every part of the county, and travel is easy throughout the year

**Physicians**—The directory of the Medical Society of the State of New York lists 83 physicians in Cattaraugus County, distributed as follows

Olean	36
Salamanca	9
Rest of county	38
	<hr/> 83

But when the list is checked up only 68 are found to be actually engaged in the practice of medicine This gives a ratio of one doctor to every 1,050 inhabitants

**Medical Societies**—The Cattaraugus County Medical Society has 49 members This is 72 per cent of the number of physicians in active prac-

tice in the county, but it is only 60 per cent of the number listed in the Directory Since some not in active practice return their membership in the County Society, the percentage of 60 is probably the more nearly correct

The County Medical Society holds bi-monthly meetings in various parts of the County The attendance usually ranges below twenty

The physicians of Olean have an organization called the Medical Club with 14 members, most of whom take an active interest in the County Medical Society The Society has no set organization, but the members take turns as hosts by twos, alphabetically, and entertain the members at a supper which is followed by a scientific program which the hosts arrange The members of the Club who were interviewed expressed themselves as eager to assist in the wider field of the County Medical Society

Twenty physicians in Olean and Salamanca and the neighboring villages had taken a course of study which had been arranged by Dr F W Sears, District State Health Officer of the State Department of Health Half the class met in Olean and the instruction was repeated in Salamanca The two courses were given twice a week during April, May and June, 1924, and the instruction was similar to that given in the Watertown course which was described on page 877 of the August JOURNAL While the course was designed primarily for health officers, those who took it praised it highly and said that it was in reality a practical course in general medicine which was of great value to the men in their general practice of medicine

The members of the County Society have been interested in the Graduate Education plan of the State Medical Society, and in the Spring of 1925 they made tentative plans for lectures in pediatrics The broader aspects of Graduation Education were considered at the September meeting, and a Committee of five, with Dr William B Johnston, of Ellicottville as Chairman, was appointed to suggest a course of instruction and report at the next meeting of the society

**Hospitals**—There are three hospitals in Cattaraugus County as follows

Higgins Memorial, Olean	100 beds
City Hospital, Salamanca	25 beds
County Tuberculosis	50 beds
	<hr/>
Total	175 beds

This gives a ratio of 2.4 beds for every one thousand of population

The Higgins Memorial Hospital has medical, surgical, and obstetrical services, and is well equipped and conducted. It is an open hospital, and staff meetings are held monthly at 8 30 in the evening. It has a history clerk, a laboratory with an expert technician, and an efficient X-ray department, but no ambulance service. It maintains a nurses' training school with 30 pupil nurses who go to Cleveland for instruction in the specialties.

The Salamanca Hospital is a general hospital, and is supported by the municipality. An addition that will double the capacity of the hospital is already planned.

The County Tuberculosis Hospital is located on top of a mountain three miles south of Olean. The site was chosen on account of the opposition which was made to a site in a more accessible settled part of the County,—the same opposition which was universally met ten years ago but which is now almost absent.

About one-third of the cases in the hospital are sent by physicians, and one-third by public health nurses, while another third are sent as the result of tuberculosis clinics which are held in various parts of the County. An addition is planned to house twenty patients.

*Public Health Work*—The official public health work of Cattaraugus County is done by an official County Department of Health and 27 health officers who serve 44 districts. The 25 health officers outside of the two cities serve 41,000 people—an average of 1,650 people for each health officer. Sixty per cent of the doctors outside of the cities, and 33 per cent of all the doctors listed in the county are health officers.

Seventeen health officers are members of the County Medical Society, and 18 have taken a special course of instruction to prepare themselves for their work.

A county public health laboratory is maintained in the Olean City Hall, and has been patronized by every physician in the county during the past year.

A venereal disease clinic is conducted weekly in Olean, and the service will soon be extended to other parts of the county.

Tuberculosis clinics are held regularly in six centers of the county.

Mental hygiene clinics are also held regularly by experts from the State institutions in Gowanda, Sonyea, and Rome.

*Public Health Nursing*—The Cattaraugus County Department of Health has a staff of 15 nurses. Olean has five supported by the City Department of Health, the School Board, the Red Cross, and the Tuberculosis Association. Salamanca, Portville and Gowanda each has a school nurse. There are 23 public health nurses in the county.

*County Department of Health*—Cattaraugus County is unique in that it is the only county in

New York State that has a County Department of Health. The laws of New York State (Section 20-b of the Public Health Law) authorize the formation of a County Board of Health which shall employ a full-time health officer, public health nurses, laboratory technicians, and other experts, and to establish laboratories, clinics, health stations, and adopt other procedures for promoting public health. The local health officers remain in office, but they are largely under the supervision of the County Health Officer. The plan provides a unit sufficiently large to carry on clinics, education, and other lines of work which supplement the purely local activities of the health officials.

The Cattaraugus County Health Department was authorized by the Board of Supervisors as the result of an offer by the managers of the Milbank Fund to give material assistance in financing the project. The Board of Health consists of five members, two of whom are physicians. The professional staff consists of a health officer, two assistant physicians, a physician technician in charge of the County Laboratory, a supervisor of school hygiene, a lay manager of publicity and education, and fifteen public health nurses. The County is divided into six districts, in each of which a health center is maintained, with headquarters for the nurses and facilities for holding clinics.

At the outset the general plan of the activity of the County Department of Health was that of a demonstration of lines of work carried on impersonally after the manner of work in a big city like New York. Examinations of hundreds of persons were made indiscriminately, and great numbers of visits were made by the dozen or more public health nurses without previously consulting the family doctors. Emphasis was placed on the word "demonstration," with considerable neglect of the principle set forth by Dr George E. Vincent: "Every doctor a health officer" (See this JOURNAL, June, 1925, page 758).

In adopting this general plan of activity, the leaders in the Cattaraugus demonstration merely followed a plan which had been advocated for years by some of the leading public health workers whose experience had been gained in the congested foreign quarters of large cities. When the present County Health Officer, Dr Stephen A. Douglass, took office in January, 1925, the principle advocated by Dr Vincent was adopted, and the facilities of the County Department of Health were placed at the disposal of the doctors and the Medical Society.

The doctors of Cattaraugus County are aware of their privileges and duties in the practice of civic medicine, and they express a willingness to adopt Dr Vincent's principle of every doctor a health officer.

F O



# DISTRICT BRANCHES



## SECOND DISTRICT BRANCH

ANNUAL MEETING, HEMPSTEAD, TUESDAY, OCTOBER 13, 1925

The Second District Branch will hold a joint outing, dinner, and meeting with the Associated Physicians of Long Island, on Tuesday, October 13th, at the Hempstead Country Club, East Front Street, Hempstead

The business meeting of the two societies will be held at the Clubhouse at 4:30 P M. An important feature of this will be the report of the Committee on Graduate Medical Education

There will be a dinner at 6 P M, the cost of which will be \$4.00 per plate. Reservations can be made for the dinner by sending a check for this amount, before October 9th, to Dr. Lefferts

A McClelland, 2 Rector Street, New York City, enclosing self-addressed envelope

A Scientific Session will follow the dinner, opening with an address by Dr. Nathan B. Van Etten, President of the Medical Society of the State of New York, followed by an exhibition of the motion picture film, "Motor Functions of Stomach," and "Gastric Ulcer," prepared by the American Medical Films, Inc., under the direction of Lewis Gregory Cole, M D

Opportunity for the use of the golf links will be available during the day upon payment of the Greens fees

## FIFTH DISTRICT BRANCH

ANNUAL MEETING, MARCY STATION, N Y, FRIDAY, OCTOBER 9, 1925

Automobiles will be at the Utica Central Station to convey members to the Marcy Station

FRIDAY, OCTOBER 9, 1925

Morning Session—10 A M

Meeting Called to Order by the President—

Nelson O. Brooks, M D, Oneida

"Address of Welcome"—Richard H. Hutchings, M D, Utica, N Y

"Treatment of General Paralysis with Inoculation of Malaria"—Preliminary Report by Clarence O. Cheney, M D, and George L. Warner, M D, Utica

Discussion Opened by Eugene N. Boudreau, M D, Syracuse

"Diagnosis of Cancer of the Stomach with Special Reference to Acid Values"—I. Harris Levy, M D, Syracuse  
Discussion Opened by Clark J. Laus, M D, Syracuse

"Surgical Procedures in Acute Perforation of Peptic Ulcers"—Gilbert D. Gregor, M D, Watertown  
Discussion Opened by Hyzer W. Jones, M D, Utica

Luncheon, 1 P M—By Invitation of Richard H. Hutchings, M D, Superintendent of the Utica State Hospital

Business Session—2 P M

Remarks by the President of the Medical Society of the State of New York—Nathan B. Van Etten, M D, New York City

"Medical Publicity"—Frank Overton, M D, Patchogue, Executive Editor New York State Journal of Medicine

"Some Opportunities of the District Branch"—Joseph S. Lawrence, M D, Albany, N Y, Executive Officer, Medical Society of the State of New York

"Post-Graduate Medical Education"—Herman G. Weiskotten, M D, Syracuse, N Y, Member of the Committee on Public Health and Medical Education

"Relief Measures During Labor"—Henry W. Schoeneck, M D, Syracuse  
Discussion Opened by George H. Bonnefond, M D, Utica

The Higgins Memorial Hospital has medical, surgical, and obstetrical services, and is well equipped and conducted. It is an open hospital, and staff meetings are held monthly at 8 30 in the evening. It has a history clerk, a laboratory with an expert technician, and an efficient X-ray department, but no ambulance service. It maintains a nurses' training school with 30 pupil nurses who go to Cleveland for instruction in the specialties.

The Salamanca Hospital is a general hospital, and is supported by the municipality. An addition that will double the capacity of the hospital is already planned.

The County Tuberculosis Hospital is located on top of a mountain three miles south of Olean. The site was chosen on account of the opposition which was made to a site in a more accessible settled part of the County,—the same opposition which was universally met ten years ago but which is now almost absent.

About one-third of the cases in the hospital are sent by physicians, and one-third by public health nurses, while another third are sent as the result of tuberculosis clinics which are held in various parts of the County. An addition is planned to house twenty patients.

*Public Health Work*—The official public health work of Cattaraugus County is done by an official County Department of Health and 27 health officers who serve 44 districts. The 25 health officers outside of the two cities serve 41,000 people—an average of 1,650 people for each health officer. Sixty per cent of the doctors outside of the cities, and 33 per cent of all the doctors listed in the county are health officers.

Seventeen health officers are members of the County Medical Society, and 18 have taken a special course of instruction to prepare themselves for their work.

A county public health laboratory is maintained in the Olean City Hall, and has been patronized by every physician in the county during the past year.

A venereal disease clinic is conducted weekly in Olean, and the service will soon be extended to other parts of the county.

Tuberculosis clinics are held regularly in six centers of the county.

Mental hygiene clinics are also held regularly by experts from the State institutions in Gowanda, Sonyea, and Rome.

*Public Health Nursing*—The Cattaraugus County Department of Health has a staff of 15 nurses. Olean has five supported by the City Department of Health, the School Board, the Red Cross, and the Tuberculosis Association. Salamanca, Portville and Gowanda each has a school nurse. There are 23 public health nurses in the county.

*County Department of Health*—Cattaraugus County is unique in that it is the only county in

New York State that has a County Department of Health. The laws of New York State (Section 20-b of the Public Health Law) authorize the formation of a County Board of Health which shall employ a full-time health officer, public health nurses, laboratory technicians, and other experts, and to establish laboratories, clinics, health stations, and adopt other procedures for promoting public health. The local health officers remain in office, but they are largely under the supervision of the County Health Officer. The plan provides a unit sufficiently large to carry on clinics, education, and other lines of work which supplement the purely local activities of the health officials.

The Cattaraugus County Health Department was authorized by the Board of Supervisors as the result of an offer by the managers of the Milbank Fund to give material assistance in financing the project. The Board of Health consists of five members, two of whom are physicians. The professional staff consists of a health officer, two assistant physicians, a physician technician in charge of the County Laboratory, a supervisor of school hygiene, a lay manager of publicity and education, and fifteen public health nurses. The County is divided into six districts, in each of which a health center is maintained, with headquarters for the nurses and facilities for holding clinics.

At the outset the general plan of the activity of the County Department of Health was that of a demonstration of lines of work carried on impersonally after the manner of work in a big city like New York. Examinations of hundreds of persons were made indiscriminately, and great numbers of visits were made by the dozen or more public health nurses without previously consulting the family doctors. Emphasis was placed on the word "demonstration," with considerable neglect of the principle set forth by Dr George E. Vincent: "Every doctor a health officer" (See this JOURNAL, June, 1925, page 758).

In adopting this general plan of activity, the leaders in the Cattaraugus demonstration merely followed a plan which had been advocated for years by some of the leading public health workers whose experience had been gained in the congested foreign quarters of large cities. When the present County Health Officer, Dr Stephen A. Douglass, took office in January, 1925, the principle advocated by Dr Vincent was adopted, and the facilities of the County Department of Health were placed at the disposal of the doctors and the Medical Society.

The doctors of Cattaraugus County are aware of their privileges and duties in the practice of civic medicine, and they express a willingness to adopt Dr Vincent's principle of every doctor a health officer.

F O

physicians against incisions upon the palm or palmar surfaces of the fingers

Dr Williams gave an encouraging picture of the results of the use of insulin during the three years since it was discovered. While formerly children with diabetes might expect only a year or two of life, now with the use of insulin they

are able to lead normal lives and to grow as fast as other children. He also said that insulin stimulates the production of insulin in the body.

The papers were of great practical interest and value. Some were lantern slide talks, but those which were written will probably be published in this JOURNAL. F O

### THIRD DISTRICT BRANCH

President Charles P. McCabe and his associate officers carried out a highly successful meeting of the Third District Branch of the Medical Society of the State of New York, on Friday, September 25th, at Twilight Park, Haines Falls, Greene County. Seventy doctors were present.

The meeting place was in the heart of the Catskill Mountains, the air was unusually clear, the arrangements for the meeting were excellent, and all those in attendance were happy at the close of a perfect day.

The morning session was opened with an address of welcome by Dr Lyle B. Honeyford, President of the Greene County Medical Society to which Dr Charles P. McCabe, President of the District Branch, responded.

The morning scientific program consisted of a symposium on lesions of the stomach, led by Dr Charles Gordon Heyd of New York City, on Diagnosis, Dr Arthur Bassler of New York City, on Medical Treatment, and Dr Charles H. Peck of New York City, on Surgical Treatment. The speakers brought out points which were new and practical, and their papers will probably be published in an early issue of this Journal.

Dr Nelson K. Fromm of Albany discussed "Some Neurological Problems," and spoke on the principal points of differential diagnosis of the acute inflammations of the central nervous system.

The greater part of the afternoon session was devoted to a discussion of problems of the medical societies—State, Branch and County. Dr N. B. Van Etten, President of the Medical Society of the State of New York, discussed the major activities of the Society in detail in a happy way. Dr Joseph S. Lawrence, Executive Officer of the State Society, outlined a field of wider usefulness for the District Branches.

Dr George F. Chandler of Kingston, a member of the Committee on Public Health and Medical Education of the State Society, outlined the plan of graduate education which the Committee has to offer to the County Societies, and urged each society to choose a serious course and carry it out. He made a convincing plea for *clinical*, as distinguished from didactical instruction, by a comparison of medical instruction

with that of the state police, of which Dr Chandler was once commander. He said that the policemen who have had extensive courses in the best didactic instruction without experience were usually failures, while the men made good when they were trained in courses based on what they actually saw. The clinical method was highly successful in training policemen and it would be equally successful in training physicians. He said that the members of his committee were especially anxious to promote teaching by the discussion of actual cases.

A pleasing feature of the program was the exhibition of a moving picture film illustrating gastric peristalsis and gastric ulcer. This film was made by Dr Gregory Cole, of New York City, for the American Films Company. It is full of action and interest, and enables the doctor to visualize the movements of the stomach, both normal and abnormal, in a way that nothing else can do. This film is recommended to county societies for use in their graduate courses.

Dr McCabe had introduced a novel feature in District Branches by appointing Committees on Medical Education, Public Health Nursing, Membership, and County Society Programs, and these committees gave brief reports. Dr Andrew MacFarlane gave a more extensive review of the nursing situation throughout the State and suggested that two types of nurses be trained and recognized—the present Registered Nurse and the Domestic Nurse.

Dr Charles Rayevsky reported on County Programs and suggested that the social side of the programs be emphasized both at every meeting and at special meetings given over to social functions only.

Dr McCabe gave a practical demonstration of the points in Dr Rayevsky's report by making excellent arrangements for entertainment. About forty members had brought their wives, who were entertained at a bridge tea under the leadership of Mrs. E. A. Vander Veer of Albany. A dance was held in the evening under the management of Mrs. Redman, hostess of Twilight Inn.

Many of the members and their wives remained over night in order to enjoy golf and other sports on the next day. F O

## SIXTH DISTRICT BRANCH

ANNUAL MEETING ITHACA TUESDAY, OCTOBER 6, 1925

Address Nathan B Van Etten, M D, New York City, President Medical Society of the State of New York

"Infections and Mental Disease," William C Garvin, M D, Superintendent, Binghamton State Hospital

"Clinical Interpretation of the Wassermann Test," William Avery Groat, M D, Syracuse

"The Use of Sodium Iodide in Focal Infections," James W Wiltsie, M D, Binghamton

"The Accessory Nasal Sinuses," illustrated by specimens, Abram T Kerr, M D, Professor of Anatomy, Cornell University Medical School

"A Case of Chronic Juvenile Lenticular Degeneration" (Wilson's Disease, lantern slides, James W Papez, M D, Professor of Neurology, Cornell University Medical School, Ithaca

"The Influence of the Thyroid on Structure and Function in Sheep and Goats," motion pictures, Howard S Liddell, Ph D, Department of Physiology, Cornell University Medical School.

Lunch will be served in the Bank Auditorium Restaurant on the same floor, at \$1 00 per plate

The Ladies' Entertainment Committee will provide entertainment for visiting ladies

## THE SEVENTH DISTRICT BRANCH

The series of District Branch meetings was begun by the Seventh which held its meeting on Thursday, September 24th, in the Chamber of Commerce building, Auburn, with about sixty members in attendance, and the President, Dr William I Dean, of Rochester, in the chair

Two sessions were held beginning at 10 30 o'clock, and with an hour's intermission for luncheon in the same building with the meeting

An election of officers resulted in the following choice President, Dr Claude C, Lytle, Geneva, First Vice-President, Dr G Kirby Collier, Rochester, Second Vice-President, Dr Alfred W Armstrong, Canandaigua, Secretary, Dr John A Lichty, Clifton Springs, Treasurer, Dr Edward T Wentworth, Rochester

Dr N B Van Etten, President of the Medical Society of the State of New York, spoke on the activities of the State Society He paid a tribute to Governor Smith for calling a meeting of representative doctors to advise him regarding medical legislation, and spoke of the bright prospects in legislative matters this coming winter He said that the special committee appointed to write a medical practice bill had met every two weeks since June, and had produced a bill embodying some of the same features which relate to the practice of law

Dr Van Etten told of the need of a more extensive plan of group insurance owing to the great amount of litigation brought against doctors, and said that he would not dare practice medicine without an indemnity policy A new plan will probably be presented to the members in the early future

The Doctor also dwelt at considerable length upon the work of the Committee on Public Health and Medical Education, and urged the leaders in the County Medical Societies to take advantage of the courses offered by the State Society He

also discussed the nursing problem, periodic health examinations, and the care of the insane and feeble-minded

Dr John M Swan, of Rochester, gave a brief description of the organization of the New York State Society for Cancer Control and urged the county societies to promote the work, especially in educating both physicians and laymen

Dr Edward T Wentworth discussed bonesetters and chiropractors from a practical point of view

The purely scientific part of the program consisted of five papers as follows

"The Treatment of Tic Douloureux," Ward Williams, M D, Rochester

"The Treatment of Scarlet Fever with Convalescent Blood Serum," Perry A. Bly, M D, Rochester

"Ureteral Stricture," Alfred K Bates, M D, Auburn

"Infections of the Hand," Harry R Trick, M D, Buffalo

"Results Obtained from Long-continued Use of Insulin," John R Williams, M D, Rochester

Dr Bly described the excellent results which had been attained in the Rochester Municipal Hospital by the use of injections of either whole blood from recovered cases, or serum from the blood or the Dochez serum

Dr Bates described some cases of stricture of the ureter in which the symptoms suggested gall bladder inflammation or appendicitis He urged that physicians bear ureteral stricture in mind in every uncertain abdominal condition

Dr Trick showed charts of the various seats of inflammation of the hands, and described the standard treatment for each This is a subject of great interest to every doctor on account of the deformity which is likely to result from improper treatment Dr Trick especially warned

his two daughters, who joined the fraternity at the dinner hour

After a pleasing dinner served in the Elks' dining room, a business session was held

Dr Shaw extended a personal invitation to all medical men to come to an "Old Fashioned Clam Bake," to be given by The Albany Country Club on Wednesday, September 16th, sports of all kinds in the afternoon, and the dinner at 6 30 P M, followed by a dance in the evening The entire program being under the supervision of the Albany County Medical Society

A discussion of training schools for nurses followed. A resolution was adopted and directed to be sent to the State Board of Education urging a modification of the present ruling whereby

small hospitals have been crowded out of the right of training nurses

The subject of holding a series of clinical lectures each week for six weeks was discussed and left for a special committee to report on

After some general business the meeting adjourned

The following members were in attendance. Drs H L Cruttenden and A H Bissell, of Cooperstown, J Perry Horle, of Fly Creek, F E Bolt, of Worcester, E C Winsor, of Schenectady, F L Winsor, of Laurens, B F Bishop, of Garrettsville, L C Warren, of Franklin, D H Mills, M E Brownell F H Marx, L S Lang, W S Dart, J C Smith, Stanton Hendricks, R D Champlin and A H Brownell, of Oneonta

---

## THE ASSOCIATION OF MILITARY SURGEONS OF THE UNITED STATES

HOTEL WILSDORF-ASTORIA, NEW YORK, OCTOBER 8TH TO 10TH

The programme will include visits to West Point, Ellis Island, the Naval Hospital and Medical Supply Depot in Brooklyn, the airdrome at Mitchel Field on the day of the Pulitzer race, the Rockefeller Institute and various hospitals, and a review of and demonstration by

the 102nd Medical Regiment of the 27th Division

Physicians who are serving or have served in the Army, Navy, Marine Corps, the Reserve, the National Guard or the Public Health Service are eligible to membership

---

## NEW YORK AND NEW ENGLAND ASSOCIATION OF RAILWAY SURGEONS

The 35th annual meeting of the New York and New England Association of Railway Surgeons is to be held at the Hotel Commodore, New York

City, on November 5th and 6th, the meetings to be on the 5th, followed by Clinics in New York Hospitals on the 6th

---

## TRAVEL STUDY CLUB OF AMERICAN PHYSICIANS

The Travel Study Club of American Physicians at its ninth Annual Reunion, held May 26th in Atlantic City, re-elected Dr Louis Livingston Seaman and Dr Richard Kovacs of New York respectively as President and Secretary-Treasurer, Dr Edward B Heckel, Pittsburgh, Pa, Dr J P Lord, Omaha, Neb, and Dr F H Albee, New York City, as Vice-Presidents

The Travel Study Club has decided on a 1926 study tour to London, Paris, Switzerland, Munich, Vienna and Berlin Participation in this tour will be limited in number and restricted to members and medical friends recommended by them, thus endeavoring to insure comfort, congeniality and equal opportunities for study on this tour

## MEDICAL SOCIETY OF THE COUNTY OF CATTARAUGUS

The Fourth Bi-Monthly meeting of the Medical Society of the County of Cattaraugus was held in Delevan, N Y, September 8, 1925

There was a fairly good attendance and those who were present were well paid

The matter of graduate attendance was brought up and referred to a committee of five members to investigate and report to the society

Two papers were read

One by Dr Byron D Bowen, of Buffalo, on "The Present Day Problems of Diabetes"

The Doctor presented the essential facts in regard to the disease in a very interesting and instructive manner

Dr Nelson G Russell, of Buffalo, presented the subject of "Treatment of Cardiac Disease" in a very practical way

Both papers were of a very high order and were well received by those present It is certain that no more instructive or practical lectures could be presented by any one than were given here and by well-known men

MYRON E FISHER.

## ROCKLAND COUNTY MEDICAL SOCIETY

The regular quarterly meeting of the Rockland County Medical Society was held on the afternoon of September 23rd at Letchworth Village with the Vice-President, Dr R F Sengstachen in the chair, and twenty members present

Dr George A Leitner, member of the special committee that was appointed by the State Society to write a new practice of medicine bill, reported that the committee had met about every two weeks and was almost ready to announce the bill He suggested that the Society invite the two candidates for assemblyman to attend the special obstetrical meeting of the Rockland County Medical Society, which will be held some time in October, and that the physicians of the county make every effort to enlighten the candidates regarding the matters of medical legislation These suggestions were put in the form of a resolution, and unanimously carried

The speaker of the day was Dr Joseph Globus, Adjunct Neurologist to Mt Sinai Hospital, New York City His subject was Diagnostic Features of Various Forms of Paralysis with particular reference to brain tumor and encephalitis Dr Globus gave a simple, clear outline of the various sites of the lesions causing paralysis, and said that if the lesion was in the forebrain, the paralysis would be of

the spastic type with firm contractures of the muscles in the older cases If the lesion was in the midbrain, the paralysis was of the rigid type with a jerky motion when the limb was forcibly moved If it was in the hind brain, or cord, the paralysis was of the flaccid type A fourth type of paralysis was that in which the lesion was in the muscle cells themselves

Dr Globus chose cases from the institution which illustrated perfectly the various types of paralysis, and those who saw this demonstration will always have a vivid idea of the meaning and recognition of spasticity, rigidity, intention tremors, incoordination, and other neurological conditions

After hearing the lecture, the members present at the meeting heartily agreed with Dr Globus when he said, "While neurology was formerly concerned principally with post-mortem states, it is now a very live specialty, full of diagnostic and therapeutic possibilities"

Dr Globus made the subject so simple and clear that its practice would appeal to general practitioners

After the meeting, the doctors were the guests of Dr C S Little, Superintendent of Letchworth Village, at a supper—an annual event to which the physicians look forward with pleasure

F O

## OTSEGO COUNTY MEDICAL SOCIETY

Quarterly Meeting of the Otsego County Medical Society was held at the Elks' Home, Oneonta, N Y, on September 8, 1925

In the absence of Dr Swanson, Dr A H Bissell was made Chairman of the meeting

The afternoon session was given over to the subject of Malnutrition and Infant Feeding Dr Henry L Shaw, of Albany, President of the Albany County Society and Pediatrician for St

Margaret's and St Peter's Hospitals of Albany, was the speaker for the occasion Dr Shaw gave a very interesting history of infant feeding and a very helpful discussion of the latest views along that line He closed his address with a humorous sketch as to how children continued to grow in spite of the variety of foods and fancies that had been indulged in during the ages past Dr Shaw was accompanied to the city by



his two daughters, who joined the fraternity at the dinner hour

After a pleasing dinner served in the Elks' dining room, a business session was held

Dr Shaw extended a personal invitation to all medical men to come to an "Old Fashioned Clam Bake," to be given by The Albany Country Club on Wednesday, September 16th, sports of all kinds in the afternoon, and the dinner at 6 30 P M, followed by a dance in the evening The entire program being under the supervision of the Albany County Medical Society

A discussion of training schools for nurses followed. A resolution was adopted and directed to be sent to the State Board of Education urging a modification of the present ruling whereby

small hospitals have been crowded out of the right of training nurses

The subject of holding a series of clinical lectures each week for six weeks was discussed and left for a special committee to report on

After some general business the meeting adjourned

The following members were in attendance Drs H L Cruttenden and A H Bissell, of Cooperstown, J Perry Horle, of Fly Creek, F E Bolt, of Worcester, E C Winsor, of Schenectady, F L Winsor, of Laurens, B F Bishop, of Garrettsville, L C Warren, of Franklin, D H Mills, M E Brownell, F H Marx, L S Lang W S Dart, J C Smith, Stanton Hendricks, R D Champlin and A H Brownell, of Oneonta

---

## THE ASSOCIATION OF MILITARY SURGEONS OF THE UNITED STATES

HOTEL WALDORF-ASTORIA, NEW YORK, OCTOBER 8TH TO 10TH

The programme will include visits to West Point, Ellis Island, the Naval Hospital and Medical Supply Depot in Brooklyn, the airdrome at Mitchel Field on the day of the Pulitzer race, the Rockefeller Institute and various hospitals, and a review of and demonstration by

the 102nd Medical Regiment of the 27th Division

Physicians who are serving or have served in the Army, Navy, Marine Corps, the Reserve, the National Guard or the Public Health Service are eligible to membership

---

## NEW YORK AND NEW ENGLAND ASSOCIATION OF RAILWAY SURGEONS

The 35th annual meeting of the New York and New England Association of Railway Surgeons is to be held at the Hotel Commodore, New York

City, on November 5th and 6th, the meetings to be on the 5th, followed by Clinics in New York Hospitals on the 6th

---

## TRAVEL STUDY CLUB OF AMERICAN PHYSICIANS

The Travel Study Club of American Physicians at its ninth Annual Reunion, held May 26th in Atlantic City, re-elected Dr Louis Livingston Seaman and Dr Richard Kovacs of New York respectively as President and Secretary-Treasurer, Dr Edward B Heckel, Pittsburgh, Pa, Dr J P Lord, Omaha, Neb, and Dr F H Albee, New York City, as Vice-Presidents

The Travel Study Club has decided on a 1926 study tour to London, Paris, Switzerland, Munich, Vienna and Berlin Participation in this tour will be limited in number and restricted to members and medical friends recommended by them, thus endeavoring to insure comfort, congeniality and equal opportunities for study on this tour



# THE DAILY PRESS



The daily papers during the first fortnight of September carried whole pages about a murder by a young man whose homicidal trend was well known to his parents and to the legal authorities. Many columns were printed regarding responsibility for the freedom from restraint which was allowed to the young man, and as usual in such cases, an office-holder—in this case a doctor in a State hospital—was made a belated sacrifice in order to appease public opinion.

Mental pathology is one of the newer branches of medicine. Its field is almost as broad as that of the body, and the literature of abnormalities in morals and behavior is as great as that in medicine and of the physical body. The field is so vast and intricate and new that few general practitioners attempt to comprehend it or put it to practical application.

If physicians are not psychiatrists, much less do laymen understand the subject of mental abnormalities. Even educated people profess to be able to judge the mental state of a patient by a few moments of conversation with him. The parents or relatives of a maniac who has just been committed to a hospital see him clothed and contrite, and are softened by his expression of repentance and his promises to be good. The parents do not realize that the patient is simply on his "company" behavior, and will be the same bad boy again when he goes home. The treatment that the patient needs is to stay in the hospital for weeks or months where he will act as a polite guest (another name for an unconscious yet potent form of discipline) until a normal working of the brain becomes a fixed habit. But the relatives can "see for themselves" that the patient is in his right mind, and so they go to law and take him home, and then when he commits arson or murder, they say that they were not properly informed regarding his condition.

The ultimate responsibility for releasing the insane lies with lawyers, judges, and juries, and their actions are based on their own inadequate knowledge and of psychiatry, or on public opinion, which is still more inadequate. If the hospital doctors refuse to sanction a release, there must be a trial and the presentation of evidence—and the lawyer on the bench is the judge of the reliability of that evidence. (See Mr. Whiteside's article in the September Journal.) If the evidence shows merely some queer action, the Judge may answer that every man does queer things sometimes. A witness who has seen an assault committed by the insane person is likely to have an exceedingly poor memory on the witness stand from fear of revenge if the insane man is released and will may the witness have fear, for there will be none to protect him.

The staffs of the State Hospitals are conducting clinics in mental hygiene, which is a euphonious name for incipient insanity or mental defects. The staff of the Utica State Hospital has conducted an extensive series of clinics in the Mohawk Valley with such success that one-fifth of the inmates of the hospital have come there voluntarily for treatment at a stage when they can probably be cured (see this Journal, August, 1924, page 813). This means that a still greater number of cases of incipient insanity are treated and cured at the clinic without the necessity of their going to the Hospital.

The kind of work which is done in the mental hygiene clinics is similar to that which family doctors could readily do, and which they will be doing within a few years. Dr. Gordon, the Chairman of the Committee on Public Health and Education of the Medical Society of the State of New York, has made inquiry among the Superintendents of the State hospitals regarding the practicality of giving courses in "office psychiatry" to general practitioners of medicine. The response is that such courses are needed and that the members of the staffs are willing to give them, and are confident that doctors can readily grasp the principles of psychiatric methods of diagnosis and treatment. However, they are not enthusiastic over the response of the doctors to invitations to attend clinics or to refer cases to them. Yet this lack of response is by no means discouraging. The idea is new, and its usefulness had first to be demonstrated. That has been done, and now the next step is to popularize it among the doctors.

Possibly one way to obtain the interest of doctors is to prepare and print a series of articles on office psychiatry. We have already had the offer of some articles along that line.

The discussion in the daily papers to which we referred at the beginning of this article has focussed popular attention on the practice of clinical psychiatry, and demonstrated the need of popular education in the subject. But the subject is exceedingly broad and far-reaching, and cannot be taught in a day or a year, or even in a decade.

If doctors do not take up the subject of mental hygiene, lay organizations will, just as they have taken away a good part of the leadership in tuberculosis control.

There must be an orderly evolution or development of instruction in psychiatric subjects. First comes the development of both the science and the art of psychiatry by the leaders. Next is the instruction of the doctors, and when the doctors are ready to practice psychiatry they will soon educate the people.



# BOOK REVIEWS



**ELEMENTS OF PHYSICAL BIOLOGY** By ALFRED J LOTKA, M.A., D.Sc. Octavo of 460 pages, illustrated Baltimore, Williams and Wilkins Co., 1925 Cloth, \$5.00

This book is an ambitious and scholarly attempt to introduce a new member into the galaxy of sciences. How far the author has gone, how well his task has been accomplished, cannot be ascertained by any mere desultory or casual perusal of the work.

The contents are divided into four parts. Part I takes up General Principles, Part II, Kinetics, Part III, Statics, Part IV, Dynamics.

The author has brought to his task the calm, detached and impersonal viewpoint of the philosopher, the logic of the accomplished mathematician, and an unusual erudition. He displays a singular knowledge of the fundamental sciences, chemistry, physics and biology.

The average professional reader will find the work on this account dull and tiresome, but to the man whose knowledge is broader a rare intellectual feast awaits his perusal of this book. F B D

**SERUM DIAGNOSIS OF SYPHILIS BY PRECIPITATION** Governing Principles, Procedure and Clinical Application of the Kahn Precipitation Test By R. L. KAHN, M.S., D.Sc. Octavo of 237 pages Baltimore, Williams and Wilkins Co., 1925 Cloth, \$3.00

The work is well presented. The arrangement of the book is good. The reader receives a clear idea of the fundamental principles essential for the development of the test, with definite enlightenment from comprehensive experiments and tables. Chapter XX leaves some doubt in the mind as to the value of the test for spinal fluids. The initial treatment of the fluids in precipitating out the globulins makes one feel that the Wassermann Test is less time-consuming and quite as reliable.

The author's deductions as to the efficacy of the test are fair, but as a general conclusion we should say that the Kahn Test has no decided advantage over the Wassermann Reaction although it provides a valuable check on the latter. We are pleased to recommend the work as a scientific, instructive and carefully written volume and the Test as a valuable routine to be incorporated in every pathological laboratory. R E. CAMPBELL.

**LUMBAR PUNCTURE.** Its Anatomical and Physiological Relations. Technique. Methods of Investigation. Diagnostic Value and Therapeutical Applications. With an Appendix on Encephalography and Puncture of the Cisterna. By MARTIN PAPPENHEIM, M.D. Translated by George Caffrey. Octavo of 248 pages. New York, William Wood & Co., 1925. Cloth, \$5.00.

This volume is of much interest to both clinician and laboratory worker. In discussing technique, the author prefers the lateral position, the patient lying preferably on the right side. Novocaine anesthesia is preferred. 1/2 per cent solution of a wheal being produced and some novocaine injected through this, after having introduced the needle vertically to a depth of about 2 cm. Puncture is preferred exactly in the median line rather than from a point to the side as there is believed to be less risk of injury to the fibres of the cauda and bleeding is less liable to occur.

Among the conditions in which lumbar puncture is stated to be certainly attended with danger are the presence of tumors of the brain in the region of the posterior cranial fossa, internal hydrocephalus, general edema of the brain, and recent apoplexy.

Over one hundred pages are devoted to the technique of the various laboratory procedures. The closing chapters are devoted to a discussion of the diagnostic and prognostic import of lumbar puncture and its therapeutical applications, with an appendix on encephalography and puncture of the cisterna cerebello-medullaris.

W. E. McCOLLUM

**CLINICAL PSYCHOLOGY** By LOUIS E. BISCH, M.D., Ph.D. Octavo of 346 pages, with illustrations. Baltimore, Williams and Wilkins Co., 1925. Cloth, \$3.00.

In this book there is collected a considerable mass of information relative to the recognition and management of mentally atypical children. The text is well exemplified by sixty case histories. The subject matter covers a much trodden field, but the manner of presentation should render the book useful to the various classes of laymen who are in need of information on juvenile psychiatry. FREDERIC DAVRAU

**HYGIENIC FUNDAMENTALS OF FOOD HANDLING** By CHARLES THOM and ALBERT C. HUNTER of the Microbiological Laboratory, Bureau of Chemistry, U.S. Department of Agriculture. 228 pages, illustrated. Baltimore, Williams & Wilkins Co., 1924. Cloth, \$3.00.

The title well describes the scope of the book. First taking up the general considerations of wholesomeness and fitness of food, its preservation, spoilage, and food poisoning and infections, the authors take up in later chapters the individual problems pertaining to each group of foodstuffs. It is a work which will be appreciated best by those most interested, that is those concerned in food handling industries, public health workers and economists.

Although the work itself covers a limited ground only, many bibliographical references are supplied so that one may be able to follow a given topic much more extensively if he desires. E. H. MARSH

**THE DETERMINATION OF HYDROGEN IONS** An elementary treatise on the hydrogen electrode, indicator and supplementary methods with an indexed bibliography on applications. By W. MANSFIELD CLARK, M.A., Ph.D. Second Edition. Octavo of 480 pages. Baltimore, Williams and Wilkins Co., 1925. Cloth, \$5.00.

This is an elementary yet exhaustive treatise on the principles and methods for the determination of hydrogen ions. The author has gained wide recognition as a leader in research on H-ions and is an authority on this subject. It is interesting to note that he began his work in the laboratories of the Dairy Division of the U.S. Department of Agriculture.

The book includes a general discussion of electrolytic dissociation and H-ion concentration, the theory and use of indicators in colorimetric determination, the theory and use of the electrometric method, a chapter on various supplementary methods, applications and bibliography. Under applications it is interesting to note the wide variety of uses, including physiology, pathology, bacteriology, pharmacology, industrial chemistry and agriculture. The bibliography is very extensive.

While displaying a meticulous care in his use of words, the author has presented an involved subject in a remarkably clear style. The worker will find here a rare combination of clear exposition of general principles, minute directions for procedure and caution against sources of error. E. B. SMITH

**LA REACTION DE FIXATION DANS LA TUBERCULOSE PAR ARCHILLE URBAIN** Preface De A BESREDA, Professeur A l'Institut Pasteur Masson et C, Editeurs Libraries De L'Academie De Medicine, 120 Boulevard Saint-Germain Paris, 1925

The Author of this work is known universally as an authority in the study of Immunity, Allergy, Serology and Complement Fixation, in tuberculous infection and disease. This work represents a very complete study of the varying phases in the complement fixation in tuberculosis, and of the interpretation of the same. He is careful to point out how invaluable an aid the reaction is when supplementing the data we acquire in any given case, by use of our physical senses—observation, auscultation etc. He regards it as rather a more precise method, perhaps, than any other, though admitting its interpretation must be based on a consideration of all the data acquired. He feels that complete accord is necessary between the laboratory and the clinic, properly to appraise and weigh the evidence. This work represents a truly valuable contribution to the Immunological Studies of Tuberculosis. FOSTER MURRAY

**AIDS TO SURGERY** By JOSEPH CUNNING, M.B., B.S., F.R.C.S., England, and CECIL A. JOLL, M.S., Lond., F.R.C.S., England. Fifth Edition. William Wood & Co, New York, 1924. Price, \$1 50

This quiz compend of 434 pages first appeared in 1904, since then it has been reprinted fifteen times and reedited four times. In structure this pocket manual conforms to the usual form of students' aids but has rather more of the virtues and less of the defects than most quiz compends. In this fifth edition Mr Joll has brought the subject matter up to date. JAMES L. COBB

**PHYSICAL DIAGNOSIS** By W. D. ROSE, M.D., Lecturer Physical Diagnosis and Associate Professor Medicine, University of Arkansas. Fourth Edition. Three hundred and nineteen illustrations. C. V. Mosby Co., St. Louis, 1924. Price, \$8 50

The need of a fourth edition of this book on Physical Diagnosis proves its value. For those who have not studied the earlier editions the reviewer would state that this is an excellent work which presents the subject matter accurately, thoroughly, clearly, completely and in an interesting manner. The many illustrations are clear, instructive and add much to the value of the book. The previous editions have been so carefully presented that there has been but little need of additions in this fourth, however, the author has made some minor additions to the subject matter of the circulatory system. H. M. M.

**MANUAL OF PSYCHIATRY FOR THE MEDICAL STUDENT AND GENERAL PRACTITIONER** By PAUL E. BOWERS, M.S., M.D. Octavo of 365 pages. Philadelphia and London, W. B. Saunders Company, 1924. Cloth, \$3.50

This book gives a very good presentation of the benign and malignant forms of mental disease. Although some of the descriptions are necessarily brief the descriptions are adequate for the purpose for which the book is intended.

To the reviewer it appears that the writer might have devoted more time to the modern psychological interpretation of not only the major forms of abnormal conduct but of the minor forms and it is felt that Freud's views in the interpretation of the neuroses might have been given a little more consideration. However, the book is well written and covers not only the various forms of the psychoses but also deals with mental deficiency, the neuroses and also gives a brief account of the Binet-Simon intelligence test. He also treats briefly the relationship of insanity to crime from which the student or general practitioner may learn what types are apt to be encountered.

Taken all in all it is felt that the book is well worth while for the purpose for which it is intended. S. R. LEAHY

**THE PRACTICAL MEDICINE SERIES** Eight volumes on the year's progress in Medicine and Surgery. Under the General Editorial Charge of CHARLES L. MRY, A.M., M.D. Series of 1924

**VOLUME I, GENERAL MEDICINE.** Edited by GEORGE H. WEAVER, M.D., LAWRASON BROWN, M.D., ROBERT B. PREPPE, A.M., M.D., BERTRAM W. SIPPY, M.D., RALPH C. BROWN, B.S., M.D.

**VOLUME II, GENERAL SURGERY** Edited by ALBERT J. OCHSNER, M.D.

**VOLUME III, THE EYE, EAR, NOSE AND THROAT** Edited by CASEY A. WOOD, M.D., CHARLES P. SMALL, M.D., ALBERT H. ANDREWS, GEORGE E. SHAMBAUGH, M.D. The Year Book Publishers, Chicago. Price \$3 per volume. Price of Series of eight volumes \$15

Volume I, General Medicine. This volume appears yearly is always worth while as it consists of abstracts of the best journals in the field. It is of value even to one who feels that he keeps well read as there are some articles that he will miss. It is a very handy book for quick reference.

The whole field of General Medicine is covered and the editors are particularly well qualified in their departments. After abstracting an article the practice is followed of commenting upon it favorably or not as seems proper to the editor. This is an interesting feature and increases the value of the book on account of the ability of the editors.

Volume II General Surgery. The year book upon general surgery is again presented in compact form and gives a very satisfactory review of the important advances during 1924.

The following features are stressed. In anaesthesia it is noted that ethylene is still being tried out, and observation seems to indicate relative safety but it is not devoid of danger. Many new instruments for special use have been described. The margin of safety in the surgery of diabetes has been widened by the use of Insulin.

Propaganda to furnish the laity with increased knowledge concerning cancer is bringing forth fruit. There is an increased tendency toward earlier diagnosis and treatment. Much attention has been given to the cause of cancer to experimental new growths, and to the post-operative treatment by radium and X-rays. It seems that blood transfusion has become more popular. Nerve injuries and the surgery of the sympathetic nervous system appear to have received an impetus. In the surgery of the thyroid more careful selection of cases for operation have been urged.

In the chest, the results of treatment of lung abscesses show improvement. Much interesting work and many good results are reported in the treatment of injuries to the heart and pericardium.

Abdominal surgery continues to hold its usual interest. Much attention has been given, especially to the stomach and duodenum. Abdominoscopy may open a valuable field. In surgery of the biliary tract Cholecystectomy continues the favorite procedure. The spleen has been frequently removed for splenomegaly.

Interest in fractures, stimulated by the late war, apparently shows no abatement. Improved methods of treatment are advocated. R. H. F.

Volume III The Eye, Ear, Nose and Throat. The size of this volume bears testimony to the many fine papers that have appeared during the year it covers in the subjects of the Eye, Ear, Nose and Throat. The completeness with which it reviews the recent work in these subjects makes it of the greatest practical value to the practitioner of medicine. For the specialist desiring a quick resume of the recent literature it forms a handy reference work. M. C. M.

(Continued on advertising page 957)

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL. 25, No 22

NEW YORK, N Y

OCTOBER 15, 1925

## THERAPEUTIC VALUE OF OXYGEN IN PNEUMONIA \*

By C A L BINGER, M.D.,

(From the Hospital of the Rockefeller Institute for Medical Research, New York, N Y)

NEW YORK CITY

TO understand adequately the present status of oxygen therapy it is well to know something of the history of this subject. Shortly after the discovery of oxygen by Joseph Priestley in 1774 and the demonstration by Priestley and Lavoissier of its importance to respiration, oxygen very quickly invaded the field of therapeutics. Indeed it came to be hailed as a panacea. Here was the life-giving principle of the atmosphere without which animals could not live. It was natural to attribute to it great and varied curative powers, and we find it being used for a whole gamut of diseases from hysteria to bubonic plague, and in a variety of forms, even in the form of oxygenated bread in which the dough was raised with oxygen instead of carbon dioxide. The absurdity of this naive enthusiasm gradually became apparent. This period was soon replaced by one in which the therapeutic attributes of oxygen were denied and in which its use gradually fell into disrepute. The reasons for the change of heart are not far to seek. Experiments done in physiological laboratories showed that the blood normally contained its full load of oxygen, furthermore, that increasing the oxygen in the inspired air had no effect on metabolic rate, or, in other words, on oxygen consumption. It was reasonable, therefore, to doubt the efficacy of oxygen administration. But perhaps the chief cause for skepticism as to the therapeutic value of oxygen was to be found in the wholly inadequate methods in its administration which for many years prevailed. Who of us has not seen the familiar picture of a moribund patient with a "death rattle" in his throat, the hurried call for an oxygen cylinder and a funnel held over the dying man's face? And yet I venture to say that none of us has ever seen it benefit the patient or do more than bolster up temporarily the waning hopes of

his relatives. Someone has said that one might as well give tincture of digitalis by spraying it about the room with an atomizer as to give oxygen by the customary tube and funnel method. We know now that what is essential is to raise the partial pressure of oxygen in the patient's alveolar air to the point where it is great enough to restore the blood to as near its normal saturation as is possible. Recent investigations by Barach (1) and by Davies (2) have shown that the funnel method never and the nasal catheter method rarely can raise the alveolar oxygen tension to a sufficient level to accomplish the desired results.

Before discussing the essentials of a satisfactory method, let me remind you of the mechanism by which oxygen is transported in the body. Normal human blood contains about 15 grams of hemoglobin per 100 cc., this is sufficient to combine chemically with 20 cc. of oxygen. When the blood contains its full quota of oxygen, which is approximately 20 cc per 100 cc., we speak of it as being 100 per cent saturated. Now the blood in the arteries is almost completely saturated, containing instead of 20 volumes per cent, 18 or 19. It is therefore normally from 95 to 98 per cent saturated with oxygen. As it traverses the tissues it loses approximately 5 volumes per cent and the blood in the veins therefore contains about 13 volumes per cent. A slightly different method of expressing this is the following. The arterial blood which as we have said, contains approximately 19 volumes per cent, differs from the blood when completely saturated by 1 volume per cent, or, in other words, it is 1 volume per cent unsaturated, and the venous blood is 7. Assuming that the blood in the capillaries is a mean between arterial and venous blood in its oxygen content, the percentage unsaturation can be roughly expressed thus

\* Read at the Annual Meeting of the Medical Society of the State of New York, at Syracuse May 12, 1925

LA REACTION DE FIXATION DANS LA TUBERCULOSE PAR  
ARCHILLE LEBLANC. Préface DE A. BESREDEA. Profes-  
seur A l'Institut Pasteur. Masson et C, Editeurs.  
Libraires De L'Académie De Médecine, 120 Boulevard  
Saint-Germain Paris 1925.

The Author of this work is known universally as an authority in the study of Immunity, Allergy, Serology, and Complement Fixation, in tuberculous infection and disease. This work represents a very complete study of the varying phases in the complement fixation in tuberculosis, and of the interpretation of the same. He is careful to point out how invaluable an aid the reaction is when supplementing the data we acquire in any given case, by use of our physical senses—observation, auscultation, etc. He regards it as rather a more precise method, perhaps, than any other, though admitting its interpretation must be based on a consideration of all the data acquired. He feels that complete accord is necessary between the laboratory and the clinic, properly to appraise and weigh the evidence. This work represents a truly valuable contribution to the Immunological Studies of Tuberculosis. FOSTER MURRAY

AIDS TO SURGERY. By JOSEPH CUNNING, M.B., B.S., F.R.C.S., England, and CECIL A. JOLL, M.S., Lond., F.R.C.S., England. Fifth Edition. William Wood & Co. New York, 1924. Price, \$1.50.

This quiz compend of 434 pages first appeared in 1904, since then it has been reprinted fifteen times and reedited four times. In structure this pocket manual conforms to the usual form of students' aids but has rather more of the virtues and less of the defects than most quiz compends. In this fifth edition Mr Joll has brought the subject matter up to date. JAMES L. COHN.

PHYSICAL DIAGNOSIS. By W. D. ROSE, M.D., Lecturer Physical Diagnosis and Associate Professor Medicine, University of Arkansas. Fourth Edition. Three hundred and nineteen illustrations. C. V. Mosby Co., St. Louis, 1924. Price, \$3.50.

The need of a fourth edition of this book on Physical Diagnosis proves its value. For those who have not studied the earlier editions the reviewer would state that this is an excellent work which presents the subject matter accurately, thoroughly, clearly, completely and in an interesting manner. The many illustrations are clear instructive and add much to the value of the book. The previous editions have been so carefully presented that there has been but little need of additions in this fourth, however, the author has made some minor additions to the subject matter of the circulatory system.

H. M. M.

MANUAL OF PSYCHIATRY FOR THE MEDICAL STUDENT AND GENERAL PRACTITIONER. By PAUL E. BOWERS, M.S., M.D. Octavo of 365 pages. Philadelphia and London, W. B. Saunders Company, 1924. Cloth, \$3.50.

This book gives a very good presentation of the benign and malignant forms of mental disease. Although some of the descriptions are necessarily brief the descriptions are adequate for the purpose for which the book is intended.

To the reviewer it appears that the writer might have devoted more time to the modern psychological interpretation of not only the major forms of abnormal conduct but of the minor forms and it is felt that Freud's views in the interpretation of the neuroses might have been given a little more consideration. However, the book is well written and covers not only the various forms of the psychoses but also deals with mental deficiency, the neuroses and also gives a brief account of the Binet-Simon intelligence test. He also treats briefly the relationship of insanity to crime from which the student or general practitioner may learn what types are apt to be encountered.

Taken all in all it is felt that the book is well worth while for the purpose for which it is intended.

S. R. LEAHY

THE PRACTICAL MEDICINE SERIES. Eight volumes on the year's progress in Medicine and Surgery. Under the General Editorial Charge of CHARLES L. MIX, A.M., M.D. Series of 1924.

VOLUME I GENERAL MEDICINE. Edited by GEORGE H. WEAVER, M.D., LAWRAISON BROWN, M.D., ROBERT B. PREPPE, A.M., M.D., BERTRAM W. SIPPY, M.D., RALPH C. BROWN, B.S., M.D.

VOLUME II, GENERAL SURGERY. Edited by ALBERT J. OCHSNER, M.D.

VOLUME III, THE EYE, EAR, NOSE AND THROAT. Edited by CASEY A. WOOD, M.D., CHARLES P. SMALL, M.D., ALBERT H. ANDREWS, GEORGE E. SHANBAUGH, M.D. The Year Book Publishers Chicago. Price \$5 per volume. Price of Series of eight volumes \$15.

Volume I, General Medicine. This volume appears yearly is always worth while as it consists of abstracts of the best journals in the field. It is of value even to one who feels that he keeps well read as there are some articles that he will miss. It is a very handy book for quick reference.

The whole field of General Medicine is covered and the editors are particularly well qualified in their departments. After abstracting an article the practice is followed of commenting upon it favorably or not as seems proper to the editor. This is an interesting feature and increases the value of the book on account of the ability of the editors.

Volume II. General Surgery. The year book upon general surgery is again presented in compact form and gives a very satisfactory review of the important advances during 1924.

The following features are stressed. In anesthesia it is noted that ethylene is still being tried out, and observation seems to indicate relative safety but it is not devoid of danger. Many new instruments for special use have been described. The margin of safety in the surgery of diabetes has been widened by the use of Insulin.

Propaganda to furnish the laity with increased knowledge concerning cancer is bringing forth fruit. There is an increased tendency toward earlier diagnosis and treatment. Much attention has been given to the cause of cancer to experimental new growths, and to the post-operative treatment by radium and X-rays. It seems that blood transfusion has become more popular. Nerve injuries and the surgery of the sympathetic nervous system appear to have received an impetus. In the surgery of the thyroid more careful selection of cases for operation have been urged.

In the chest, the results of treatment of lung abscesses show improvement. Much interesting work and many good results are reported in the treatment of injuries to the heart and pericardium.

Abdominal surgery continues to hold its usual interest. Much attention has been given, especially to the stomach and duodenum. Abdominoscopy may open a valuable field. In surgery of the biliary tract Cholecystectomy continues the favorite procedure. The spleen has been frequently removed for splenomegaly.

Interest in fractures, stimulated by the late war apparently shows no abatement. Improved methods of treatment are advocated.

R. H. F.

Volume III. The Eye, Ear, Nose and Throat. The size of this volume bears testimony to the many fine papers that have appeared during the year it covers in the subjects of the Eye, Ear, Nose and Throat. The completeness with which it reviews the recent work in these subjects makes it of the greatest practical value to the practitioner of medicine. For the specialist desiring a quick resume of the recent literature it forms a handy reference work.

M. C. M.

(Continued on advertising page xiv)

perature and in the pulse rate, and sometimes, though not invariably, a reduction in the number of respirations per minute. A decrease in pulse rate is to be expected after oxygen administration, indeed this occurs in normal individuals. A reduction in the number of respirations does not occur so consistently. We believe there are other causes besides anoxemia in pneumonia which occasion rapid respiration. A more satisfactory understanding of what may be expected from the use of oxygen in pneumonia may be had from an analysis of a few cases treated in the oxygen chamber at the Hospital of The Rockefeller Institute. The most significant change, on inspecting the patient, is the change in color—the blueness of the lips and of the finger nails usually giving way to a normal pinkish color. There is frequently, though by no means invariably, marked improvement in the patient's psyche, with abatement, if not disappearance, of delirium, restlessness and drowsiness.

The charts of 5 cases treated in the oxygen chamber are included in this report. The upper section shows the average daily temperature, pulse and respiration. The next section shows the percentage unsaturation of the arterial blood taken while the patient was breathing atmospheres containing the per cents of oxygen indicated by the dots. The remainder of the chart is self-explanatory.

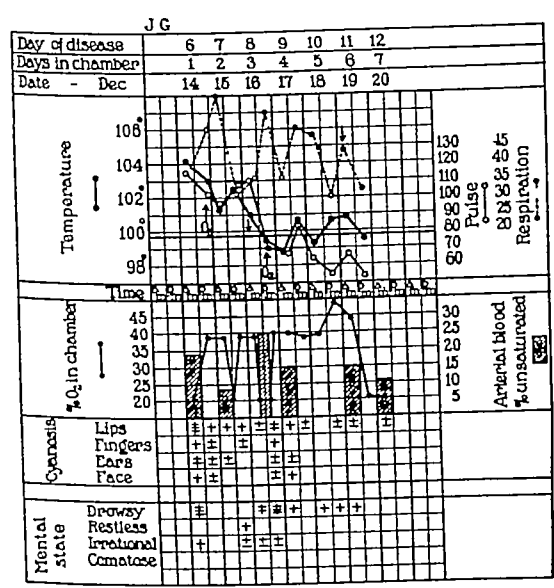


CHART I

Chart No 1 (J G) A case of Type II lobar pneumonia showed at the time of first arterial puncture while breathing atmospheric air a percentage unsaturation of arterial blood of 18. The patient was put into the oxygen chamber and the oxygen raised to 38 per

cent, with the result of a fall in his unsaturation to 7 per cent. Subsequently the patient was again exposed to atmospheric air, with the result that his blood became 25 per cent unsaturated. This condition again subsided after raising the oxygen in the chamber to 40 per cent. At this time there was a residual unsaturation of 15 per cent which did not yield to oxygen administration. This was probably due to the shunting of blood through consolidated un-aerated lung tissue to which the oxygen-rich atmosphere could not have access. The persistence of rapid respiration in spite of the gradual fall in pulse and temperature is consistent with both clinical and experimental observations which have been made, indicating that in pneumonia the rapid breathing is aggravated by anoxemia, though probably not primarily due to it.

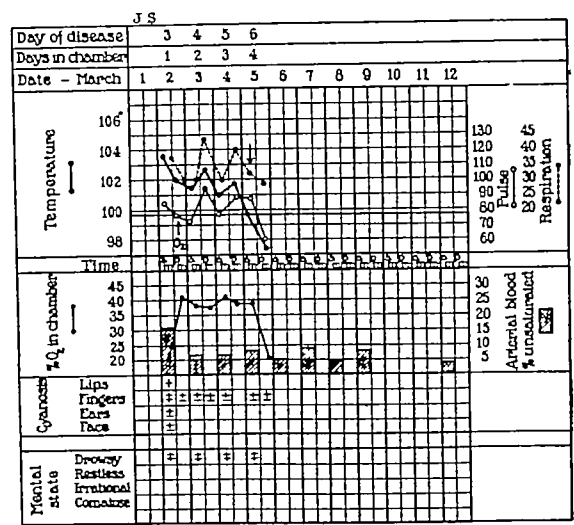


CHART II

Chart No 2 (J S) An elderly man with Type IV pneumococcus infection showed a satisfactory response as far as disappearance of anoxemia was concerned, and this too is shown in Chart No 3 (S N), a case of Type I lobar pneumonia. That disappearance of anoxemia is, however, not necessarily associated with recovery is well shown in Chart 4 (S T) where there was a 28 per cent reduction in unsaturation with disappearance of cyanosis, but nevertheless the patient died. This patient had a severe blood infection which did not yield to antipneumococcus serum treatment.

Chart No 5 (W J) shows only a slight decrease in unsaturation, which was not very severe, 12 per cent, before oxygen therapy was started. This patient likewise died, with a septicemia of Type I pneumococcus, which persisted in spite of serum therapy.

$$C = \frac{1 + 7}{2} = 4$$

4 representing the volume percentage of unsaturation in the capillary blood. Lundsgaard and Van Slyke (3) have shown that clinical cyanosis appears when capillary unsaturation has reached an approximate level of 6 volumes per cent. This is true under normal circumstances when there is no marked anemia present. For the presence of anemia may mask the existence of a severe oxygen unsaturation, since the cyanotic color which indicates the existence of unsaturation depends for its appearance on the absolute concentration of reduced hemoglobin of capillary blood. This is an important point and it is well to remember that a patient with anemia may be suffering from oxygen want without the usual accompanying cyanosis. Clinically, cyanosis is certainly one of the outstanding features of oxygen want. We are now aware that oxygen want, even in a normal subject, may cause a trend of serious and distressing symptoms which may be acute in onset when the subject is suddenly exposed to atmospheres of low partial pressures of oxygen or when as in pathological states, there is something which prevents normal diffusion of atmospheric oxygen through alveolar epithelium. There are chronic forms of oxygen want with which we are not for the present concerned. In a disease like pneumonia we are dealing primarily with acute anoxemia. Within recent years the problem of oxygen transport in the body has received renewed attention largely at the hands of two British physiologists, Haldane and Barcroft, and their co-workers. Something in the nature of a controversy has sprung up between them as to whether, under conditions of oxygen want, the lungs have or have not the capacity for secreting oxygen. Without entering into this subject further let me mention it only in connection with a great number of experiments which have been done on normal individuals under conditions of oxygen deprivation, experiments done in negative pressure chambers, and observations made on various mountain peaks, from Teneriffe to Pike's Peak, and from Monte Rosa in Switzerland to Cerro de Pasco in the Peruvian Andes. A few years ago I had the privilege of taking part in an expedition to the Peruvian Andes, led by Mr. Barcroft for the purpose of investigating the effect of high altitudes on the human organism. If you will permit me, I will quote from a paper recently presented before the New York Academy of Medicine on this subject in which I have recounted some of the sensations of acute oxygen want and discussed its general significance.

"In the company of Dr. Alfred Redfield I left

Lima, which is at sea level, at about eight o'clock in the morning and within six hours we had crossed the continental water-shed at Ticlio at an altitude of some 15,000 feet. At this point a wash-out on the railroad necessitated our getting out of the train and walking approximately 200 yards to another train. I can best describe my own sensations by saying that I felt like an octogenarian who had spent a winter's night on a hard park bench and had been suddenly aroused by a hit on the head with a policeman's night stick. There was intense occipital and frontal headache, palpitation, precordial pain, rapid breathing, nausea, and a great sense of depression. The other members of the expedition experienced the same effects and the symptoms, including sleeplessness, visual disturbances, vertigo, and in some instances, elevation of temperature continued for several days. And yet all these symptoms were brought on in my own instance by a reduction of the percentage saturation of my arterial blood from 95 to 84. If we examine the dissociation curve of oxyhemoglobin which represents the manner in which hemoglobin combines with oxygen when subjected to increasing partial pressures of oxygen, we shall see that a change such as I have described was brought on by a fall in the tension of the alveolar air of approximately 50 mm. Now the object of all this is simply to show you what a profound series of untoward symptoms can be brought about by reducing the pressure of oxygen in the blood of a normal human being. And yet the great majority of patients with lobar pneumonia suffer from just such a reduction of oxygen pressure. Indeed we frequently see a percentage saturation very much lower than the one I have cited. Stadie showed, in a series of 33 pneumonia patients, that none recovered whose arterial saturation was below 70 per cent. If we consider that the patient with pneumonia has to fight a severe, progressing infection with its associated toxemia, it is perfectly clear that the added disadvantage of anoxemia may be such as to overcome him. And it becomes apparent that it is to his advantage to save him from the extra burden on his cardio-respiratory and central nervous systems which anoxemia involves."

That the oxygen content of the blood can be raised in patients suffering from pneumonia by the proper administration of oxygen has now been shown by several independent investigators. In Table 1 it will be seen that an increase in the percentage saturation of the arterial blood occurred in every instance after the patient had been exposed to an atmosphere containing about twice the concentration of oxygen present in ordinary air. In these patients one sees usually a slight drop in tem-



improvements have been made by Yandel Henderson (5) and Davies (2). Another satisfactory portable method is that of Barach (6) in which the patient breathes into a bag through a mouth piece or nose piece, provision being made for continuous removal of carbon dioxide. It is, to be sure, often very difficult in delirious patients to apply successfully a method requiring the use of either mask or mouth piece. To circumvent this difficulty a number of bed tents have been described, one by Leonard Hill (7), one by Roth (8) of the Battle Creek Sanatorium, and recently, one by Barach and Binger (9). These tents, though perhaps not practicable for general practitioners, have their place in hospital work. Of course, the ideal method of oxygen administration in hospital patients is the chamber of which several have been constructed. There are at present, to our knowledge, two such chambers used for therapeutic purposes, one at Guy's Hospital in London and the other at the Hospital of The Rockefeller Institute in New York. The one in New York (10) consists of an air-tight, fireproof room, 10 x 10 x 8 feet in dimensions, with a vestibule which allows passage in and out of the chamber with only slight loss of oxygen and a ventilation system to provide for cooling and drying the air and scrubbing it free from carbon dioxide. Two photographs of this chamber are shown here. The advantages of the chamber method are primarily that it permits of adequate and uninterrupted nursing care with the continuous administration of oxygen of known concentrations even to delirious and refractory patients. Furthermore, the chamber permits us to make physiological observations on the patient throughout the course of the disease.

It is our practice to take blood from an artery, usually the femoral, after the manner described by Fraser (11) before putting the patient into the chamber and then to raise

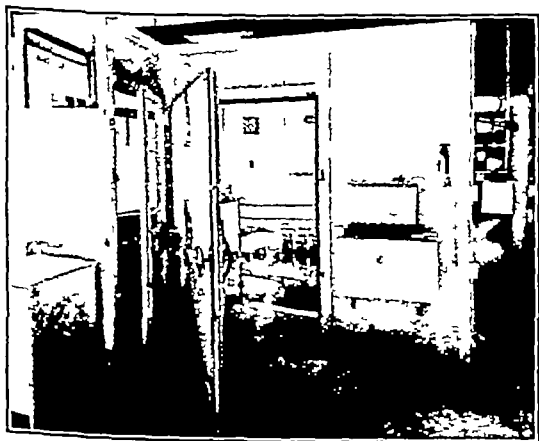


II Interior of chamber viewed through wide door on east wall. (a) window in south wall, (b and b') dampers of outflow ducts, (c and c') dampers of inflow ducts, (e) thermostat, (f) plug for electrocardiogram, (g) chain for bell signal, (h and h') automatic sprinkler heads.

the oxygen in the atmospheric air sufficiently to overcome the existing anoxemia. In our experience from 40 to 50 per cent will usually accomplish this, if indeed it can be accomplished. This fact is determined by a second arterial puncture. The chamber method has enabled us to put the use of oxygen on a quantitative basis. To obtain the best results with this as with any other drug it should be used quantitatively.

#### BIBLIOGRAPHY

- 1 Barach, A. L. Personal Communication to the Author
- 2 Davies, H. W., and Gilchrist, A. R. *Edinburgh Med Jour* 1925, N° S. vol. XXXII, p. 25, *Lancet*, 1925, vol. I, p. 916
- 3 Lundsgaard, C., and Van Slyke, D. D. *Cyanosis Medicine Monograph* vol. II, Baltimore, 1923
- 4 Haldane, J. S. *Respiration* New Haven, 1922
- 5 Henderson, Yandel, and Haggard H. W. *Jour Amer Assn* 1922 vol. LXXIX, p. 1137
- 6 Barach, A. L., and Woodwell, M. N. *Arch Int Med* 1921 vol. XXVIII, p. 4
- 7 Hill, L. *Jour Physiol* (Proceedings), 1921, vol. LV, p. 20
- 8 Roth, Paul. *Bull Battle Creek Sanatorium*, 1924, vol. XIX, p. 178
- 9 Barach, A. L., and Binger, C. A. L. (In press)
- 10 Binger, C. A. L. *The Modern Hospital*, 1925, vol. XXIV, p. 186
- 11 Fraser, F. R., Graham, G., and Hilton, R. *Jour Physiol* (Proceedings), 1923-24, vol. LVIII, p. 34



I View of chamber from east. (a) wide door through which bed can be rolled, (b) panic bolt, (c and c') doors to vestibule, (d) wet and dry bulb thermometer, (e) food lock, (t) speaking tube, (g) refrigeration and scrubbing system.

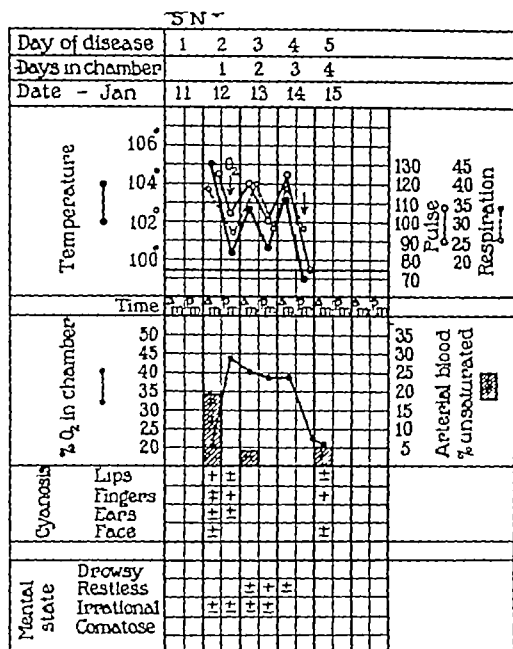


CHART III

As indicated by the last two cases, when there is a persistent bacteremia there is little reason to expect recovery, even though the state of anoxemia has been successfully dealt with. This has been true in the main in most of the fatal cases, 16 of 21 fatal cases having had continuous bacteremia until death.

We are not in a position at this time to treat the subject of oxygen therapy in pneumonia

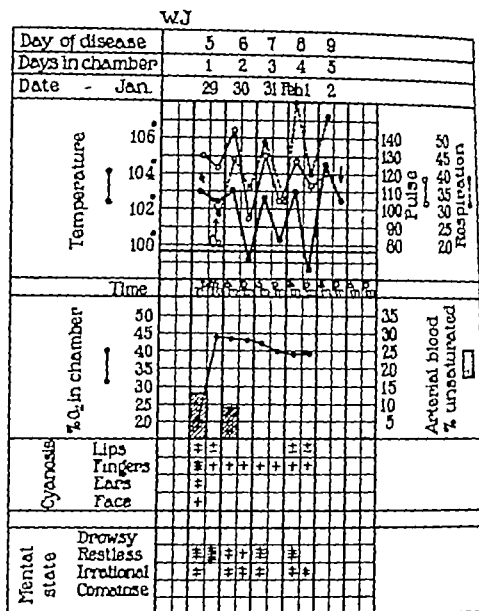


CHART V

statistically, as our series is not sufficiently large and the material is of too complicated a nature for statistical analyses. For the present we must confine ourselves to a clinical study of the individual patients for the proper evaluation of oxygen as a therapeutic agent. It is likewise unwise to expect too much of it. It is in no sense a specific. We believe, however, that it removes one of the obstacles which a sick patient must surmount on his road to recovery, and when it is properly given one may look usually for improvement in cyanosis, improvement in the patient's psyche, slight reduction in his pulse rate, and at times in his rate of respirations. This may be just sufficient to tide the patient over his critical days until he has established a sufficient immunity to handle his infection, often, to be sure, it may simply prolong his life by a few days when the bacterial infection is such as to overwhelm him.

A few words should be added as to what is meant by adequate methods of oxygen administration. There is at present no ideal method available for the general practitioner, but there are several methods which, in spite of certain disadvantages, accomplish the desired result. The desired result is to raise the oxygen of the inspired air to from 40 to 50 per cent, and to do this continuously with the minimum discomfort to the patient and a not too great extravagance in the use of oxygen. Methods which accomplish this are those described by J. S. Haldane (4) in which the patient breathes oxygen through a mask from a bag into which the gas is discharged at a known rate. Modifications of this method and it would seem,

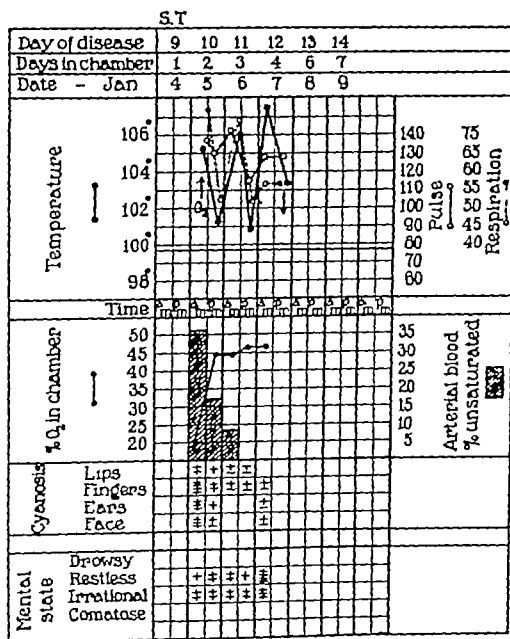


CHART IV

the tissues along its course and furnishes a channel in which the ureter slides as it contracts arises from the cellular tissue of the base of the broad ligament, blends with and encloses the sheath of Waldeyer, formed of smooth muscle bundles, extending from the bladder. The sheath is thicker below the broad ligament. For this reason it is easier to palpate the ureter, anterior to the broad ligament.

### ANATOMY

The ureters are an inch apart in the trigone, about an inch behind the internal urethral opening, two inches behind the external urinary meatus on the anterior vaginal wall. They are about two inches apart at their entrance into the bladder, where they run through the bladder wall for three-quarters of an inch. These points are about one-half an inch in front of the lateral borders of the cervix, on the anterior vaginal wall about one inch from the crossing of the ureter by the uterine artery above the lateral fornix. After leaving the bladder, the ureters curve over the anterior vaginal wall and lateral fornix to a point half way between the lateral border of the cervix and the lateral pelvic wall where they are crossed by the uterine artery on a level with the internal os, about an inch from the lateral border of the cervix, about two inches from the ureteral opening in the bladder. From the point of crossing, the uterine artery accompanies the ureters for one to two inches, through the base of the broad ligament, to a point on the pelvic wall, just above the spine of the ischium where they turn upward on the pelvic wall, sometimes in front and sometimes behind the internal iliacs to the pelvic brim, where they leave the pelvis, through the infundicular pelvic ligaments mesial to the ovarian arteries. The right ureter is more often in front of the division of the common iliac, the left, behind.

*Technic of Palpation of the Female Pelvic Ureters Anterior to Broad Ligaments* See Picture No 1

To palpate the ureters from the ureteral orifices at the trigone, to the base of the broad ligaments. To orient their position. Imagine a line on the anterior and lateral vaginal wall, from a point about half an inch, in front of the lateral border of the cervix, where the ureter enters the bladder wall, to a point half way between the lateral border of the cervix and the lateral pelvic wall. Here the ureter passes under the base of the broad ligament. The fingers introduced into the antero-lateral vault of the vagina, counter pressure is made downward, through the abdominal wall, to the side of the symphysis pubis with the abdominal hand. Draw the fingers forward. As the tissues slip through the fingers, the ureter is felt as a cord like body about the size of a goose quill, displaced in its bed of cellular tissue,



No 1 Technique of palpation anterior to broad ligaments Described by author

as it slips through the fingers. It can be felt again and again, and rolled from side to side under the palpating fingers, by moving the fingers towards the broad ligament and drawing them forward toward the bladder. The normal ureter is not tender. If diseased it is thickened, enlarged and tender, sometimes as large as a lead pencil or larger. Palpation brings an intense desire to urinate. It is easy to distinguish a diseased ureter by comparing it with its fellow, as it is rarely diseased to an equal extent.

*Technic Posterior to Broad Ligament* See Picture No 2

A Judd, *Journal of Obstet*, Vol lxxiii, No 6, 1910, advises palpating it posterior to the broad ligament, where it is felt above the spine of the ischium sometimes as high as an inch above. He advises palpating it with the fingers in the lateral vaginal fornix, behind the broad ligament. Sweeping the fingers above the point of its location and then slightly bending the ends of the



No 2. Examining finger palpating ureter posterior to broad ligament Judd technic.

Name	Type	Temperature		Pulse		Respiration		Cyanosis		% Sat of Art. Blood	Stay in Chamber	% O <sub>2</sub> in Chamber
R T	IV	103.5	103	118	117	44	48	+	++	76	94	2
I W	II	103.5	102	105	103	32	33	++	+	69	98	1
A S	IV	102.5	100.5	116	99	47	38	++	0	84	89	2
M B	IV	104.7	103	108	105	35	30	++	+	81	94	6
L P	II	99.2	99.4	94	90	36	38	+	0	89	94	3
T S	II	104	102.5	120	113	38	41	+	±	78	91	4
I S	St aur hem IV	104.5	104.5	117	108	43	45	+	±	87	91	4
C K	I	100.2	100.5	95	87	51	35	+++	±	73	100	7

## THE IMPORTANCE AND TECHNIQUE OF PALPATION OF THE FEMALE PELVIC URETERS\*

By DAVID W TOVEY, M D,

NEW YORK CITY

Howard Kelly, in the *Annals of Surgery*, 1906, wrote "I am glad to have this opportunity of calling your attention to an important but still much neglected diagnostic point. As the normal ureters are to be found so easily, it is yet more easy to detect and examine diseased ureters. In a number of instances in which the diagnosis had not been made, he was able to set the question entirely at rest, as rapidly as he could carry the finger into the vagina, sweeping it over the anterior vaginal wall. One side would be normal, while on the other, a thick hard ureter. He says 'I cannot say too much in extolling a method of diagnosis so simple and certain as this'."

Max Sanger in the *Archive of Gyn*, Vol I, 1886, in an article, "Palpation of the Ureters in the Female" remarks that it was peculiar that he had not before included palpation of the ureters, in his vaginal findings. He reports cases of ureteritis, treated for long periods, for cystitis.

Albert Judd, *Journal Obstet*, vol lxxxiii, No 6, 1916, describes a method of palpation of the ureters behind the broad ligament. He claims that they could be felt in 90 per cent of the cases during routine vaginal examination. In an article read before the *American Association Obstet Gyn*, 1920, I said "Palpation of the pelvic ureters should be a part of every vaginal examination, and described the technic of palpation of the ureter, anterior to the broad ligament."

Again in 1923 in a paper read before the same association. The Importance of Palpation of the Pelvic Ureters in the Diagnosis of Abdominal Disease, I said "The anastomosis of the nerve plexuses of the ureter, with the nerve plexuses of all the abdominal nerve plexuses, explains why pain due to disease of the urinary tract may be intensified in different regions of the body, and why diseases of the ureter and kidney are mistaken, for different abdominal conditions,

from cervicitis and ectopic pregnancy to gall stones and gastric ulcer! Palpation of the ureter will give the clue to the diagnosis."

Mayo reports most of the cases of kidney and ureteral stones which they encountered, had been mistaken for abdominal conditions and operated on for diseases of the ovary, stomach, gall bladder or appendix.

Barney reports That 18 per cent of his cases of ureteral calculi, had one or more previous operations. The urine was negative in 8 per cent and the X-ray in 6 to 11 per cent of the cases.

Knestschnier reports that in 44 per cent of his pyelitis cases, were operated on for mistaken abdominal conditions.

In a former article I expressed the belief That many of the symptoms of the cystitis following gynecological operations, are due to ureteritis, as the cystoscope shows a normal bladder. That infections of the cervix, are a frequent cause to ureteritis, giving symptoms of cystitis and reflex pains in different parts of the abdomen. 15 per cent of gynecological cases have diseases of the urinary tract, according to Danasseuther. A thickened ureter will give a clue to the diagnosis if the technique to be described is followed.

The normal ureters can be palpated in most cases. There is nothing between the finger and the ureter but the vaginal wall. It is easier to palpate the ureters than the ovaries, as the ureters under normal conditions are always found in the same position in the pelvis. Moderate displacement of the uterus in any directions alters but slightly the relation of the ureters to each other or to the sides of the pelvis. The cervix if nearer to one side of the pelvis, is nearer to that ureter than to the other, but the position of the ureters in their course through the pelvis is not changed. The ureteral sheath described by Sampson, *Johns Hopkins Bulletin*, Feb, 1904, is formed by the peristasis of the ureter, from

\* Read before West Side Clinical Society March 1925

sign of pregnancy present Right ureter enlarged, tender, intense desire to urinate on palpation Diagnosis of pregnancy with ureteritis and pyelitis The spotting was due to reflex disturbance following ureteritis

6 S H 29 years

Sent for operation of ectopic pregnancy Last menses two and one-half months Irregular bleeding, attacks severe pain in right ovarian region, nausea and fainting Patient said pain felt as if a tube the size of a banana was in the pelvis Examination Uterus enlarged, softened, Ladins sign of pregnancy present In the left corner a hard mass the size of a plum Bloody discharge of brownish color from vagina Right ureter enlarged and very tender Palpation brought an intense desire to urinate Diagnosis Pregnancy two and one-half months in left corner Ureteritis due to stone, confirmed by cystoscopic examination

7 D S 60 years

Large kidney shaped mass on the left side extending into kidney region Palpation revealed normal ureter Ureteropyelogram showed normal ureter and kidney pelvis Diagnosis Tumor not kidney sarcoma of spleen removed at operation

8 J U 35 years  
Since birth of child three years ago indigestion,

pain right abdomen, frequent urination Treated for cystitis advised to have appendix and right ovary removed Her physician thought he felt an enlarged appendix Vaginal examination Cervix lacerated, eroded and infected Pelvic organs normal Right ureter enlarged and tender Palpation caused an intense desire to urinate Diagnosis Cervicitis and ureteritis Amputation of the cervix and local treatment cured the patient Physician felt thickened ureter

9 M P 35 years

Patient sent by her physician who thought he felt an enlarged appendix Complained of attack of severe pain Right iliac region, nausea, epigastric distress, frequent painful urination Vaginal examination Right ureter enlarged, size of a finger very tender Palpation brought an intense desire to urinate Thickened ureter felt abdominal palpation and thought to be an enlarged appendix Diagnosis T B Kidney confirmed by cystoscopic examination

10 J R 25 years

Pain on the right side Indigestion constipation epigastric distress Operation for appendectomy Right corphorectom and Lane kink without relief X-ray and urine negative Palpation hard tender mass in right lower ureter Diagnosis Stone in ureter confirmed by examination

## DIAGNOSTIC CURETTAGE IN SO-CALLED IDIOPATHIC UTERINE BLEEDING \*

By EMIL NOVAK, M.D.,

From the Gynecological Department of Johns Hopkins Medical School  
BALTIMORE MD

**N**O subject in gynecology has been more extensively studied and written about than that of uterine hemorrhage There are of course certain cases in which the mechanism is rather obvious i e, those in which it is caused by ulcerative and destructive processes, such as cancer With these we shall not concern ourselves in this paper Nor shall we discuss that large group in which a pelvic lesion of some sort is present (chronic adnexitis, ovarian or uterine tumor, displacement, etc), although there is much uncertainty as to just how the bleeding is brought about The type of bleeding with which we shall deal in this paper is that which is noted in the en-

tire absence of any tangible anatomic lesion of the pelvic organs

Such bleeding has been variously designated as "idiopathic," "essential," or "functional" It may occur at any period of reproductive life but is most frequent at or near the menopausal age It may be observed in young girls at or near the age of puberty In some cases, perhaps most characteristically, it takes the form of menorrhagia, while in others metorrhagia is observed It is not within the scope of my paper to discuss the clinical aspect of this subject, except perhaps to stress again the fact that such bleeding, perhaps of extreme degree, may occur in patients whose organs, so far as the most careful bimanual examination will reveal, are perfectly normal

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse, May 12, 1925

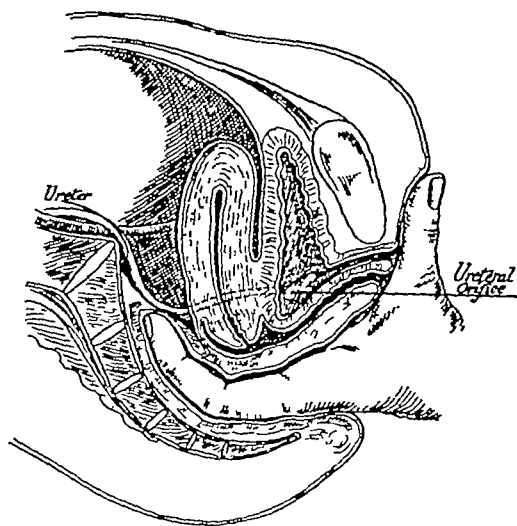
fingers, as one might in picking the strings of a guitar, sweeping then over the ureter, straightening the fingers out and going back and bending them again, always getting the feel from above downward

**Rectal Palpation** Described by W E Ashton  
See Picture No 3 Practise of Gynecology,  
page 659 Saunders, 1905

The ureter can be palpated through the rectum, from the base of the broad ligament along the posterior wall of the pelvis to the superior straight *Technique* The finger introduced into the rectum and passed upward and backward where the common iliac divides The internal iliac artery is then located and traced downward by the tip of the finger Palpating somewhat behind and to the side of the artery, the ureter can be followed along its course until it passes under the base of the broad ligament Because of the thickness of the ureteral sheath, I believe it is easier to palpate it anterior to the broad ligament It was easy to teach students at the N Y Polyclinic to palpate the ureters, once they had learned their position, by inserting ureteral catheters As a rule they try to make it difficult and feel for the ureters high in the pelvis, instead of in the normal location, on the anterior lateral vaginal wall In the latter part of pregnancy the ureters are palpated against the fetal head At this time they do not follow the pelvic wall to the spine of the ishium but after accompanying the internal iliac artery, they pass beneath the broad ligaments, just below the pelvic brim The broad ligaments are drawn upward by pregnancy

1 Howard Kelly—Diseases of the Urinary Tract  
*Ann Surg*, 1906

2 Max Sanger—*Archiv for Gyn*, Vol I, 1886



No 3 Examination of the ureters by rectal palpation. Showing the left ureter being palpated through the rectum by the left index finger Ashton gynecology

3 A M Judd—Palpation of the Female Ureters for Vagina *Journal Obstet*, Vol. xxiii, No 6, 1916.

4 D W Tovey—*Amer Assoc Obstet Gyn Abdominal Surgeons*, Vol xxv, page 281, 1922.

5 D W Tovey—Same Vol, xxxiii, 1920, page 221.

6 Mayo-Braasch—Dilatation of Ureter and Renal Pelvis *Jour A M A*, 1919, Vol 23, page 731

In the following cases palpation of the ureters gave a clue to the diagnosis

1 U S 25 years

Nausea, pain epigastric distress, temp/104 pain and tenderness in the region of the appendix. Appendectomy advised by her physician Vaginal examination Right ureter enlarged, tender palpation brought an intense desire to urinate. The left ureter enlarged and tender but not as large or tender as the right A diagnosis of pyelitis was confirmed by examination

2 N H 32

Pain felt over left ovarian region, worse at menses No bladder symptoms Sent for operation of removal of ovary Left ovary normal. Left ureter enlarged, tender Palpation brought intense desire to urinate Diagnosis of ureteritis Examination by cystoscope and ureteropyelogram, showed stricture of the lower ureter

3 S U 30 years

Sent with diagnosis of ectopic pregnancy of an acute gall bladder Complained of an acute pain and tenderness in the gall bladder region with chills and fever, nausea and vomiting A half grain of morphine gave no relief Vaginal examination Right ureter enlarged, tender and small stone felt about one inch above the bladder Diagnosis confirmed by cystoscope and ureteropyelogram Patient later passed a stone about the size of a shoe button

4 H K 48 years

Tumor right side of abdomen diagnoses as enlarged gall bladder Frequent urination. Blood in urine attributed to inflamed urethral meatus X-ray negative Vaginal examination right ureter enlarged and tender, palpation brought intense desire to urinate Pyelogram Pus kidney with large soft stone size of a plum in kidney pelvis Large pyonephritic kidney and soft stone removed at operation

5 Y D

Sent with diagnosis of ectopic pregnancy Last menses three months ago Severe pain in right ovarian region accompanied by spotting Urine examination normal Vaginal examination Uterus enlarged size 2½ months, Ladnib

sign of pregnancy present. Right ureter enlarged, tender, intense desire to urinate on palpation. Diagnosis of pregnancy with ureteritis and pyelitis. The spotting was due to reflex disturbance following ureteritis

6 S H 29 years

Sent for operation of ectopic pregnancy. Last menses two and one-half months. Irregular bleeding, attacks severe pain in right ovarian region, nausea and fainting. Patient said pain felt as if a tube the size of a banana was in the pelvis. Examination. Uterus enlarged, softened, Ladins sign of pregnancy present. In the left corner a hard mass the size of a plum. Bloody discharge of brownish color from vagina. Right ureter enlarged and very tender. Palpation brought an intense desire to urinate. Diagnosis. Pregnancy two and one-half months in left corner. Ureteritis due to stone, confirmed by cystoscopic examination.

7 D S 60 years

Large kidney shaped mass on the left side extending into kidney region. Palpation revealed normal ureter. Ureteropyelogram showed normal ureter and kidney pelvis. Diagnosis. Tumor not kidney, sarcoma of spleen removed at operation.

8 J U 35 years

Since birth of child three years ago indigestion,

pain right abdomen, frequent urination. Treated for cystitis advised to have appendix and right ovary removed. Her physician thought he felt an enlarged appendix. Vaginal examination. Cervix lacerated, eroded and infected. Pelvic organs normal. Right ureter enlarged and tender. Palpation caused an intense desire to urinate. Diagnosis. Cervicitis and ureteritis. Amputation of the cervix and local treatment cured the patient. Physician felt thickened ureter.

9 M P 35 years

Patient sent by her physician who thought he felt an enlarged appendix. Complained of attack of severe pain. Right iliac region, nausea, epigastric distress, frequent painful urination. Vaginal examination. Right ureter enlarged, size of a finger, very tender. Palpation brought an intense desire to urinate. Thickened ureter felt abdominal palpation and thought to be an enlarged appendix. Diagnosis. T. B. Kidney confirmed by cystoscopic examination.

10 J R 25 years

Pain on the right side. Indigestion, constipation, epigastric distress. Operation for appendectomy. Right corphorectom and Lane kink without relief. X-ray and urine negative. Palpation hard tender mass in right lower ureter. Diagnosis. Stone in ureter confirmed by examination.

## DIAGNOSTIC CURETTAGE IN SO-CALLED IDIOPATHIC UTERINE BLEEDING\*

By EMIL NOVAK, M.D.,

From the Gynecological Department of Johns Hopkins Medical School

BALTIMORE MD

**N**O subject in gynecology has been more extensively studied and written about than that of uterine hemorrhage. There are of course certain cases in which the mechanism is rather obvious, i. e., those in which it is caused by ulcerative and destructive processes, such as cancer. With these we shall not concern ourselves in this paper. Nor shall we discuss that large group in which a pelvic lesion of some sort is present (chronic adnexitis, ovarian or uterine tumor, displacement, etc.), although there is much uncertainty as to just how the bleeding is brought about. The type of bleeding with which we shall deal in this paper is that which is noted in the en-

tire absence of any tangible anatomic lesion of the pelvic organs.

Such bleeding has been variously designated as "idiopathic," "essential," or "functional." It may occur at any period of reproductive life, but is most frequent at or near the menopausal age. It may be observed in young girls at or near the age of puberty. In some cases, perhaps most characteristically, it takes the form of menorrhagia, while in others metrorrhagia is observed. It is not within the scope of my paper to discuss the clinical aspect of this subject, except perhaps to stress again the fact that such bleeding, perhaps of extreme degree, may occur in patients whose organs, so far as the most careful bimanual examination will reveal, are perfectly normal.

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse, May 12 1925.

Many explanations have been offered for this form of menstrual abnormality. The pathological study of the subject may be said to date from the work of Scanzoni in 1863. The explanation offered by this author was a purely anatomical one, the bleeding being attributed to a chronic inflammation of the myometrium. It is of interest to note that the rôle of the myometrium has been reemphasized by certain much more modern investigations. Under this head may be put the theory of Theilhaber, that the bleeding is due to an "Insufficiencia uteri" brought about by a replacement of muscle by connective tissue, and also that of Anspach, who believes it may be explained by abnormalities in the distribution of the elastic tissue about the blood-vessels.

In this connection, one may also mention the view urged by Pankow, Rees, Findley, and others that arterio-sclerosis of the uterine vessels plays an important part in the causation of such bleeding. It is probable that such factors as these play a part in some cases. For example, one will at times observe, after either a miscarriage or a full-term delivery, the most persistent bleeding, which continues after even the most thorough curettage. Bleeding of this type is especially frequent, in my experience, in women who have had many pregnancies in rather rapid succession. The only explanation which seems possible is that there is a deficiency in the uterine musculature, although microscopic demonstration of such a deficiency is not nearly so satisfactory as might be wished.

The same statement may be made as to the occasional role of arterial disease in the production of uterine bleeding. From time to time one sees patients at or near the menopause, and not infrequently far beyond the menopause, who exhibit a troublesome, though usually very moderate, metrorrhagia. The blood pressure in such cases is commonly quite high, and other symptoms of hypertension are usually present. Diagnostic curettage is, of course, indicated, because of the ever-present danger of malignancy. Not infrequently, however, the curetting will yield only a very scant amount of tissue, which under the microscope is found to be a normal, usually senile endometrium. Such a syndrome is sufficiently frequent to make us feel that arterial disease may in at least a small proportion of cases play a part in the production of uterine bleeding.

Speaking generally, however, uterine bleeding of either of the two types just described is not included under the designation of essential, idiopathic or functional bleeding. The latter occurs in women who otherwise are apparently in good health, and in whom the bleeding can not be explained by such factors as repeated

pregnancies, myometrial deficiency, or arterial disease. For diagnostic, even more than for therapeutic, purposes curettage is clearly indicated whenever such unexplained bleeding has persisted for any length of time. When the bleeding occurs in a woman at or near the menopausal stage, the vital importance of such a procedure is obvious. In a large proportion of cases the microscopic examination of the scrapings will reveal a perfectly characteristic picture, which we have therefore come to associate with this form of bleeding.

The condition is spoken of as hyperplasia of the endometrium. It was described originally by Cullen, as far back as 1900, and in recent years has been the subject of much study, especially in the German clinics and laboratories. At the last meeting of the American Gynecological Society (1924) Martzloff and I presented a detailed study of 66 cases which had been encountered in our laboratory of Gynecological Pathology at the Johns Hopkins Hospital, in less than five years. The lesion is therefore a relatively frequent one.

The term hyperplasia is an appropriate one, because there is evidently a genuine increase in the tissue elements of the endometrium, both epithelial and stromal. The hyperplasia of the epithelium elements is indicated by the thickening of the surface and gland epithelium, so that, especially in the latter, it is not uncommon to find more than one layer of cells, with rather heavily staining nuclei. The stromal increase is indicated by the frequent presence of considerable numbers of mitoses, though this finding is not constant. At times the stromal overabundance is so marked that large fields of stroma are noted, the gland elements being relatively sparse. In other cases, the reverse is observed.

From a diagnostic standpoint, however, by far the most characteristic feature is the gland pattern. Large cystic glands are found, often side by side with glands which are narrow and undilated. There is thus produced what we have called a swiss-cheese pattern. In marked cases this is extremely well-defined, so that the diagnosis can be made at a glance. In the milder cases, the characteristic picture may be seen only here and there in the section, and even then may not be at all outspoken. Speaking generally, however, it may be said that the microscopic diagnosis is extremely easy. For a detailed description of the pathology of this interesting endometrial lesion, as well as of its clinical aspects, the reader is referred to the above quoted paper by Novak and Martzloff.

The gross picture in the endometrium in cases of hyperplasia differs in different cases. In the most typical instances, there



is an enormous overgrowth, usually polypoid, producing the picture which has so commonly been spoken of as polypoid endometritis. The latter term is a misnomer, because of the usual absence of any inflammatory changes in the endometrium. True endometritis has little tendency to cause polypoid overgrowth. Where the endometrium is so overabundant the curette will bring away great quantities of polypoid tissue, so that the suspicion of malignancy may be strong. The distinction, however, is usually very easy to make even at operation. No matter how abundant and polypoid the endometrium may be in hyperplasia, its surface is usually smooth and intact with no evidence of the friability and breaking down seen in all except the most incipient cancers. Especially startling are the cases of hyperplasia in young girls, where the curette may at times bring away huge quantities of the hyperplastic endometrium. In a larger number of cases, however, only a moderate overgrowth may be observed, while in still others there may be little or no gross evidence of the lesion. And yet the microscopic picture is the same regardless of the degree of gross overgrowth.

Since the endometrium in functional bleeding so commonly shows hyperplasia, the question arises as to whether the bleeding may not be due to the endometrial lesion. If this were so, it could scarcely be called functional, in the narrower sense of that much abused word. There is much evidence, however, to show that the endometrial condition, and the bleeding, instead of being associated as cause and effect, are alike due to a more fundamental cause, a disturbance of ovarian function. For example, hyperplasia of the endometrium is, generally speaking, found only during the years of active cyclical ovarian function. Abolition of the latter by such means as X-ray, radium, or castration will inevitably be followed by cessation of the bleeding. On the other hand mere removal of the hyperplastic endometrium by curetting is followed in a large proportion of cases by a recurrence of the hyperplasia and also of the bleeding. In other words the underlying cause, i.e., the functional disorder of the ovary continues to exert its effects. Just what the disorder is it is impossible to say in the present state of our knowledge but certainly it seems fair to assume that it is in the nature of a hypersecretion of the ovary or one of its constituent elements. This question, as well as that of the associated histologic changes in the ovary, has been more fully discussed in a recent paper by the present author.

So common is it to find hyperplasia in cases where there is no demonstrable gross disease in the pelvis that failure to do so should lead to the suspicion that some of the better recog-

nized causes of bleeding, perhaps a submucous myoma or an unsuspected chronic adnexitis, may have been overlooked. On the other hand, in a certain proportion of cases without demonstrable gross disease the diagnostic curette will bring away tissue which is, so far as we can determine, perfectly normal. We thus apparently have two groups of functional cases, one in which the endometrium is normal and a second, much larger group, in which the typical picture of hyperplasia is found. Just what makes the difference between the two groups we cannot say, although it is a temptation to believe that they are produced by different types of functional aberration. This question is now being studied in our laboratory.

Certainly there is nothing incredible in the concept that ovarian disorders may cause alterations in the endometrium. No stronger proof of this is necessary than that offered by the striking changes in the histology of the endometrium at different phases of the menstrual cycle, changes which are universally conceded to be due to cyclical function of the ovary. Why, then, could not an abnormally functioning ovary bring about an abnormal change in the ovary? As far back as 1882 Brennecke spoke of what he called "endometritis ovarialis," an endometrial lesion due to ovarian disorder. It was probably the condition now designated hyperplasia. Even before this, in 1875, Olshausen had described, as a cause of severe and long-continued hemorrhage, the lesion which he designated "endometritis fungosa." His description leaves little doubt that it was identical with what we now more properly call hyperplasia. Olshausen looked upon the condition as a chronic inflammatory process, and unlike Brennecke, did not in any way associate it with disturbance of ovarian function.

A final emphasis may be placed upon the importance of hyperplasia in connection with bleeding at or near middle life, i.e. during the cancer epoch. At least one-half of all cases are seen at or near the menopause. We have, very properly, been urging upon women the importance of bleeding as a danger signal of cancer during these years. The external forms of cancer, especially squamous cell cancer of the cervix, are ordinarily easily diagnosed by inspection and palpation, with confirmatory microscopic examination of cervical clippings if necessary. The internal forms, i.e., adenocarcinoma, are diagnosable only by means of microscopic examination of scrapings. The point that I wish to emphasize is that, in cases of menopausal bleeding where diagnostic curettage is necessary, the microscopic examination of the scrapings will show the perfectly benign condition of hyperplasia considerably

more often than adenocarcinoma. This is all the more true if we are dealing with patients still in the menstruating epoch, for adenocarcinoma, in a large proportion of cases, is noted in women well beyond the menopause, while hyperplasia is characteristically confined to the menstruating years. There can be no harm in presenting this hopeful aspect of the matter to patients in whom we are faced with the possibility of cancer. I believe that women will be all the more willing to submit to diagnostic curettage, when this is indicated, if we tell them, as we truthfully can, that in a large proportion of cases, even where no gross benign lesion like inflammatory disease or a

hobnail is present, the cause of the bleeding will be found to be a condition which not only is non-cancerous, but which does not even exert any predisposing influence in the development of cancer.

#### REFERENCES

- Cullen. Cancer of the Uterus. 1900, p. 479.  
 Cullen. Address in Gynecology. *Canad Med Assn Jour*, 1913, 3, 658.  
 Novak and Martzloff. Hyperplasia of the Endometrium. A Clinical and Pathological Study. *Amer J Obst and Gyn*, 1924, 8, 385.  
 Novak. Relation of Hyperplasia of the Endometrium to So-called Functional Uterine Bleeding. *Jour Amer Med Assn*, 1920, 75, 292.

### IDIOPATHIC UTERINE BLEEDING FROM THE CLINICAL STANDPOINT\*

By WILLIAM P. HEALY, M.D., F.A.C.S.,

NEW YORK CITY

UTERINE bleeding must always be regarded as a symptom indicative of either physiologic or pathologic activity.

This activity may be local in character and may originate in the endometrium, the uterus and adnexae or the adjoining pelvic structures. It may on the other hand result from constitutional disturbances or from endocrine imbalance.

It may be of a physical or indeed even of a psychic character. For the rhythmic recurrence of the menstrual cycle in some women seems to be so delicately balanced that it is easily disarranged by many of the ordinary activities and responsibilities of life.

This discussion is to be restricted to the type of uterine bleeding known as idiopathic, but often discussed under other headings such as myopathic essential uterine insufficiency, etc.

The title of the paper indicates that in this group we are unable to find any gross pathologic change occurring uniformly in all of the cases to account for the bleeding.

The microscopic study of the endometrium is usually reported as showing a condition of chronic hyperplastic glandular endometritis. Often indeed it is reported as showing normal endometrium with no pathologic change. Under what clinical conditions then do we find this symptom complex?

It may occur at any age from puberty to the menopause but is, on the whole, probably more common in the first half of menstrual life, that is before the 30th year. George M. Brown,<sup>†</sup> in a study of 2,447 cases of menstruation reports that 72.3 per cent were regular in type from the beginning, 18.9 per cent became regular in

a certain time and only 8.7 per cent remained irregular or abnormal.

As far as I have been able to determine idiopathic uterine bleeding occurs just as frequently in the physically well developed as in those poorly nourished and I have been unable to find that there was any underlying neurasthenic or psychic factor common to the group.

It occurs in married and single women but is more apt to be associated with sterility than otherwise.

There is a natural division of the cases into two groups, those which occur at puberty and those occurring at the climacteric.

In each group one can readily understand that there may be an endocrine imbalance for they are placed at times which represent epochs in the life cycle of the female. Moreover one must realize that the anatomic features present while possibly normal for each group are totally different in the two groups. At puberty we have immature structures about to take over new function, whereas at the climacteric we are dealing with tissues which have functioned more or less rhythmically for many years and which may have experienced extensive changes in their histologic structure as a result of pregnancy.

The chief and practically the only primary symptom is abnormal uterine bleeding indicated by a profuse or prolonged menstrual flow, which may be continuous or intermittent, recurring after intervals of a day or two. Altogether the patient may bleed on more days of the month than she remains free from bleeding.

There are other symptoms but practically all of them result from the secondary anemia which follows the persistent bleeding.

Examination of the patient's blood has not given us any information of practical value from

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse May 12, 1925.

† Brown G. M. *Jour Mich State Med Soc* Jan., 1924.

either the diagnostic or the therapeutic standpoint

In the years before the advent of gland therapy the tendency was to treat instances of abnormal uterine bleeding of this type, which did not respond to ordinary medical treatment, by curettage of the uterus. This procedure often was successful and when it failed, curettage was repeated from time to time as the bleeding recurred. Finally in many instances hysterectomy was done in order to bring about permanent cure.

Since the advent of organotherapy persistent attempts have been made, with more or less success, to control the bleeding by means of oral or hypodermic administration of various gland substances or extracts, either singly or in combination of several glands. In general it must be admitted that the results of such treatment have not been satisfactory in either the adolescent or the climacteric groups. From time to time individual cases seem to respond to one preparation or another or to one combination or another of the gland substances.

In the writer's experience, however, it has been quite impossible to proceed with any degree of assurance as to ultimate results with this form of therapy.

Nevertheless we continue in the use of the various preparations more or less empirically for as we have said there undoubtedly is every reason for believing an endocrine imbalance exists in many of the cases of idiopathic uterine bleeding.

In the younger group of cases I would suggest that the treatment at first should be along general medical and hygienic lines, if the results are not satisfactory after a reasonable time, then organotherapy should be resorted to. In the event of failure of this plan, the next procedure should be curettage, which should not be too vigorous and should not be repeated in less than four to six months in these younger women.

If the first or second curettage fails to give relief from the bleeding, one can then fall back upon the use of radium applied within the uterine cavity above the internal os. This in my experience is a safe form of therapy in the girl or young woman, provided the dose is properly controlled and it will nearly always give a good result. It is much better I believe, never to use radium in a young woman without having at hand a report on the microscopic study of the tissue removed by curettage.

This is essential for if the interglandular stroma is made up of a structure closely resembling lymphoid tissue it will be very susceptible to irradiation and will melt away very quickly and cause a complete disappearance of the endometrium.

This naturally would result in a more or less

permanent amenorrhoea, a very unfortunate circumstance in a young woman. With regard to dosage it would seem safe to use from 150 to 300 milligram hours, depending somewhat upon the age of the patient and the size and consistence of the uterus. The smaller dose is indicated in the young girl and in the small uterus. If this fails to give the desired result it should positively not be repeated in less than six months.

The small dose is naturally slow in bringing about changes in the histologic structure of the tissues irradiated and it may be several months before these changes are of sufficient magnitude to influence the symptoms. A second dose of radium applied during this time will undoubtedly cause cumulative radiation effects in the tissues and may result in amenorrhoea for a long time, if not permanently.

We have carried out the plan of treatment outlined for the younger group of cases for the past ten years, in other words since radium has been available. On the whole the results have been reasonably satisfactory in the control of the bleeding, the maintenance of a normal menstrual cycle thereafter, and the occurrence of conception resulting in the birth of normal children.

So much for the younger group. What shall we do for the older women, forty years of age or older, who present no gross pathology but in whom idiopathic uterine bleeding occurs?

Our problem here is much more simple, it is seldom necessary to consider the question of future pregnancy or even retaining the menstrual function. If these issues are paramount the patient should be treated somewhat along the plan outlined for the first group. If not we need only rule out the question of malignancy by a thorough curettage with microscopic study of the removed tissue and at the time of the operation insert radium capsules into the uterine cavity above the internal os for a total dosage of 800 to 1,200 milligram hours. This dosage seldom fails to stop the bleeding within two to six weeks and usually results in permanent amenorrhoea especially if 1,000 or more m g hours treatment is given.

Therefore it may be said that this is practically a specific remedy or method of treatment in this group of cases.

In the literature one finds references to many other forms of treatment for idiopathic uterine bleeding such as irradiation of the thyroid gland, or the spleen, or the liver with the roentgen ray, with reports of cases successfully treated. Also the intravenous use of sera of various kinds and of solutions of sodium citrate intravenously. The writer has had no experience with any of these methods.

## TREATMENT OF FRACTURES OF THE NECK OF THE FEMUR\*

By WILLIAM CRAWFORD WHITE, M.D., F.A.C.S.

NEW YORK CITY

A SURVEY of recent literature does not give one any firm belief in any method. We had made use of the Whitman method at the Lincoln Hospital but I did not feel sure that it was the only method of treatment. In 1890 the abduction method was introduced but it has not yet had a universal acceptance.

Royal Whitman<sup>1</sup> states that "in aged subjects it has been demonstrated that efficient treatment of the fracture by the abduction method is actually more conservative than life-saving neglect, since it relieves pain, and permitting elevation of the head of the bed and frequent changes of posture, prevents hypostatic congestion and bed sores. Furthermore it has long since been proved that neither advanced age, or the situation of the fracture precludes repair if the opportunity is assured. Shortening of the limb and lameness are not inevitable. The spica is retained for eight to twelve weeks or until it may be assumed or demonstrated by Roentgen-ray examination that union is sufficiently firm to permit movements of the limb. On its removal the patient should remain in bed several weeks for muscular reeducation and the restoration of function in the disused joint, the limb being drawn out to the limit of abduction by the attendant. Full weight bearing is not permitted until free and painless movement and Roentgen-ray examination indicates stability of repair. Rarely less than six months and in the central type it may require a much longer time. If, therefore, an early locomotion is desired a protective hip brace should be provided. In others there appears to be a preliminary so-called absorption of part of the neck, but in most instances the fragments eventually unite if contact is maintained for a sufficient time." "Since if properly applied, the abduction method assures fixation of the fragments, the insertion of nails or screws is unnecessary and even harmful because of injury to cancellous structure on which repair depends and if, as in some instances, there was subsequent absorption of the central part of the neck, the fragments would be actually held apart rather than opposed. A bone peg may in some instances promote union, but functional results are often far from satisfactory, and indications are insignificant in number."

There does not seem to be any question about bone union in the fractures about the base of the neck, but when we come to the central fractures we have different reports. Johan Waldenstrom of Falun, Sweden<sup>2</sup> had 14

cases treated with the abduction method, and had union in eight, three pseudo-arthroses with good function and three pseudo-arthroses with bad function. Delbet and Basset<sup>3</sup> have never seen union of an intracapsular fracture except in cases fixed by metal screws. Uno Lindberg of Upsala, Sweden<sup>4</sup>, had five cases of transcervical fracture with union in three, and he quotes O. Lofberg<sup>5</sup> who has had 70 cases with union in 39 cases when treated by the abduction method. Of 98 cases 63 had presented an excellent or a good functional result.

Campbell<sup>6</sup> had 28 central fractures treated by the abduction method and 85 per cent gave a good functional result, by which is meant that the patient was able to walk without support, pain or discomfort, and with every evidence of bony union. A slight limp persisted in the majority, though quite a number walked perfectly. In two studied a gradual coxa vara developed, although union had appeared firm. He believes that there is no method by which we can determine union except time, with the development of perfect function and stability. A. O. Wilinsky<sup>7</sup> reports two cases treated by fixation with a bone peg, in an abduction spica. He expresses doubt if more than 15 per cent of intracapsular cases obtain union with the abduction treatment in those insufficiently or badly treated. He expresses no opinion about those well treated. He says "that if tried the abduction treatment requires at least four months" and then if no union "an operation at this late date would be futile because of changes, whereas if it is done early there would be a closer approach to the normal." He advises in the robust a living graft of bone through the trochanter into the head. Then abduction in a plaster splint for two months. At the end of three months allow ambulatory treatment with braces until six months, when they may be discarded.

Again Campbell<sup>8</sup> says that "if no union occurs in a central fracture of the neck of the femur at the end of eight weeks, in all probability an ununited fracture exists. Clinical experience teaches us that under the most favorable circumstances union is delayed in this region, and as stated a permanent status of non-union is reached much earlier."

We have then as choice of treatment, the palliative, the traction and suspension with adhesive or caliper traction, the closed reduction with the abduction and plaster spica, the bone graft, and the reconstruction operation of Whitman. The palliative method is chosen only when the patient is so decrepit and asthenic that any interference would be judged

\* Read before the Surgical Section New York Academy of Medicine

impossible. This is largely a matter of personal opinion and will vary with different surgeons as to the percentage. I believe that this group should be small. The most of the patients obtain the best results with the plaster spica after closed reduction and complete abduction. This may be qualified by saying that suspension and traction has gained some friends who use it in the treatment of some fractures about the base of the neck, I have not had sufficient personal experience of the traction to express an opinion. The reconstruction and the bone peg operations should be reserved for the occasion when union can not be obtained.

It is my experience that the plaster spica with its encasement of the patient is in some patients a severe mental and physical strain, and that it can not be used in all cases. To obtain a satisfactory reduction and application of the abduction method a general anaesthetic is required, and in some this is a dangerous procedure. Our abduction method tried to follow the method of Dr. Royal Whitman. We break up the fracture site and do not allow a Roentgen-ray diagnosis of impaction to keep us from attempting to improve the position. We think that this is important in order to obtain sufficient abduction and internal rotation. We use the Hawley table and apply a plaster spica from toes to axilla with the extremity in abduction, extension and inward rotation when possible. This last point is sometimes difficult for us to obtain. To our annoyance at the end of the operation we sometimes find that we have not as much inward rotation as we had thought. The other lower extremity is left free and a window is made in the abdominal wall for meal expansion or else a dinner pad is inserted. After the first day it is our custom to turn the patient on his face twice a day. The elevation of the head of the bed helps prevent pulmonary congestion. A big help to the patient is any overhead apparatus that makes it possible for the patient to help himself a little. I do not like the method in which the both lower extremities are kept in abduction in plaster in order to fix the plaster. It is uncomfortable and almost makes it impossible to turn the patient over on his face.

The spica is kept on from 60 to 90 days with the longer period for the intracapsular fractures. There is but little if any advantage in removing the foot and leg portions of the cast before the whole comes off, and there is the disadvantage that there is often much pain and discomfort, with edema. After the cast has been removed the patient is kept in bed for several weeks more, and then he is allowed crutches and home, with instruction not to bear weight within six months of the time of

the accident. A supportive splint is desirable but not usually possible. Massage is of great help. We find that the knee often gives them trouble over a long period, and I wonder if the full extension and the forcetful internal rotation does not cause too much strain on the ligaments with a secondary peri-arthritis.

I feel that in the large majority of cases the abduction treatment of Whitman is indicated and that it may be successfully used in both the intracapsular and extracapsular fractures. In central fractures one may obtain bone union and good function. However there are central fractures in which bone union does not occur and one must be prepared for additional treatment. It seems to me that a wait of one year to see if bone union will occur is too conservative. On the other hand immediate operation is too radical. I prefer to believe that, in many of these non-union cases, it can usually be determined at the end of two months that there will be no union. Then one has the choice of the bone peg or the reconstruction operation.

I have had no personal experience with the bone graft in the fracture of the neck except to watch several well known surgeons struggle with it and make me realize that it is a difficult procedure. I have had two reconstruction operations to report and will show lantern slides tonight of one. The operation is easier than the bone graft. However I believe that the bone graft operation is to be preferred to the reconstruction in the cases operated upon under one year.

The facts given below are based on a review of forty cases—thirty-six from the wards of the Lincoln Hospital and four private cases. Of the forty cases, nine had no active treatment and thirty-one had the abduction treatment of Whitman. Two of these abduction cases later had the reconstruction operation of Whitman.

One of the palliative cases had a fracture of the neck of the femur in a femur stump that had been non-weight bearing and so had no indication for interference. Of the other eight cases one died in the hospital, two months after admission and five were transferred.

Of the thirty-one cases treated by the abduction treatment, four died in 25, 22, 42 and 5 days respectively after the application of the plaster. And they were of the ages 69, 60, 58 and 56 years. One had pulmonary tuberculosis, one developed lobar pneumonia, and two gradually became irrational, incontinent and died.

I have made late examination on three of the palliative cases and nineteen of the abduction cases, with an inspection of the early and recent Roentgen ray films of nineteen. Fourteen of the cases were intracapsular and I have traced ten, twenty-six were extracapsular and I have traced twelve. Of the intracapsular cases, five show clinical evidence of union at the fracture site.

and I believe that there is bone union. Of the non-union cases two go about with canes and have only slight pain. They have had increased shortening since leaving the hospital. Two had considerable atrophy of bone with marked pain in the hip and disability and came to the reconstruction operation of Whitman. Both gave good results. The last is only seven months since the abduction treatment. There seems to be fibrous union only. She walks in a splint with crutches.

All the cases had some shortening varying from one-half to two inches in one case of non-union. Eleven required the use of a cane and eleven walked without support and had only a very slight limp. The usual abduction was from thirty to forty-five degrees. Of the abduction cases four later failed to have abduction. Three of these were non-union cases while the fourth was an excess callus case. Of the three cases that were followed that had no active treatment one was paralyzed, one had no abduction and the other had thirty degrees. This last case was a fracture with no displacement. The abduction cases had good rotation with the exception of the cases without bone union and one that was improperly treated at the start. One of the palliative cases had good rotation and the other was only fair. Flexion of the thigh with the leg in extension was absent in the non-union cases but present in the others.

The case with the excess callus was bed ridden. The housewives usually were able to do one-half

to three-quarters of their work. The men were not able to do more than a light job.

### SUMMARY

1 Eleven out of the twenty-two cases could walk without a cane, pain or discomfort and gave clinical signs of union.

2 Five out of the ten intracapsular fractures appear to have bone union. All the extracapsular fractures had bone union.

3 We had shortening of the limb in all cases with a limp that varied from slight to marked.

4 The abduction treatment is the method of choice but it can not be applied to all cases. There are people so decrepid that they can not be subjected to general anaesthesia and immobilization in a plaster spica without grave danger.

5 There is a type of intracapsular fracture in which one can tell in about two months if there is going to be no union. Such cases should not await radical procedure longer but be subjected to either a reconstruction or an autogenous bone graft.

### REFERENCES

- 1 Royal Whitman, *Annals of Surgery*, Vol. LXVI, pp 374-391
- 2 Johan Waldenstrom, *Journal de Chirurgie*, Vol. XXIV, pp 129-162
- 3 Delbet and Basset, *Fracture du col de femur*, 1921
- 4 Uno Lindberg, *Acta Chir Scand*, July 12, 1924 pp 55-91
- 5 O Lofberg, quoted by Royal Whitman
- 6 W C Campbell, *Annals of Surgery*, Vol LXX, pp 600-602
- 7 A O Wileasky, *Annals of Surgery*, Vol LXVII, pp 631-640
- 8 W C Campbell, *Archives of Surgery*, Vol VIII pp 782-790

### INTRACAPSULAR FRACTURES

Name	Age Sex	Cast	Out of Bed	Weight Bearing	Shortening	Abduct	Rotate	Support	Time After
1 D	35 F	85 Days	105	6 Mo	1/2 inch	30	O K	no	27 Mo
					bone union	X-ray			
2 F	40 F	42 "	69	5 Mo	3/4 "	0	0	crutches	5 Mo
					no bone union	X-ray		reconstruction	Op
3 F1	50 F	58 "	68	5 Mo	1/2 "	45	O K	no	11 Mo
					bone union	no late X-ray			
4 G1	58 F	85 "	100	6 Mo	3/4 "	30	O K	no	30 Mo
					Clinical union	no proof	X-ray		
5 Go	14 M	66 "	75	6 Mo	1 1/4 "	30	no	no	7 1/2
					epiphyseal	X-ray shows	bone union		
6 Iv	51 F	89 "	110	6 Mo	1/2 "	0	1/2	cane	1 Yr
					X-ray	no union	reconstruction	operation	later
7 Na	42 M	80 "	102	8 Mo	1/2 "	30	O K	cane	24 Mo
					X-ray does not show	union	definitely		
8 N1	47 F	79 "	110	7 Mo not act	1/2 "	30	O K	splint	7
					X-ray shows	no bone union			
9 O'B	17 M	90 "	100	7 Mo	1/2 "	45	O K	no	2 Yr
					X-ray shows	no bone union			
100s	56 F	35 "	81	11 Mo	3/4 "	0	0	cane	14 Mo
					cast off because of	decubitus	X-ray shows	no union	



# EDITORIALS



The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

Editor-in-Chief—ORRIN SAGE WIGHTMAN, M.D.,

New York

### COMMITTEE ON PUBLICATION

E. ELIOT HARRIS, M.D., *Chairman*

New York

WILLIAM H. ROSS, M.D.

Brentwood

DANIEL S. DOUGHERTY, M.D.

New York

Executive Editor—FRANK OVERTON, M.D.

Patchogue

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

President—NATHAN B. VAN ETTEM, M.D.

New York

First Vice President—WILLIAM H. ROSS, M.D.

Brentwood

Second Vice President—FREDERICK H. FLAHERTY, M.D.

Syracuse

Speaker—E. ELIOT HARRIS, M.D.

New York

Vice Speaker—GEORGE M. FISHER, M.D.

Utica

Secretary—DANIEL S. DOUGHERTY, M.D.

New York

Assistant Secretary—HOWARD GILLESPIE MYERS, M.D.

New York

Treasurer—CHARLES GORDON HEYD, M.D.

New York

Assistant Treasurer—JAMES PEDERSEN, M.D.

New York

### CHAIRMAN, STANDING COMMITTEES

Arrangements—EDWARD R. CUNIFFE, M.D.

New York

Legislation—HENRY L. K. SHAW, M.D.

Albany

Public Health and Medical Education,

CHARLES A. GORDON, M.D., Brooklyn

Scientific Work—ANDREW MACFARLANE, M.D.

Albany

Medical Economics—WILLIAM WARREN BRITT, M.D.

Tonawanda

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex President and the Councilors of the District Branches

First District—JOHN A. CARD, M.D.

Poughkeepsie

Second District—JOSEPH S. THOMAS, M.D.

Flushing

Third District—CHARLES P. MCCABE, M.D.

Greenville

Fourth District—HORACE M. HICKS, M.D.

Amsterdam

Fifth District—NELSON O. BROOKS, M.D.

Oneida

Sixth District—GEORGE H. FOX, M.D.

Binghamton

Seventh District—WILLIAM I. DEAN, M.D.

Rochester

Eighth District—HARRY R. TRICK, M.D.

Buffalo

### COUNSEL

GEORGE W. WHITESIDE, Esq., 27 Wilham St.

Telephone, Broad 1744

New York

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St.

New York

### EXECUTIVE OFFICER

JOSEPH S. LAWRENCE, M.D.

51 Chapel Street, Albany

### SECTION OFFICERS

#### Medicine

Chairman—L. WHITTINGTON GORHAM, M.D.

Albany

Secretary—WARDNER D. AYER, M.D.

Syracuse

#### Surgery

Chairman—EDWARD S. VAN DUYN, M.D.

Syracuse

Secretary—GEORGE E. BRILBY, M.D.

Albany

#### Obstetrics and Gynecology

Chairman—ALFRED C. BECK, M.D.

Brooklyn

Secretary—NATHAN P. SEARS, M.D.

Syracuse

#### Pediatrics

Chairman—ROGER H. DENNETT, M.D.

New York

Vice-Chairman—ARTHUR W. BENSON, M.D.

Troy

Secretary—JOHN ATKMAN, M.D.

Rochester

#### Eye, Ear, Nose and Throat

Chairman—EUGENE E. HINMAN, M.D.

Albany

Secretary—JAMES W. WHITE, M.D.

New York

#### Public Health Hygiene and Sanitation

Chairman—ARTHUR D. JAQUES, M.D.

Lynbrook

Secretary—LEO F. SCHIFF, M.D.

Plattsburg

#### Neurology and Psychiatry

Chairman—CLARENCE O. CHENEY, M.D.

Utica

Secretary—THOMAS E. DAVIS, M.D.

New York

For a list of the Officers of the county medical societies, see this JOURNAL, advertising page XVIII

For list of District Branch Officers, Standing Committees and Special Committees, see this JOURNAL, advertising page third cover

## MEDICAL SOCIETY SALESMANSHIP

The Medical Society of the State of New York has many kinds of service to offer to its members. It is organized on the mutual plan. Its members govern the Society and share in its profits. The Society is what the members make it, and its profits depend on the amount of investment which the members put into it, and how well they manage it.

It is equally true that the profit which an individual member gets out of the Society depends on the amount of his investment in time and effort, and his intelligence in putting his investment to use. Dividend checks are not mailed to him—he must go and get them. He must take an interest in the activities of his Society—in its JOURNAL, in its meetings and clinics, in the work of its committees, and in its social gatherings.

One of the great problems of the leaders of the Medical Society of the State of New York is that of the salesmanship of plans. After they have studied a problem for weeks or months, and have devised an excellent solution, they must try to sell it to their confreres—and then the objections begin to roll in. Some don't like the name of the idea, and others ask if it works automatically and is foolproof. Some object to its cost, and others are just indifferent.

It takes salesmanship to convince the ten thousand members of the Medical Society of the State of New York. The two basic ideas underlying salesmanship are the printed advertisement and personal solicitation.

The principal advertising medium of the Medical Society of the State of New York is its

**JOURNAL** The **JOURNAL** contains the announcements of the officers and committeemen and the plans of the activities of the Society. Any one reading the files of the **JOURNAL** during the past year will find sufficient material to write a complete history of every activity of the Society. But while the **JOURNAL** is invaluable as a record, it lacks the element of repetition on which advertising success rests. It is not enough to make an announcement once, for it reaches only a small percentage of the people. It must be repeated over and over until a buyer cannot keep from saying "Gillette" when he wants a razor, and "Uneda" when he wants a biscuit, and the "County Medical Society" when he needs the help of a consultant.

What supplies the element of repetition in medical society salesmanship? A few county societies have their own publications which are efficient reminders of the activities of the society. There are also group societies, and organizations of specialists, and staff meetings of hospitals, all

of which remind the doctor of his duties in civic medicine.

The second element in salesmanship is personal contact with field workers. What would a manufacturing company do without its field agents who are always at the service of their customers to explain and demonstrate their wares. The officers and committeemen of the State Society have done their field work exceedingly well and have come into friendly contact with at least 50 per cent of the members throughout the State. Add to this the frequent contacts of the officers and committeemen of the District Branches and the county societies, and the aggregate makes a field force which is comparable only by that of the churches.

The machinery of the Medical Society of the State of New York is running smoothly and with increasing efficiency. But while the leaders will supply the material to feed the fires of inspiration and education, the rank and file of members must do the stoking.

## THE PITY OF IT

There is a peculiar psychology, somewhat general at the present time, in so-called "freedom of speech."

This land of ours has ever been tolerant and even over-zealous in seeing that the vociferous and loud-spoken should have all the air and opportunity necessary to relieve their overburdened chests. The law is particularly lenient in that it permits this exuberance even to the stage of insult, and strangely fortifies the abuser of freedom in giving him a ready access to the courts to combat and obtain damages, when an outraged citizen calls him by his right name.

The end result is rather unfortunate. A quack or charlatan, or even a misguided crusader, shouts out his noisy propaganda, reasonably sure that the respectable and orderly portion of the community will stand back rather than be caught in bad company. This accomplishes the desired result.

The purveyor of misstatement promptly becomes brazen, and bringing into play his extraordinary muscles of expiration he emanates the quadruple extract of all the departed martyrs. Yea, he takes upon himself the sorrows of the world, and in one fell jump he establishes himself as the leader of a crushed minority who would labor hopelessly but for his unselfish devotion. If the minority will keep the said martyr under careful observation and hand him enough rope, sooner or later adjectives will fail and he will state somewhat shyly "Now that the crowd is here, we will have a few words on Anti-Vivisection." He might also hand you a circular somewhat as follows:

"Are you going to submit to Medical Tyranny? A timely warning! Help save our Country from the Autocrats," etc. This outburst is the charlatan's protest against the law which requires a proper registration of physicians.

Another crew of malcontents don't want to be vaccinated. Still others don't believe in eating meat. One lurid pamphlet quotes with great gusto opinions of men so eminent that one had a title of M A, D C L, M R C S, and L R C P. A man with so distinguished a title don't need meat—he don't need anything except the great outdoors where men are men.

A gentleman by the name of A. Montagne under the title "A message to Cancer Patients. Why despair—Cancer is curable," gotten out over the name of the Maryland Anti-Vivisection Society has the following sentence in closing, "We should fail in a pressing duty were we to omit the mention of the C - T Treatment of Cancer" has proved itself successful in many cases, several of which are known to us."

What a boon to humanity—but how about the poor deluded person to whom this is sent, and believes in the brazen effrontery of the charlatan.

We question very seriously whether any well-balanced individual is mentally nimble enough to keep up with one who makes lying a profession—AND THERE'S THE PITY OF IT.

Abraham Lincoln, even in absentia, lends us a word of encouragement in his admonition "You cannot fool all of the people all of the time."



Were it possible to present these matters of health and public weal before all the people, there would still be a group of dissenters who, like a rotten apple, would insist on being present in the basket even though they contaminated their healthy neighbors.

It occurs to us that a profitable experience might be enjoyed by our Anti friends if all who could spare the time might summer in the pest house and learn at first hand the foolish fear of

smallpox, and in their leisure moments they might study what a great boon smallpox was in the middle ages—and then along came vaccination and as improvement in technique was developed, Europe was cleansed of a great scourge.

The children in the schools know this, and when the minds of these poor deluded Anti reach the growth of a child of ten, they will know it too.

There's the pity of it

---

## THERAPEUTIC STANDARDS

A small hospital with an open staff has difficulty in maintaining up-to-date standards of treatment. The staff usually includes all the doctors in the vicinity of the hospital, and they are general practitioners rather than specialists and original workers. While consultants are always available, yet they are not expected to be on call for every unusual case.

Every hospital is expected to exemplify the highest standards of therapeutic measures, and the members of the staffs are conscientious in their endeavors to give the patient the best possible treatment. The general practitioners are pretty well up in the newer discoveries. They can give insulin with intelligence, especially when they have the assistance of an expert laboratory technician. They know the indications for salvarsan, and can give it with expertness.

The medical limitations of the family doctor are along the lines of the general managements of the cases. What is the present accepted procedure in a case of vomiting of pregnancy? The older treatment involved the termination of pregnancy as an early procedure, but now rest and mental repose, and the use of water and glucose are the accepted therapeutic methods. But how shall these methods be carried out? Success requires much skill and attention to details.

Take the management of fevers as another illustration. We have all expected to see a dry tongue in pneumonia, but dryness of the mouth is a sure sign of dehydration with all its discomforts and dangers. The modern standards of practice require that water be given to those patients by mouth, by rectum, by hypodermoclysis, and intravenously until the tongue is moist and the kidneys resume their function.

Dehydration is accompanied by a deficiency of

sugar in the blood, with its train of acidosis from the imperfect utilization of fats and proteins. The modern standards of medical treatment require the administration of glucose or sugar to fever cases with dry tongues. How it shall be given—by mouth, by rectum, or intravenously—will depend on the indications of the case and the skill of the doctor.

How can a hospital attain a high grade in the management of cases?

The hospital staff might adopt standard methods either formally or informally.

The hospital might adopt a system of General Rounds by the entire staff once every week or month. Patients and doctors would all be benefited if every case were seen periodically by the entire staff.

Each member of the staff might be appointed to perfect himself in some particular line. No one can attain a high grade in all lines of medicine, but every doctor can attain a high grade in some line.

Articles might be prepared and published in the medical journals on practical subjects that are not covered by text books.

Every small hospital can be a center at which a very large proportion of the doctors in its vicinity can learn to practice up-to-date methods. Not all that is up-to-date centers in the laboratory. Any doctor can order a test made and get it done if an interne and a laboratory technician are available. The greatest need of every hospital is that its staff should develop increasing skill in the art of caring for its patients.

Therapeutic standards are set forth by the American College of Surgeons, and are well within the reach of even small hospitals.



# MEDICAL SURVEY



## MEDICAL SURVEY NUMBER 16—CAYUGA AND SENECA COUNTIES

**EDITOR'S NOTE** The information on which the survey of Cayuga County is founded was obtained principally from Dr A J Bennett, President of the Cayuga County Medical Society, and Dr G F Ross, Secretary, Dr A K Bates, Dr T C Sawyer, Health Officer of Auburn, and Dr F W Sears, District State Health Officer.

Cayuga County lies on the east side of Cayuga Lake. It extends south for about 55 miles from Lake Ontario, and lies about one-third of the way from Syracuse to Rochester. Its frontage on Lake Ontario is only ten miles, and its width at its southern end is about twenty-five miles. Its area is 703 square miles. Its surface is rolling, and fruit farming is one of its important industries.

The population of Cayuga County was 65,221 in 1920, which is about 2,000 less than in 1910, and only 10,000 greater than in 1850. Yet the people are prosperous and progressive.

The County has only one city, Auburn, which has a population of 36,192. It has only three villages with populations over 1,000: Moravia, population, 1,331; Port Byron, 1,035; and Weedsport, 1,379. There are 6,333 people dwelling in incorporated villages, and 22,696 living in the strictly rural sections.

**Physicians**—There are 82 physicians listed in the County by the Medical Directory of the Medical Society of the State of New York. They live in 17 centers—55 physicians in Auburn, and 27 in the rest of the County. Auburn has one doctor in every 650 population, and the rest of the County, one in 1,100 people.

Auburn is the medical center of Cayuga County, and is also the center politically and geographically. Good roads extend through every part of the County, and transportation is easy. The doctors in the extreme north end of the county go to Oswego and Syracuse for hospitals and consultants, and those in the south end patronize the hospitals in Ithaca and Cortland, but most of the county cases of sickness go to the Auburn hospitals.

**Hospitals**—Cayuga County has two hospitals, both in Auburn.

The Auburn City Hospital was founded in 1878 and has 85 beds, but a million-dollar addition now under construction will give it a capacity of 150 beds. The hospital is privately supported, although it is called the "City Hospital." It is a general hospital with services in medicine, sur-

gery, obstetrics, and eye, ear, nose and throat. It has an appointive staff, but nearly all the doctors in the city are on it. Two internes are employed, monthly staff meetings are held, and the standards of the American College of Surgeons are observed. A history clerk is employed, and a training school with 50 pupil nurses is maintained. It also has a laboratory and an X-ray department. It is planned to add an outpatient department to the new hospital.

Mercy Hospital was opened five years ago. It has 25 beds, and conducts a training school for nurses.

The City of Auburn maintains a tuberculosis hospital with 20 beds.

Cayuga County has 2 hospital beds in every 1,000 population, but when the addition to the City Hospital is completed, it will have 25 beds in every 1,000 population. But since hospitals in adjoining counties are used, a full quota of hospital beds is available.

**Medical Societies**—The Cayuga County Medical Society has 62 members, which includes over 75 per cent of the physicians listed in the county. Monthly meetings are held, usually in Auburn. The attendance at the meetings averages over 20 members.

Auburn formerly had an academy of medicine, but it was discontinued when the staff meetings of the hospital were instituted about five years ago.

**Public Health Work**—The official public health work of Cayuga County is done in 30 districts which are served by 20 health officers. Each health officer outside of Auburn City serves an average of 1,500 people.

Seventy per cent of the doctors outside of Auburn are health officers, and 75 per cent of the health officers have taken special courses of instruction.

The health officer of the City of Auburn, Dr T C Sawyer, gives nearly all his time to the office. His outstanding accomplishment has been the suppression of endemic diphtheria by the use of the Schick test and immunization with toxin-antitoxin. Nearly every school child and many of the pre-school age have been immunized. The work is being actively continued in the schools, and public sentiment is overwhelming in its favor.

A health center is maintained in the Neighborhood House, where prenatal, child welfare, men-

tal hygiene, and dental clinics are conducted. A venereal disease clinic and one in tuberculosis are conducted by the city.

The city water is filtered, and bacteriological examinations are made regularly. The water ranks among the purest in the State.

The only grades of milk permitted to be sold in Auburn are pasteurized and "Grade A" raw.

Tuberculosis work in Auburn is done by a special city nurse. The city maintains a tuberculosis hospital with 20 beds, but none is maintained by the county. The county employs a tuberculosis nurse.

School medical inspections are well conducted, and toxin-antitoxin immunizations are done to a greater extent than anywhere else in the State.

The county has a tuberculosis committee whose work is maintained by the sale of Christmas Seal Stamps.

*Public Health Nurses*—There are seven public health nurses employed in Cayuga County, as follows:

County nurse  
Weedsport Community Nurse  
Auburn Board of Health  
Auburn schools  
Red Cross at Auburn, Bedside  
Metropolitan Life Insurance Company  
Auburn Neighborhood House

*Impressions*—We talked with a number of physicians of Cayuga County during the meeting of the Seventh District Branch, and were impressed with their sense of civic duty. A small city that will build a million dollar hospital for the use of its doctors generally has confidence in its physicians and in their spirit of civic service.

## SENECA COUNTY

*EDITOR'S NOTE* The information regarding Seneca County was supplied principally by Dr. F. W. Lester, Past-President of the Seneca County Medical Society, and Dr. William M. Follett, the present Secretary.

Seneca County adjoins Cayuga County on the west. It fills the rectangle between Cayuga and Seneca Lakes, and is 35 miles long and 15 across at its widest part. It has an area of 336 square miles, nearly all of which is devoted to fruit and general farming, but two large pump manufacturing works are located in Seneca Falls, employing about 1,500 to 2,000 operators. The lines of travel are north and south, for the lakes limit it east and west. The civic center of the county is Waterloo, the county seat, located at the north end of the county.

Seneca County had a population of 24,735 in 1920, but in 1850 there were 25,441 people living in the country. This decrease in population is explained by the fewer number of people required to till the farms owing to the present use of machinery. The county is now more prosperous than ever.

The centers of population are four villages with a total population of 11,269. The two villages having populations over 1,000 are Seneca Falls, population 6,389, and Waterloo, population, 3,809. The number of people living outside the villages is 13,466.

*Physicians*—There are 33 physicians in Seneca County listed in the Medical Directory of the State Society, of whom 8 are on the staff of the Willard State Hospital and the rest are located in seven centers. If the physicians in the State Hospital are not counted, each physician serves an average of 1,000 people.

*Hospitals*—There are two general hospitals in Seneca County. 1. That in Seneca Falls. It has 25 beds. It has an open staff, which holds a monthly meeting. It has a laboratory in which the physicians and nurses examine specimens. It is owned and operated by the Township of Seneca Falls. 2. Waterloo Memorial Hospital at Waterloo, N. Y., is an open hospital with 15 beds.

While Seneca County itself has only 16 beds for every 1,000 people, yet the people are within easy reach of hospitals in Auburn, Geneva and Ithaca, and so have hospitals available for all cases.

*Medical Society*—The Seneca County Medical Society has 26 members, which is 75 per cent of the physicians listed in the County. It holds two meetings annually, and the average attendance is between 15 and 20 members.

Many of the doctors of Seneca County are regular attendants at the monthly meetings of the Academy of Medicine in Geneva, which is only a few miles beyond the western boundary of Seneca County.

*Public Health Work*—The official public health work of Seneca County is done by eight health officers, every one of whom belongs to the County Medical Society—an enviable record. Six of the health officers have taken a special course of instruction. Each health officer serves 3,000 people—a high average.

The county supports a tuberculosis nurse, and Seneca Falls has a school nurse.

*Impressions*—Seneca is a rural county, lying between two lakes, and having close connections with its neighbors on the north and south. Its doctors are progressive, and are ready to cooperate in Graduate Education.



# DISTRICT BRANCHES



## SIXTH DISTRICT BRANCH

The annual meeting of the Sixth District Branch, which is composed of the Counties of Broome, Chenango, Chemung, Cortland, Delaware, Otsego, Schuyler, Steuben, Tompkins, and Tioga, was held on October 6, in the Bank Auditorium, Ithaca, the President, Dr George H Fox, of Binghamton, was in the chair, and 85 members were in attendance. About twenty ladies accompanied the doctors.

The following officers were elected for the next two years

### President

Dr Wilber G Fish - - - - - Ithaca

### First Vice-President

Dr LeRue Colegrove - - - - - Elmira

### Second Vice-President

Dr George M Cady - - - - - Owego

### Secretary

Dr Hubert B Marvin - - - - Binghamton

### Treasurer

Dr Stuart B Blakely - - - - Binghamton

Two sessions were held, with a recess for lunch, which was served in the room adjoining the meeting place.

Dr N B Van Etten, President of the Medical Society of the State of New York, gave an address on the principles and objects of the society. He called special attention to the need of medical insurance and to the graduate education plans of the State Society.

Dr Daniel S Dougherty, Secretary of the State Medical Society, addressed the society on the details of a Secretary's work. He said that a permanent secretary is invaluable to a county society, and while presidents come and go, a society does well to keep its secretary in office year after year.

Dr Dougherty spoke of the introduction of business methods of the State Medical Society. The Society now has an income of \$100,000 annually and a proposed amendment to the by-laws, to be acted on at the next annual meeting, provides for a permanent Board of Trustees that will manage the finances of the Society.

The Doctor also advised the doctors to read the Journal, for it contains a record of the various acts and activities of the State and every respect

County Societies. He also referred to the value of the advice of Mr Whiteside, the Counsel of the State Society, and mentioned the legal point that a doctor who in the kindness of his heart, assures a patient of a quick recovery, is liable for damages in the event of death.

The scientific program was as follows

Infections and Mental Disease—Dr William C Garvin, Superintendent of the Binghamton State Hospital

The Clinical Interpretation of the Wasserman Test—Dr W Avery Groat, Syracuse

The Use of Sodium Iodide in Focal Infections—Dr James W Wiltsie, Binghamton

The Accessory Nasal Sinuses (Illustrated with Specimens)—Dr Abram T Kerr, Professor of Anatomy, Cornell University Medical School

A Case of Chronic Juvenile Lenticular Degeneration (Wilson's Disease) (Illustrated with Lantern Slides)—Dr James W Papez, Department of Neurology, Cornell University

The Influence of the Thyroid on Structure and Function in Sheep and Goats (Illustrated with Motion Pictures)—Howard S Liddell, Ph D, Department of Physiology, Cornell University

Dr Garvin described cases of insanity that were caused by infective and exhaustive states with which general practitioners had to deal in the early stages of the mental conditions. He made a plea for a greater consideration of psychiatric states by the family doctor. The staff of the State hospitals go out to several cities in order to conduct clinics at which physicians are welcome. Plans are also being considered to bring fundamental instruction in psychiatry within reach of the family doctors.

Dr Liddell's motion picture talk was on the effects of the removal of the thyroid gland from young sheep and goats.

Moving pictures were exhibited showing the physical weakness and mental dullness of the abnormal sheep and the stimulating effects of thyroid extract given to animals.

The meeting was unusually successful in

## NEWS NOTES

### MEDICAL SOCIETY, COUNTY OF QUEENS

A regular meeting of the Medical Society of the County of Queens was held Tuesday, September 29, 1925, at the Eagle Palace, Jamaica, at 8 30 P M, with the President, Dr Courten in the chair After the minutes of the previous meeting had been read and approved, the following candidates were elected to membership

Doctors James I Schoonmaker, John P Scheneble, Joseph J Schanno and Henry George Peter

Dr Thomas C Chalmers then gave a brief resume of the new medical practice act, framed by the committee of the State Medical Society to be presented to the legislature at its next session

The secretary, in accordance with instructions of the Comitia Minora read the following recommendations (1) a report of the Committee on Illegal Practice of the Department of Health, relative to the Lincoln X-Ray Laboratories, 32 162nd Street, Jamaica and of an investigation of a physician, Dr A S Bughee of Manhattan, one of the proprietors of the laboratories mentioned, (2) a letter from the Queens Council Boy Scouts of America, thanking the society for medical service at Camp Matinecock during the summer, and requesting volunteer physicians for the summer of 1926, and (3) an announcement from the *New York State Medical Journal* of the appointment of Mr Joseph B Tufts as advertising manager, with offices at 17 West 43rd Street, New York City, and a request for individual physicians to approach patients and friends dealing in commodities of interest to physicians, with a view to increase the amount of advertising in the *Journal*

Dr C S Prest, Executive Secretary of the Queensboro Tuberculosis Association made a brief announcement of the motion picture, "Working for Dear Life" now being exhibited by the initiative of his association and blanks for health examination to physicians

He also mentioned the facilities of the association to supply information to physicians relative to sanatoria for tuberculosis patients

In the Scientific Session, in the address by Dr Frank D Jennings, on "Graduate Medical Education" A history of the development of the movement for graduate medical education in Kings County was given, including the Friday afternoon lectures and the work of the Joint Committee for Graduate Medical Education of the Long Island College Hospital and the Kings County Society Dr Jennings emphasized the obligation resting upon organized medicine to promote education of the profession, and showed that the Kings County Society had sensed the need, opportunity and duty Instruction must be fundamental, basic and designed to help individual physicians in the solution of every day problems He also showed that general hospitals can be made teaching centers, available to all physicians in their districts, not merely to the members of its staffs

Dr Thurston Welton of Brooklyn, discussed briefly the address of Dr Jennings

Dr Walter J Highman of New York City, in his talk on "Common Sense in the Management of Syphilis," commented on the complexities concerning the disease, resulting from recent addition to laboratory methods of diagnosis and to the armamentarium for treatment In spite of complexities, a large share of the treatment of syphilitic patients must be undertaken by the general practitioner because qualified specialists are not available for many cases, nor are they necessary in all cases Diagnosis is usually not difficult, and the laboratory will clean up 90% of the doubtful cases In simple every day aspects, the problems of treatment can be met by the general practitioner Dr Highman cited instances where the exercise or lack of exercise of broad common sense was the determining factor successful or unsuccessful issue of the case There was an attendance of 70

### TOMPKINS COUNTY MEDICAL SOCIETY

The September meeting of the Tompkins County Medical Society was held in the Ithaca Chamber of Commerce parlors Tuesday evening the 15th, with about 40 members and visitors present. President John W. Judd in the chair.

This being the first regular meeting since May the minutes of the May meeting were read and approved, also those of the joint meeting with the Cortland County Society in June.

The report of the Comitia was made by reading its minutes.

A communication was read from Dr. Joseph S. Lawrence, Executive Officer of the State Society, suggesting that County Medical Societies deposit any historical relics and old minute books they may have, in the State Medical Library at Albany for safe keeping. This society, having deposited its first record book in the Cornell University Library, it was moved and carried that it be left there for the present.

A communication was read from Dr. Orrin S. Wightman, Editor, *New York State Journal of Medicine*, suggesting that members of County Medical Societies solicit, in their ter-

ritory, advertising for the State Journal, the object being to double such advertising for the coming year.

It was moved and carried that this matter be laid upon the table.

The application of William M. Maloney, M.D., for membership was presented and being endorsed by the Censors he was duly elected.

The request of the State Department of Health that this society suggest such of its members as will be willing to conduct clinics for pre-school children in this county, was presented, and it was moved and carried that Dr. Helen D. Bull be so designated.

The President appointed Drs. Luzerne Co-ville and Henry B. Sutton a committee to present at the next meeting suitable resolutions upon the death of Dr. Jennie G. Seeley.

Arthur L. Holland, M.D., of New York, presented a very interesting and instructive paper on the subject of "Gastric Ulcers" which received the close attention and interest of all present, bringing out a rather full discussion and many questions. After a rising vote of thanks to Dr. Holland the meeting adjourned for lunch.

---

### ORLEANS COUNTY MEDICAL SOCIETY

The regular annual meeting of Orleans County Medical Society was held at Lone Star Inn, Albion, at 4 p. m., Tuesday, September 29, 1925.

The following officers were re-elected for the ensuing year: La Verne F. Waters, Medina, President; John Dugan, Albion, Vice-President; J. K. Durling, Albion, Secretary-Treasurer; Geo. F. Rogan, Medina, John Sutton, Albion, J. F. Eckerson, Shelby, Censors; Delegate to State Society, Dr. J. F. Eckerson, Shelby; Alternate, Dr. R. E. Brodie, Albion.

Dr. J. Arthur Elson was elected to membership.

Dr. Joseph S. Lawrence, Executive Officer of the State Medical Society, gave a talk on "Congenital Syphilis," and illustrated the talk with lantern slides. Dr. Lawrence also spoke on the functions of the county and state society from the standpoint of service to the doctor and the public.

Fourteen members and one guest were present. Dinner was served in the dining room of the inn.



# THE DAILY PRESS



Doctors can offer toxin-antitoxin to the public, but the people will not take it unless they are strongly impressed with its need. There are several methods of educating the people to take the preventive against diphtheria. Dr. William H. Park was the first to demonstrate the practicality of utilizing the schools for giving it to the pupils. The State Department of Health used that method successfully to suppress an epidemic of long standing in the city of Auburn. There, the unusual number of deaths in spite of the use of all the common means of prevention led the school authorities to advocate the administration of toxin-antitoxin to all the children. The imminent danger from a great number of carriers impelled the people almost unanimously to consent to the immunization of the school children. And Dr. Sawyer, the Health Officer, is now having no difficulty in immunizing the young children who are entering school for the first time. (See this Journal, page 973.) The anti-vaccinationists and other unscientific propagandists have probably utilized more newspaper space than doctors and departments of health have used in advocating the serum immunizations, but the tide has turned, and people generally are being educated.

Whenever the immunization of school children has been advocated, a campaign of education has been necessary in order to get the people to consent to its use on their children, and the newspapers have been the principal means of carrying information to them and inducing them to accept the procedure. The toxin-antitoxin campaigns that have been conducted in the smaller cities by the State Department of Health have been excellent demonstrations of the value of newspaper publicity in the medical education of the people.

The diphtheria epidemic in Nome, Alaska last winter afforded an opportunity to do the most effective piece of medical education that had ever been presented through the newspapers. The story of the race to carry antitoxin to the stricken city was as dramatic as that of the rescue of the crew and passengers of a sinking ocean liner, and was fully utilized by the newspapers day after day. The unusual human interest of the story—the dire need of dying children, and the heroic dash of a hundred miles over the snow through an Arctic night—led millions of people to follow the newspaper accounts day after day up to its culmination in the relief of the epidemic.

Contrast this story with that of the story of alleged danger from frozen antitoxin that had been featured in the newspapers only a few months earlier. The antitoxin that was carried

to Nome was frozen in the incredibly low temperature of sixty degrees below zero, and yet it was safe and effective.

When William J. Shannon started on the first stretch of the journey, he set an example which drivers of other dog teams were glad to emulate. Nothing except the compulsion of his own conscience led him to start with his noble dogs at nine o'clock at night to carry the antitoxin sixty miles through the most bitter cold imaginable, and there were others just as heroic as he to continue the journey.

It was fortunate that Shannon was willing to come to New York State with his dog team at the solicitation of public spirited citizens, and lend his influence to toxin-antitoxin campaigns. That he should do this was as proper as that Dr. Grentell should come from Newfoundland and lecture to large audiences who were attracted by his fame as a self-sacrificing physician ministering to a people in dire need. We understand that Shannon is a kindly, modest man, as are all true heroes and lovers of their fellow men.

We are impelled to write this introduction by the receipt of a clipping from the *Olean Times* of September eleventh, describing the visit of Shannon to Olean and the neighboring villages of Cattaraugus County. We believe that the following account from the newspaper is a model as an effective piece of medical publicity.

"William J. 'Bill' Shannon, famous Alaskan 'musher,' who started the antitoxin for diphtheria stricken Nome on the initial part of its eight hundred mile journey was greeted with a great ovation when he appeared in this city today with his 'huskies.' He arrived in the city at eleven o'clock this morning and drove the team to St. Mary's school where a large number of school children and men and women were assembled.

"Prior to the arrival of 'Bill,' toxin-antitoxin was given to seven pupils. The toxin-antitoxin is an absolute preventive of diphtheria while the antitoxin is a cure. It was the antitoxin that was carried to Nome by the Alaskan mushers.

"Shannon was introduced by John Armstrong of the county health association and gave an interesting account of his journey over the frozen snows of the far north. He said:

"'Nome, an isolated town eight hundred miles from the nearest railroad center, Chenana, was stricken by diphtheria and the only possible cure was antitoxin. I was in Chenana at the time and volunteered my dogs and myself to the aid of the stricken people. The antitoxin arrived on the railroad at Chenana and I was there ready

to start I wrapped up my precious package in two furs and a canvas and loaded it on my sled. That was nine o'clock at night. I started at once for the next nearest station, which was sixty miles, and where there was another team ready to carry on.

"When I started it was 50 degrees below zero and I rode for a few miles. When the thermometer drops below 40 degrees, a frost fog settles over the country and it was through this fog that I had to go. It was so dense that I couldn't see my dogs ahead of me, but I knew that my head dog, "Blackie" could guide me through all right as he had been over the same trail many times before.

"After a time the cold became so unbearable that I walked ahead of the team. I was afraid to run behind them because I feared my lungs would freeze and that would cause bleeding of the mouth and eventual death. I finally reached a little road house, the only one between my starting and stopping points.

"After some effort, I aroused the owner and told him to make me a pot of coffee in a hurry. While the coffee was being made, I sheltered my dogs in a lean-to and found that three of them had frozen lungs. I took the antitoxin and placed it among the rafters in the house to let it warm through. After drinking five or six cups of steaming black coffee, I continued on my journey, leaving the three frozen dogs behind.

"I treaded ahead of the team for the greater part of the twenty-eight miles to the station where another team took up the journey. All

of the last part of the trip was made with the thermometer hovering about the 60 degree below mark. I arrived at the station at about eleven o'clock in the morning. My hands and feet were frost bitten and my face was stiffened from the intense cold."

"The dogs that Shannon has with him are part of the team that he used on his heroic trip. The three that were frozen died, but will long be remembered by the citizens of Nome. The trip to Nome was made in five and one-half days. The best time that had been made prior to that was fifteen days, according to Shannon.

"Toxin-antitoxin was also administered to five children at the city hall this noon after which the team departed for Franklinville, where they are scheduled with their master to stage a demonstration before the school children and community. The toxin-antitoxin taken to Franklinville was given to Shannon by Dr. Stephen A. Douglas at St. Mary's school this morning amidst the cheering of hundreds of school children."

History is mostly biography, and current history in the newspapers is always written around some person (see this Journal, August, 1925, page 888). Shannon's contribution to the toxin-antitoxin campaign is based on his thrilling experience which will always make a compelling appeal to all persons, especially to children. Wherever he appears, his presence is a sure antidote for anti-vaccinationist propaganda, and an inspiration for the acceptance of immunization against diphtheria.





# BOOK REVIEWS



**INFANTILE PARALYSIS IN VERMONT, 1894-1922** A Memorial to Charles S. Caverly, M.D. Octavo of 375 pages. Burlington, Vt., State Department of Public Health, 1924

Many will recall that the first epidemic of Infantile Paralysis in this country, occurred in the Otter Creek Valley of Vermont, during the summer of 1894. Dr. Charles S. Caverly, who had been president of the Vermont State Board of Health since 1891, sensed almost immediately the seriousness of the malady. His untiring efforts in a State-wide campaign resulted in the collection of valuable data which was made the basis of an article in the December 1894 issue of the "New York Medical Record."

During the following 24 years with Caverly still at the helm, additional data was collected. In 1914, the most serious outbreak took place, creating a serious problem. His vision was broad—through his efforts an anonymous friend of the State donated a considerable sum of money for the study of the cause and treatment of the disease, from Boston he summoned the late Dr. Robert Lovett while from New York he sought the advice of Flexner and others.

The outcome of their combined efforts is known to all who even have a passing interest in this disease. Much was contributed to the epidemiology by the laboratory workers, a survey of the cripple problem was made—clinics were established at various centers, field workers were trained in details of after care, a brace shop organized and the afflicted frequently re-examined.

All this did Caverly see—in his 27 years as President of the Board—and in September, 1918, passed to the Great Beyond, with his dreams unrealized, but with his heart gladdened by the progress made. How cheered would he have been to have seen the establishment of Kimball Cottage in Boston, where the operative phase was carried on—or to have witnessed the opening of Ormsbee House, a school for the exclusive use of cripples, at Proctor, Vt.<sup>1</sup>

This is a splendid memorial volume. The State of Vermont may well extol Caverly's greatness and add a solemn note of regret for the recent passing onward of that other benefactor to the Green Mountain State, Dr. Robert W. Lovett, of Boston.

DONALD E. MCKENNA

**THE HUMAN TESTIS, ITS GROSS ANATOMY HISTOLOGY, PHYSIOLOGY, PATHOLOGY, WITH PARTICULAR REFERENCE TO ITS ENDOCRINOLOGY, ABERRATIONS OF FUNCTION AND CORRELATION TO OTHER ENDOCRINES, etc.** By MAX THREEK, M.D., Surgeon-in-Chief American Hospital, Consulting Surgeon, Cook County Hospital, Chicago, Ill. 308 illustrations. J. B. Lippincott Co. Phila., 1924.

In this volume the author has endeavored to present all the information obtainable from various textbooks and scientific publications in English and foreign languages on the important subject of the testis. This book is a compact work that embraces and elucidates the important questions relative to the anatomy, histology, physiology, pathology, dystrophias, endocrinology, aberration and other important questions concerning the human testes.

A number of questions relative to the various phases of this work are still unsettled and controverted, especially concerning the endocrinology of the testes. Many of the statements in medical publications are founded as the result of chemical research,

while other are exaggerated, and not based on facts and thereby do more harm than good. Many of the conclusions embodied in this volume are the results of a combination of personal observations associated with laboratory research. All obtainable data contained in the literature as a contribution of other workers have been brought down to date. Relative to the endocrinology of the testes, the author publishes his own findings, and also the surgical application of knowledge gained on sex gland transplantation and all the obtainable data on this phase of the work by his personal acquaintance and communication with many of the investigators in this field of research. There is a full bibliography and many photographs of gross specimens and microphotographs illuminate the text. On the whole, a very readable and complete treatise on the subject.

PHILIP GOLDFADER.

**FIRST STEPS IN ORGANIZING A HOSPITAL. AN EXPOSITION OF IDEALS AND PRINCIPLES INCIDENT TO THE INCEPTION AND ORGANIZATION OF A HOSPITAL.** By JOSEPH J. WEBER, M.A. Editor, *The Modern Hospital*. The Macmillan Co., New York, 1924.

This book would scarcely appeal to those who have given the subject any consideration but may serve a useful purpose to an enthusiastic but uninformed group in attempting to organize a hospital.

The medical profession would no doubt be represented on the committee and would have rather definite ideas of organizing their end of the proposed hospital rather than follow the form laid down in this book. Why pad the book with some sixty pages of examples of forms according to the laws of Illinois, examples of by-laws, form of agreement with architect, etc.?

R. E. S.

**THE SCIENCE AND ART OF ANESTHESIA.** By COLONEL WILLIAM WEBSTER, D.S.O., M.D., C.M., Professor Anesthesiology, University Manitoba Medical School, Chief Anesthetist, Winnipeg General Hospital. Illustrated. The C. V. Mosby Co., St. Louis, Mo. 1924. Price, \$4.75.

As a teacher of anesthesia Dr. Webster has probably felt the need of a brief outline of his subject, and his students, as they have passed through his course year after year have been aided by the use of it. The little paper-covered syllabus we can still remember as one of the essentials of the medical course, it concisely epitomized the subject in a few pages. But why not allow the work to remain in the informal dress of the syllabus instead of making it into a large book by the familiar methods of the publisher?

The subject matter is orthodox. The author's experience as a pathologist has undoubtedly added to his inherent interest in the chemistry of the subject. The chapter on physiology is brief but clear and the discussion of the subjects of shocks, acidosis, the estimation of cardiac strength and the relation of temperature and humidity to postoperative recovery show the marks of practical experience.

The chapters on ethyl chloride in a favorable light and of chloroform in a rather deprecatory way are given more space than usual. As a whole, the book fulfills its purpose of being a sound, sensible guide to the student and the general practitioner in the choice and administration of an anesthetic.

G. W. TONG.

to start I wrapped up my precious package in two furs and a canvas and loaded it on my sled. That was nine o'clock at night. I started at once for the next nearest station, which was sixty miles, and where there was another team ready to carry on.

"When I started it was 50 degrees below zero and I rode for a few miles. When the thermometer drops below 40 degrees, a frost fog settles over the country and it was through this fog that I had to go. It was so dense that I couldn't see my dogs ahead of me, but I knew that my head dog, "Blackie" could guide me through all right as he had been over the same trail many times before.

"After a time the cold became so unbearable that I walked ahead of the team. I was afraid to run behind them because I feared my lungs would freeze and that would cause bleeding of the mouth and eventual death. I finally reached a little road house, the only one between my starting and stopping points.

"After some effort, I aroused the owner and told him to make me a pot of coffee in a hurry. While the coffee was being made, I sheltered my dogs in a lean-to and found that three of them had frozen lungs. I took the antitoxin and placed it among the rafters in the house to let it warm through. After drinking five or six cups of steaming black coffee, I continued on my journey, leaving the three frozen dogs behind.

"I treaded ahead of the team for the greater part of the twenty-eight miles to the station where another team took up the journey. All

of the last part of the trip was made with the thermometer hovering about the 60 degree below mark. I arrived at the station at about eleven o'clock in the morning. My hands and feet were frost bitten and my face was stiffened from the intense cold.

"The dogs that Shannon has with him are part of the team that he used on his heroic trip. The three that were frozen died, but will long be remembered by the citizens of Nome. The trip to Nome was made in five and one-half days. The best time that had been made prior to that was fifteen days, according to Shannon.

"Toxin-antitoxin was also administered to five children at the city hall this noon after which the team departed for Franklinville, where they are scheduled with their master to stage a demonstration before the school children and community. The toxin-antitoxin taken to Franklinville was given to Shannon by Dr. Stephen A. Douglas at St. Mary's school this morning amidst the cheering of hundreds of school children."

History is mostly biography, and current history in the newspapers is always written around some person (see this Journal, August, 1925, page 888). Shannon's contribution to the toxin-antitoxin campaign is based on his thrilling experience which will always make a compelling appeal to all persons, especially to children. Wherever he appears, his presence is a sure antidote for anti-vaccinationist propaganda, and an inspiration for the acceptance of immunization against diphtheria.

rative well shows. The book is written in the scientific manner, but in very readable form for the layman

Lister was early impressed with the destructive consequences of suppuration, and at once began the study of its causes and possible prevention. No flight of scientific inspiration led him to his theory of antiseptics, but step by step he worked up to the demonstration of the value of antiseptics, notably carbolic acid. Other problems in wound healing were patiently worked out by him, especially that of the absorbable ligature, resulting in the use of catgut, properly prepared.

The story of Lister's success provides inspiration and example to every young surgeon. His education and training were from the start on broad and scientific lines. At no time was he diverted from his great interest in his profession or his purpose to work up into the higher places in Surgery, then a much smaller field than today. His expressed high ideals in his work, his gentleness in the handling of patients, the beautiful touches of family life as shown in his correspondence, all indicate the great refinement of his nature.

It is to be hoped that a special edition of this work may be brought out at a low price, to bring it more widely into the hands of physicians and students

R. W. W.

**INSULIN IN GENERAL PRACTICE. A Concise Clinical Guide for Practitioners.** By A. CLARKE BEGG O.B.E. M.D., Ch.B., M.D. 12mo of 130 pages, illustrated. London, William Heinemann, 1924 Cloth, 5s

The book is well described by the title and gives a very good general idea of the principles of treatment of diabetes mellitus

The usual laboratory tests are first described, MacLean's method of blood sugar estimation being given. The author still occasionally uses Graham's ladder diet but generally follows what seems to be the best procedure at present, that is, to give the patient a maintenance diet and see how he handles it. The average patient who is not confined to bed is given a diet of about 2,300 calories of carbohydrate 70 grams, protein 80 grams and fat 185 grams. This diet the author calls the "Standard" diet and states that a few can do with less and some require more. A fast day once a week is recommended. A number of standard diets are given attention being given to the cost. Nearly all provide for the English afternoon tea.

The standard diet given seems higher than is often necessary except for a man doing physical work, as many patients are satisfied, maintain a proper body weight and can do without insulin on diets of from 1,700 to 2,000 calories. This is especially true of rather elderly and obese patients.

The closing chapters describe the treatment of acidosis coma and gangrene. The book is highly recommended as an excellent guide and gives in a brief manner a very good idea of the subject

W. E. McCOLLUM

**TEXTBOOK OF DIFFERENTIAL DIAGNOSIS OF INTERNAL MEDICINE.** By M. METTHES M.D. Authorized translation of the fourth German edition with extensive additions by I. W. Held M.D. and Mr. H. Gross M.D. Royal octavo with 908 pages with 176 illustrations. Phila. P. Blakiston's Son & Co. 1925 Cloth \$12.00

With this translation of the fourth German edition this excellent textbook makes its first appearance in English. The author has the faculty of presenting his subject in an accurate, compact and practical form easily read, understood and retained. The subject matter includes apparently all useful information concerning the differential diagnosis of related or confusing conditions. The translators have added to the value of the volume by presenting their own comments and opinions and giving also the American view of many diagnostic points. The book is printed upon heavy paper in easily read type, and is well illustrated. This is a valuable book not only for reference but for information and study.

HEURY M. MOSES

**CLINICAL MEDICINE FOR NURSES.** By PAUL H. RINGER, A.B.M.D. Second Edition, revised. 12mo of 306 pages, with illustrations. Phila., F. A. Davis Co., 1924 Cloth, \$2.50

This book represents the substance of a series of lectures delivered for several years at the Asheville, N. C. Mission Hospital. Symptoms and their meaning and complications have been treated rather than bacteriology and pathology, as the author states in the preface.

All the common diseases are described in a brief manner. The volume is a very good one for the use of training schools which give a full course.

W. E. McC.

**DISEASES OF THE HEART.** By Dr. HENRI VAQUEZ. Translated and edited by GEORGE F. LADLAW, M.D. Octavo of 743 pages, illustrated. Philadelphia and London, W. B. Saunders Company, 1924 Cloth, \$3.50

Vaquez's introduction of twelve pages so faithfully sketches the steps in study and investigation of cardiac disease, by which we have reached our present day conceptions, and is so finely done that it not alone constitutes a valuable feature of his volume but it sweeps the ground from under the feet of those who would spurn the lessons of the past and neglect to acknowledge the debt of modern medicine to the masters now gone.

We pick up this book hoping to gain a view of cardiology from the French standpoint and we are not disappointed. Vaquez has done his utmost to give us comprehensively the French story of heart disease in its various phases, and while he naturally stresses the contributions of his Gallic compatriots, it cannot be said that he neglects the facts of research as developed in other countries.

The volume has riches in every chapter, and not the least is the full bibliography at the end of each.

Every cardiologist writes with a certain classification in mind and it is interesting to note that Vaquez follows the anatomic grouping although he stresses etiology throughout. This arrangement is outstanding, when we consider the etiologic grouping of the Boston school and the physiologic classification of the English writers.

The style is inviting. Thayer in his introductory remarks comments on the graphic description of angina pectoris, and this chapter is typical of the book. Prolonged Subacute Endocarditis is a subject that is characteristically well presented, and here American investigators receive special notice.

Syphilis of the heart is accorded discussion in the compass of 14 pages, and would possibly merit more extended remarks when the size of the book, 743 pages, is considered. Radiology is discussed in 15 pages and is a subject in which the investigations of the author are noteworthy, Bordet being a co-worker in the studies. Eighteen pages are devoted to the electrocardiograph, and here Vaquez emphasizes the point that bedside observation still outweighs laboratory diagnosis.

Blood Pressure is discussed in a chapter of 28 pages and Arterial Hypertension in an interesting chapter of 32 pages. The author summarizes his views by stating that hypertension is the result of over-activity of the chromaffin system renal and vascular lesions appearing later.

Gallop rhythm is held to be due to vibration of the degenerated ventricular wall dilating suddenly in early diastole. The opinions of the distinguished author are given with considerable emphasis, although he modestly states that the "book is probably incomplete, but in it I have at least said all that I know."

In treatment, discussion is thorough and Strophanthus receives kinder criticism than is usual in America. These final chapters round out a volume of great value, which it is a privilege to have translated into English.

FRANK BETHEL CROSS

**THE CHILD-HEALTH LIBRARY** A Series of ten books by practicing specialists Edited by JOHN C GEBHART Pocket-size volumes, published by Robert K. Haas, Inc., New York. 1925 Price of set, with book-ends, \$3.00

**Vol. I Prenatal Care and the Baby's Birth** By Harbeck Halsted, M.D. In the introduction by Haven Emerson, M.D., occur these words, which are a fitting commentary on the series "Health is as personal as work or play, however much we may hear of public health, public health works, and the public playground"

So the authors of these health stories have acted, as it were, like honest trustees of science, and are putting before you, the beneficiaries of all knowledge, the information you need to bring to you and yours, health, and perhaps (with it) beauty of person and character"

**Vol. II Babies—Their Feeding and Care** By Louis C Schroeder, M.D. This is a valuable short summary for the mother interested in the ordinary diet and hygiene of babies up to two years.

**Vol. III The Neglected Age. The Child from Two to Six.** By Bernard S Denzer, M.D. This includes diet, games, books, and mental hygiene.

**Vol. IV Dangers of the School Age.** By Alice Asserson, M.D. Among other things are given some of the symptoms that may be a warning to the mother of the onset of an acute illness.

**Vol. V Communicable Diseases of Childhood.** By Stafford McLean, M.D. A short, readily understood summary of infection and immunity precedes the individual diseases.

**Vol. VI Hygiene of the Mouth and Teeth** By Thaddeus P Hyatt, DDS. The advice given for lancing the gums seems like returning to the good old days of fifty years ago, and if the child is in the hands of a competent physician it will be spared this unnecessary pain.

**Vol. VII What Children of Various Ages Should Eat.** By Lucy Gillett, M.A. Caloric values interpreted in terms of common measure bring caloric feeding to any mother.

**Vol. VIII How Children Ought to Grow** By John C Gebhart. Improvement could be made in the height, weight and age tables.

**Vol. IX Psychology of the Child.** By David Mitchell, Ph.D. Very valuable.

**Vol. X. Educational Problems** By David Mitchell, Ph.D. Intelligence tests are evaluated.

The set is put up in a neat box, and a pair of book ends goes with each set. The title of each volume is stamped on the cover, and could be made plainer if it were colored.

The set is distinctly valuable to the mother with the growing child, and if she will follow the advice given to consult the physician, some of the peculiar advice will do no harm.

ARCHIBALD D SMITH

**AN OUTLINE OF ENDOCRINOLOGY** By W M CROFTON B.A., M.M. 12mo of 126 pages with illustrations. New York: William Wood and Company, 1925. Cloth, \$2.25

The author has succeeded in bringing together in a readable manner the most important facts in endocrinology, especially the anatomy, pathology and histology of the glands of internal secretion. The glands discussed are the pineal, pituitary, thyroid, thymus, parathyroid, suprarenal, gonads, gastro-intestinal mucosa and pancreas.

Organotherapy or the practical handling of endocrinology is not dealt with in as discriminating or critical a manner as the microscopic or chemical end. There is a tendency to accept as the last word in therapy his own personal results, especially with pluriglandular products and with pancreatic extracts which he gives by mouth and which in his opinion serve equally as well as insulin.

The term "adapter" is proposed as a generic term for all the different co-ferments produced by the pancreas. He advances the hypothesis that in diabetes the cells of the body, owing to the absence of the pancreas co-ferments, are thrown back into the condition of pre-placental days and need the food which they were obtaining then.

The book is well written and should prove of interest to those who wish a good description of the histology and pathology of the glands of internal secretion.

M B GORDON

**MEDI-CULT The A-B-C of the Medical Profession.** By B F LORANCE, M.D. Octavo of 73 pages, illustrated. Boston, Richard G Badger, 1924. Boards, \$2.50

This book is very well written. We would have wished the author had utilized his excellent style to give the reading public some larger work, choosing a greater scope for his purpose.

As it is, it will repay layman and cult-worshiper to learn, not only the "A.B.C." of the Medical Profession, but the truth about the many Cults that constantly force their way into the minds of the credulous sick and suffering. Here these Cults are shown with their camouflage removed.

The simplicity and clarity with which the subject is presented is most noteworthy.

This little book may do more to open the eyes of the outraged public than has all the venom cast upon these—Osteopaths, Chiropractors, etc., by all the Medical Societies for years.

HARRY APPEL.

**PRACTICAL ANAESTHETICS** By H EDMUND G BOYLE, OBE, M.R.C.S., L.R.C.P. and C LANGTON HEWER, MB, BS, M.R.C.S., L.R.C.P. Third Edition. London, Henry Frowde and Hodder & Stoughton, 1923. 12mo of 187 pages, illustrated. Cloth, \$2.00 (Oxford Medical Publications)

This, the third edition, is a small volume with a title which describes its content. It discusses the theory of anesthesia very little and covers quite completely the practical administration of the various anesthetics and the use of the different types of apparatus which are popular across the water.

It is interesting to learn the English point of view in anesthesia, even though it differs from ours. Boyle and Hewer appear to give chloroform the favored place in their choice of anesthetic, to judge by the fact that twenty pages of the book are devoted to it, while the discussion of ether is completed in twelve pages. Still in comparison with earlier English books on anesthesia we find that the modern methods of using nitrous oxide and ether approach more nearly what we are accustomed to in this country.

G W TONG

**LORD LISTER.** By Sir RICHMAN JOHN GODLEE, Bt KCVO, MS, FRCS. Third Edition, Revised. Oxford University Press, American Branch, New York, 1924. Price \$7.00

This edition of the biography of Lord Lister is little changed from the two preceding editions. Notes have been added in the text, and a summary of the latest methods of wound treatment is appended for comparison with those practised by Lister.

The recent death of the author, Sir Rickman J Godlee Lister's nephew, makes it unlikely that the work will undergo further revisions. It stands, therefore, as a classic in medical biography, and might well claim a place in the library of every surgeon and every medical student.

It is a fascinating story of achievement by a balanced logical mind which by persistent observation and industry reached conclusions which opened up to humanity the enormous blessings of the antiseptic treatment of wounds. It is difficult for the present day student to realize the horrors of preantiseptic days, which the nar-

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 23

NEW YORK, N Y

NOVEMBER 1, 1925

## THE PROBLEM OF THE CHRONIC CARDIAC CRIPPLE— A GENERAL SURVEY \*

By JAMES B HERRICK, M.D.,  
CHICAGO ILL.

THE popular conception of heart disease, a conception shared by not a few doctors, is of an affection incurable, liable or likely to cause sudden or dropsical death, and for which practically nothing can be done. No prevention, no treatment except digitalis and rest, no prospect except an invalid's life of useless inactivity, an early, and generally a sudden death. This conception is due partly to an element of truth, partly to tradition that in passing truth from one generation to another is prone to distort facts, partly to the influence of the staggering figures showing the enormous death rate from disease of the heart and blood vessels.

It is the primary purpose of the recently organized Heart Associations, a purpose in which State and other medical societies, together with the general practitioner, will surely join, to try to improve these figures, to lessen the incidence of heart disease, and to lengthen out the life of the cardiac sufferer so that he may have a reasonable opportunity of dying the old man's death from pneumonia or at least be offered a fair chance of death in a hold up or in an automobile accident.

In the second place these associations wish to combat the erroneous that is contained in the conception to which reference has been made. They desire to educate doctors, patients and the public to a knowledge (1) that in some measure heart disease may be prevented, (2) that to a large degree an early cardiac breakdown may be forestalled, (3) that a single breakdown does not necessarily spell disaster, future invalidism and early death, (4) that knowledge of the nature of the illness with readjustment of living and working conditions may often transform the cardiac cripple from a timorous, dependent invalid into a wage-earning, self-respecting citizen.

It must be admitted that with our present imperfect knowledge of the cause of rheumatism

\* Read at the Annual Meeting of the Medical Society of the State of New York, at Syracuse, May 13 1925

and chorea and our inadequate methods of treating these diseases a large proportion of cases of acute carditis cannot be prevented. This is to be deplored for acute rheumatic carditis is the forerunner of much of the chronic cardiac invalidism. Nor can we claim very striking results in warding off the degenerative processes that accompany the marching years or the conditions that induce premature arteriosclerosis and atheromatosis with their serious cardiac effects. Yet the prevention when possible, the intelligent and thorough treatment when prevention has failed, of such infectious diseases as rheumatism, chorea, scarlet fever, diphtheria, tonsillitis and syphilis will help to prevent the development of heart complications. Preaching the gospel of moderation as opposed to that of the strenuous life with its numerous phases of speed mania may ward off many an early manifestation of high blood pressure, enlarged heart or angina pectoris.

If the objection be raised that I am speaking beside the question, as the topic assigned is not how to prevent heart disease but what to do with the individual who has it, I may fairly retort that the most logical and efficient way to treat the chronic cardiac cripple is to annihilate the disease that causes the crippling. I am not straying from the text if I stress the fact that in every way we should encourage all efforts to solve the question of rheumatism, its cause, its communicability, its early detection especially in its milder and atypical forms, the means of warding it off, and its specific treatment. Accurate scientific knowledge on these points rather than empirical guess work is the greatest need today in our contest against heart disease. May the investigations of Dr Swift and all others similarly occupied be rewarded by the results they so well deserve.

But to speak more directly of the problem of the chronic cardiac cripple.

The clinics that are under the tutelage of the Heart Associations have a serviceable classification of patients with heart disease with which

**DISEASES AND DEFORMITIES OF THE FOOT** By JOHN JOSEPH NUTT, B.L., M.D., F.A.C.S., Professor Orthopedic Surgery, Polyclinic Medical School and Hospital, Surgeon-in-Chief, New York State Orthopedic Hospital for Children. Second Edition, completely revised. E. B. Treat & Co., New York, 1925. Price, \$4.00.

The author discusses diseases and deformities of the foot, both those limited to the foot alone, and those where the foot lesion is part of a condition affecting other parts of the body.

Although the book is intended for the use of the general practitioner who has had no special training in orthopedics, we doubt very much whether the wish of the author is fulfilled, particularly as regards enabling the physician to treat foot deformities, after studying the text. We must remember that the treatment of deformities of the foot, as well as deformities of other parts of the body, requires a working knowledge of certain definite mechanical principles which require time to learn and considerable experience to apply properly.

However, we believe the book is of value in acquainting the physician with the various deformities so that he may intelligently advise the patient as to what should be done.

The section on club foot and infantile paralysis is particularly thorough and well presented.

J B L.

**PATHOLOGY AND BACTERIOLOGY OF THE EYE.** By E. TREACHER COLLINS, F.R.C.S., and M. STEPHEN MAYOU, F.R.C.S. Second Edition. Octavo, 731 pages, 306 illustrations, four colored plates. Philadelphia, P. Blakiston's Son and Co. 1925. Cloth, \$10.00.

To those of the younger generation of ophthalmologists the third edition of this work comes as a boon long needed. This is easily seen, first, because of its wide reputation handed down, and secondly, because of its peculiarly valuable text. This book approaches the subject from an angle which is very hard to find simulated in other works. Could we now have a new edition of Parson's famous work, with an appendix by Verhoeff, our minds would feel once again that our studies could be more orderly arranged.

Collins and Mayou supply a need which we can get in no other way, namely, in the vast and obscure subject of neoplasms. It seems to the reviewer that the ophthalmologists of fifteen or twenty years ago had a better and more evenly balanced library than is possible to get now from modern books, and it is to be hoped that this revision is but a beginning of the renaissance to come.

J N EVANS

**THE LIFE OF SIR WILLIAM OSLER** By HARVEY CUSHING. Two volumes. New York, Oxford University Press, 1925. Cloth, \$12.50.

*I will make a man more precious than five gold*  
—ISAIAH, xiii 12

This great work of Harvey Cushing, in two volumes, is everything a biography ought to be. The brilliant career of the extraordinary Celt (his make-up was that of the Welsh mother, not of the Anglo-Saxon father) yclept Osler who came to us and to the whole world of medicine out of his Canadian homeland, is painted so graphically upon Cushing's broad canvas that the man and his significance can be fully understood. Every incident or personage that shaped his life seems not to have been overlooked. It is the most satisfactory and the most absorbing biography that a medical man could read today.

The first volume covers the Canadian (1849-1884) and United States (1884-1905) periods, while the second one embraces the Oxford epoch (1905-1919).

This great "inseminator of other men's minds" is fortunate in his biographer, who succeeds surpassingly in portraying a rare spirit linked in some magical way with

the choicest souls of the past, he is a high priest of the pen who initiates one happily into Eleusinian mysteries, of course, the pervasive charm of the work is at bottom the charm of Osler, made to live again, it is a triumphant union of great art and a great subject.

Osler's uniqueness in his tremendous influence upon the mass of the profession even more than upon those in the forefront, which influence will increasingly affect all the medical men of posterity, is made clear in this biography. It is his fine intellect and gracious soul, shining especially out of his non-technical writings, that will rank him in the hearts of his fellow physicians, not less than his achievements for public health and for bedside teaching and its correlation with pathology as revealed in the mortuary.

The dying humanist showed his sunny nature equally with the living man of affairs. His whimsicalities and thoughtfulness concerning others even while passing slowly through the shadows of the valley was characteristic of the man. In many respects the most remarkable passages in the biography are those detailing Osler's last days.

Even the war and the loss of his son Revere at the front did not alter the humanist's traits of character and perspective, so deep-buttressed were they in sweetness and in light. Here we have the full measure of the man.

In the Westminster Abbey of medical fancy he belongs with those in the most sacred corner, under a rose-window of memory which shall be forever lit by the glow of his colleagues' affection.

A. C. JACOBSON

**X-RAY ATLAS OF NORMAL AND ABNORMAL STRUCTURES OF THE BODY** By ARCHIBALD M'KENDRICK, F.R.C.S. (Edin.), D.P.H., F.R.S.E., Surgeon-in-Charge Surgical X-ray Department, Royal Infirmary, Edinburgh, and CHARLES R. WHITTAKER, F.R.C.S. (Edin.), F.R.S.E., Assistant Lecturer Anatomy, Surgeon's Hall. William Wood & Co., New York and Edinburgh. 1925. Price, \$10.00.

This work is made up of a series of radiograms of normal and abnormal structures of the body. These radiograms are in general well reproduced. The part of this work devoted to abnormal structures includes injuries and diseases of the bones and joints, including tumors of the bone. There are also some plates of common pathological conditions found in the gastro-intestinal tract and genito-urinary system.

This work should serve as a book of reference, especially to the beginner in Roentgenology.

J G W

**LABORATORY DIAGNOSTIC METHODS. PATHOLOGICAL, BACTERIOLOGICAL, SEROLOGICAL AND CHEMICAL.** A manual for physicians, medical students and laboratory technicians. By JOHN A. KOLMER, Professor Pathology, Graduate School of Medicine, University of Pennsylvania, and FRED BOERNER, Associate in Bacteriology, Graduate School of Medicine, University of Pennsylvania. D. Appleton and Co., New York, 1925.

The value of this work is so incontestable that little need be said regarding it. In the first section the clinical pathological examinations are described fully and concisely. The subjects have been so well covered that nothing of importance has been omitted. In Section 2, is presented the bacteriological methods for examination, this is followed by a section devoted to clinical serological methods and the closing part of the volume discusses blood analysis. The various examinations are arranged in such brief yet comprehensive descriptions that the book is invaluable to the practitioner and laboratory worker who wishes a dependable working manual for time saving reference. This book should form a part of the library of every pathological laboratory.

R E CAMPBELL

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 23

NEW YORK, N Y

NOVEMBER 1, 1925

## THE PROBLEM OF THE CHRONIC CARDIAC CRIPPLE— A GENERAL SURVEY\*

By JAMES B HERRICK, M.D.,  
CHICAGO ILL.

THE popular conception of heart disease, a conception shared by not a few doctors, is of an affection incurable, liable or likely to cause sudden or dropsical death, and for which practically nothing can be done. No prevention, no treatment except digitalis and rest, no prospect except an invalid's life of useless inactivity, an early, and generally a sudden death. This conception is due partly to an element of truth, partly to tradition that in passing truth from one generation to another is prone to distort facts, partly to the influence of the staggering figures showing the enormous death rate from disease of the heart and blood vessels.

It is the primary purpose of the recently organized Heart Associations, a purpose in which State and other medical societies, together with the general practitioner, will surely join, to try to improve these figures, to lessen the incidence of heart disease, and to lengthen out the life of the cardiac sufferer so that he may have a reasonable opportunity of dying the old man's death from pneumonia or at least be offered a fair chance of death in a hold up or in an automobile accident.

In the second place these associations wish to combat the erroneous that is contained in the conception to which reference has been made. They desire to educate doctors, patients and the public to a knowledge (1) that in some measure heart disease may be prevented, (2) that to a large degree an early cardiac breakdown may be forestalled, (3) that a single breakdown does not necessarily spell disaster, future invalidism and early death, (4) that knowledge of the nature of the illness with readjustment of living and working conditions may often transform the cardiac cripple from a timorous, dependent invalid into a wage-earning, self-respecting citizen.

It must be admitted that with our present imperfect knowledge of the cause of rheumatism

and chorea and our inadequate methods of treating these diseases a large proportion of cases of acute carditis cannot be prevented. This is to be deplored for acute rheumatic carditis is the forerunner of much of the chronic cardiac invalidism. Nor can we claim very striking results in warding off the degenerative processes that accompany the marching years or the conditions that induce premature arteriosclerosis and atheromatosis with their serious cardiac effects. Yet the prevention when possible, the intelligent and thorough treatment when prevention has failed, of such infectious diseases as rheumatism, chorea, scarlet fever, diphtheria, tonsillitis and syphilis will help to prevent the development of heart complications. Preaching the gospel of moderation as opposed to that of the strenuous life with its numerous phases of speed mania may ward off many an early manifestation of high blood pressure, enlarged heart or angina pectoris.

If the objection be raised that I am speaking beside the question, as the topic assigned is not how to prevent heart disease but what to do with the individual who has it, I may fairly retort that the most logical and efficient way to treat the chronic cardiac cripple is to annihilate the disease that causes the crippling. I am not straying from the text if I stress the fact that in every way we should encourage all efforts to solve the question of rheumatism, its cause, its communicability, its early detection especially in its milder and atypical forms, the means of warding it off, and its specific treatment. Accurate scientific knowledge on these points rather than empirical guess work is the greatest need today in our contest against heart disease. May the investigations of Dr Swift and all others similarly occupied be rewarded by the results they so well deserve.

But to speak more directly of the problem of the chronic cardiac cripple.

The clinics that are under the tutelage of the Heart Associations have a serviceable classification of patients with heart disease with which

\* Read at the Annual Meeting of the Medical Society of the State of New York, at Syracuse, May 13 1925

you are probably familiar. It is based on the capacity of the heart to perform its function. They have a class in which the heart shows no disability, another with slight disability, another with marked disability, etc.

For my purpose this afternoon I wish to modify the classification a little and to make five groups of patients with heart disease: 1. the chronic cardiac cripples. It is not intended to supplant the other, it would not answer the purposes of the clinic, but it may help to get before us in a little clearer light some of the salient features of the problem.

The five groups of cardiac cripples are as follows:

1 Patients who have no heart disease but think they have.

2 Patients who have heart disease but think they have not, at least they are ignorant of the fact.

3 Patients who have heart disease, who know it, who think they are incapacitated for all work and doomed to early death, but who are mistaken in their belief.

4 Patients who have heart disease but refuse, or are unable, to act on proper advice as to its management.

5 Patients who have heart disease, know it, are willing and able to accept, and to act in accordance with, advice as to its proper management.

May I call attention a little more in detail to some of the features of these five groups?

*Group 1* The patient has no heart disease but thinks he has.

In all the cardiac clinics the percentage of referred and visiting patients found on examination to be non-cardiac is large. Yet they have come to the doctor in the clinic just as others go to the specialist or to the family doctor because they—or perhaps the anxious parent—think they have some affection of the heart. A little palpitation or a spell of breathlessness, fatigue and anxiety from watching the last hours of a mother's cardiac breakdown, the news of the sudden anginal death of a friend, reading or gossip concerning the symptoms and dangers of heart disease may be sufficient to arouse fear and even to start mimicry in the one who is susceptible and neurotic. And often it is the doctor who thoughtlessly though in innocence, lets fall the hint as to low blood pressure, weak or rapid heart action, a faint murmur or lack of perfect rhythm, together with a word of caution as to over-exertion, which hint arouses in the impressionable individual a dread of the disease that is sometimes almost as bad as the disease itself. I am not including in this list the so-called irritable heart, an innocent extrasystole, certain types of tachycardia, or sinus arrhythmia, for while these are generally not serious they are definitely

cardiac in their manifestations and must be so classed.

It is in this type of case that the trusted family doctor, the wise specialist or the patient dispensary physician can by thorough examination, frank explanation, tactful suggestion and encouragement give reassurance and hope to one who is often sorely and genuinely distressed because of worry over the fancied disease.

*Group 2* The patient has heart disease but does not know it. He comes in for symptoms not recognized by him as cardiac. Perhaps the lesion is discovered in a routine health examination or accidentally during some acute illness or accident. Here is the opportunity to inform and to educate so as to prevent an early breakdown. He must be guarded against the danger of doing that which is liable to harm him. It may be unnecessary to tell the patient, perhaps only the parents need know. The blunt assertion that heart disease exists, that activity must be restricted may cause anything but favorable results. The utmost tact is required. There are honest, helpful yet gentle ways of telling a man he has even angina pectoris.

*Group 3* The patient has heart disease but is overfearful concerning it and especially is apprehensive regarding exercise. The anxious mother forbids the child to play, the adult feels that he takes his life in his hand if he walks up a flight of steps.

Instruction is needed here. It may be necessary to emphasize that not only may some hearts endure the strain of moderate exercise but some hearts need such exercise. Many individuals should be told that from the cardiac standpoint they may, can, and must work.

Two years ago a group of young women in Chicago opened a summer camp for a few weeks to cardiac children, *Group A*. These women were astonished to be told that the third floor of the building would be available, that the children would easily manage the stairs. They were relieved of anxiety when at the end of the season they found that all the children had gone through the summer not only unharmed by the stairs but benefitted by the outing and they admitted that they had learned much as to the capacity for exercise of a damaged heart.

*Group 4* The patient has heart disease but will not or cannot act on the advice given. He may decline through ignorance, or through obsession as to the value of certain cults, or the stress of poverty or the urge of riches may make him feel unable to do as he is told. All that the doctor or the clinic can do here is to advise, persuade or perhaps put the patient in touch with agencies that will make it possible for him to carry out the physician's directions.

*Group 5* The patient has heart disease, knows



What to do for these five groups? How to do it? How to get the first four groups into the last group where the patient is amenable to treatment? It is a big problem, involving many contacts—the patient, the home, the school, the workshop, the office, the employer, the compensation board, the employee, the union, the public health department, the family doctor, the clinic, the dispensary, the hospital, the convalescent home, the social service department, the vocational guidance organizations and many others, contacts that are medical, humanitarian, social, economic

The task though formidable is not impossible. It involves chiefly two things, first, the finding of the patients and then the education of doctors, patients and the public as to the proper management of these cases

Surveys of schools, examination of workmen, spread of the doctrine of periodic health examinations, attention to this matter on the part of family doctors will result in a disclosure of the cardiac cripples

In the matter of education we should begin with ourselves. Few of us are as wide awake as we should be to the magnitude of this question, to its importance and to the possibilities of good that may result. As has been said we need more accurate knowledge as to the cause of rheumatism and arteriosclerosis. Clinical and laboratory research should be encouraged. We should have more definite knowledge as to the communicability of rheumatism, chorea, tonsillitis and some of the purpuras. The lesson should be hammered home that the prevention of syphilis and its early intensive treatment will lessen the number of cases of heart disease in young adults and those older. Gonorrhoea, tonsillitis, scarlet fever should be viewed as dangerous from the standpoint of possible acute or chronic carditis. Prolonged rest in rheumatic carditis should be more generally practiced. Many physicians need elementary schooling in physical diagnosis of the heart, not so much that they may be able to detect a change in size, an altered rate or rhythm or an adventitious sound as that they may interpret such finding sanely and not extravagantly.

And how much there is in the way of education of the patient—the home life, the type of exercise, the appropriate diet, the school, occupation, marriage, childbearing. These features will, I am sure, be brought out by others and need not be here dwelt upon.

Hospitals, dispensaries, clinics need education. Too often the hospital in its desire for rapid turn over discharges the patient with a cardiac breakdown too early. It should be shown the error of such an act. The dispensary and the cardiac clinic, the latter the connecting link between the patient and his home, the workshop and the hospital, should be made to realize—I think most of them do realize—the opportunity they have for studying these cases as individuals, for treat-

ing them by advice and drugs, and through the indispensable social service department seeing that the patient lives as directed.

The public must be made to see that the heart problem is not simply one of how best to care for a hopeless invalid, not simply one of charity and kindheartedness. It must be made to see as well its sociologic and utilitarian aspects. The man with heart disease may be 25, 50 or 75 per cent efficient as a worker and wage earner. With work suited to his physical condition he may make good up to 100 per cent. He need not necessarily be an object of charity for whose support the community is taxed, he may himself become a taxpayer or a taxdodger. He may be converted from a liability into an asset. It was estimated that in one year in a small cardiac clinic in Chicago \$26,000 had been earned by patients who without the instruction as to the nature of their illness, the proper use of drugs, etc., would have earned nothing, but would have been dependent on others for support.

All this implies education and what is commonly called propaganda. Interest must be aroused and maintained. The clinic is the informing focus from which productive information is to emanate, because instruction is here not alone didactic, it is practical. One case thoroughly studied by doctor and social worker in its medical and social aspects, followed up at home, school and factory is worth more from the missionary point of view than gospel tidings proclaimed in a lecture or pamphlet. The concrete example of the case benefitted is the best kind of advertisement of the cause.

Still, the more fortunate class of people, those higher in the social scale, will be more effectively reached at first at least, by means of talks, lectures, newspaper and magazine articles and bulletins. We have had in Chicago a very useful help in our Heart Association Bulletin published at frequent intervals. The Health Department has asked us to get out one number of its monthly bulletin.

The Chicago Heart Association was asked if it would not for publication in the *Journal of the Manufacturer's Association* answer the question why today so many prominent men were dying of heart disease. One of our members saw his opportunity and in his reply informed the editor that men of wealth and prominent had no monopoly on heart disease, the poor and the middle class were also afflicted. He invited the co-operation of these men of wealth and influence in trying to find out how the tragedies and fatalities of heart disease, among rich and poor, might be lessened.

The influence of the Heart number of *The Survey* has been, I am sure, widespread and helpful.

I fear I have yielded to the temptation offered

by the very broad topic assigned me—a general survey of the problem—to speak rather vaguely and in discursive manner. If I sum up the few points I have tried to make it would read somewhat as follows:

The problem is to correct erroneous notions concerning heart disease and erroneous practice, it is to arouse public interest and to see that this interest is intelligent because enlightened by the spread of accurate and scientific information, to foster laboratory and bedside research, to back up the efforts of the general practitioner, the specialist, and particularly the doctor in the clinic and the social worker, all those who come into

close personal contact with the patient, recognizing that these represent the backbone, the brain and cord of the movement without which it will collapse and its efforts be incoordinate and fruitless, to encourage the convalescent home, to assist in occupational training and occupational placement.

In short it is, so far as possible, to prevent the disease, to prevent the early breakdown, to prevent the consigning of the cardiac cripple to the junk heap. When, and if, all these efforts fail, to see that the days of the final breakdown are made as happy and free from suffering as possible.

## STATISTICAL ASPECTS OF THE PROBLEM OF ORGANIC HEART DISEASE\*

By LOUIS I DUBLIN, Ph.D.,

NEW YORK CITY

**H**EART disease in its various manifestations is first in the order of causes of death and, I am inclined to think, the first also in the amount of damage it does through disability and invalidism. The evidence for mortality is much more complete and decisive so that I shall give that first. The annual quota of deaths in the United States is now close to 200,000. If present conditions continue, one in every five of the population living at age of 10 will eventually succumb to organic heart disease. The child at ten years of age is now three times as likely to die eventually from heart disease as from tuberculosis. At age 35, the probability of dying eventually from heart disease is, among males, nearly four times that for tuberculosis and, among females, the probability is almost six times that for tuberculosis. A revolutionary change has taken place in the general mortality picture during the last twenty-five years coincident with the development of preventive medicine and the public health movement.

It is also very likely that the pre-eminence of heart disease as a cause of death will increase rather than decrease as time progresses. The gradual improvement in the death rate for such diseases as tuberculosis, pneumonia, and others that are coming under control, will transfer many additional persons to the later ages in life when heart disease is likely to strike them down. Under conditions of twenty or thirty years ago, many of them would have died in early life from the conditions referred to, today, they survive to middle life only to become victims of heart disease, cancer, apoplexy, or Bright's disease. This is an item which must not be lost sight of,

especially in view of the fact that the medical profession is not so well organized to control heart disease as it has been for twenty years organized to combat tuberculosis. It is for this reason that I consider heart disease the outstanding problem in contemporary preventive medicine. Nothing within the province of the physician today compares with it. I have in another place estimated that if heart disease could be eradicated as a cause of death, every one in the population would have about two years added to his expectation of life—not a small matter when the economic value of a year of life is considered.

The first question I would like to take up with you is whether the mortality from heart disease is beginning to show any signs of improvement. Between 1910 and 1918, the indications were that the mortality rate was rising slightly. The years 1917 and 1918 showed the maximum death rates of this period. The three following years, 1919, 1920, and 1921, were years of low rates, and there is every indication that this was largely due to the elimination of many persons through the influenza in 1918 who would ordinarily have died of heart disease in subsequent years. Beginning with 1922, the trend has been slightly upward, and there is really no saying what the picture in the immediate future will be like. In the first four months of 1925, the experience among the sixteen million Industrial policyholders of the Metropolitan, which is usually very sensitive as an index of what will be found later in the general population, showed an increase of four per cent over the same months of the year before. The facts for the fourteen years beginning with 1911 are shown in the following table.

\*Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse, May 13, 1925.

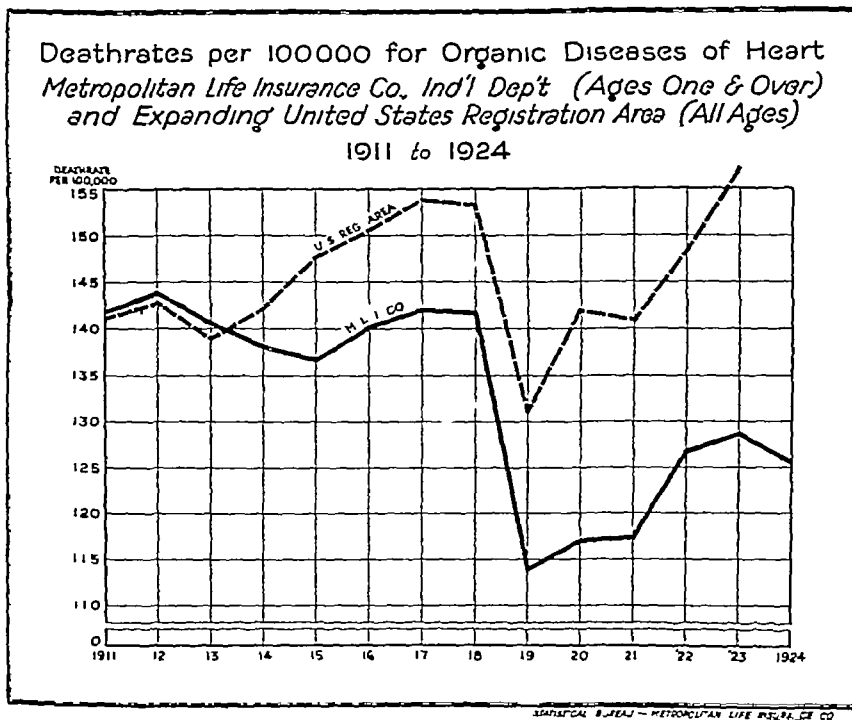
TABLE 1

Death rates per 100,000 for Organic Diseases of Heart. Experience of Metropolitan Life Insurance Company, Industrial Department (Ages one and over) and Expanding U S Registration Area (All ages)

Year	Metropolitan Life Industrial Dept. Ages one and over	Expanding U S Registration Area (All ages)
1924	125.5	*
1923	128.7	157.3
1922	126.7	148.4
1921	117.4	140.9
1920	117.0	141.9
1919	113.9	131.0
1918	141.7	153.3
1917	142.0	153.8
1916	140.2	150.6
1915	136.7	147.6
1914	138.1	142.2
1913	140.6	138.9
1912	143.8	142.8
1911	141.8	141.1

\* Not available.

monia combined. After forty, the rate of mortality rises precipitously, and the priority of heart conditions is then unquestioned. But it should not be forgotten that these deaths of middle-aged men and women, in most instances, involve a loss of many years of productive life to which they would ordinarily have been entitled, and often of years of diminished efficiency and even of complete invalidism prior to death. Deaths at these ages also produce in many cases broken families, widows, and orphaned children thrown upon the community for support. The curve of mortality from heart disease by age is a very interesting one, and I present one herewith in contrast with the curve for tuberculosis. The latter disease now shows its maximum at or about twenty-five years of age and then declines with advancing years. But heart disease crosses the tuberculosis curve about the age of forty-five and then mounts to its huge maxi-



Heart disease is pre-eminently a condition of the older ages of life, but, it is by no means to be neglected as a cause of death in the early years. In 1924, for example, the Metropolitan Life Insurance Company recorded close to twenty thousand deaths from heart disease among its Industrial policyholders. Of this number, 1,600, or eight per cent were of persons under the age of twenty-five, and 3,400, or 17 per cent, were under the age of forty. In other words, one-sixth of the insured who died from heart disease were at their prime. At the younger ages of adult life, heart disease is responsible for as many deaths as are all forms of pneu-

monia at the oldest ages. The principal damage to the community has, however, been accomplished long before old age is reached. Sixty-eight per cent of all heart disease deaths, in the experience of the Metropolitan Life Insurance Company, occur before the age of sixty-five.

Among white persons, the death rates are very much the same for the two sexes up to the age of twenty-five. After the age of twenty-five, the death rate for white males is higher than for females and the excess between the sexes becomes greater with advancing age. The rate among colored people is at every age higher than for whites. In fact, during the main age

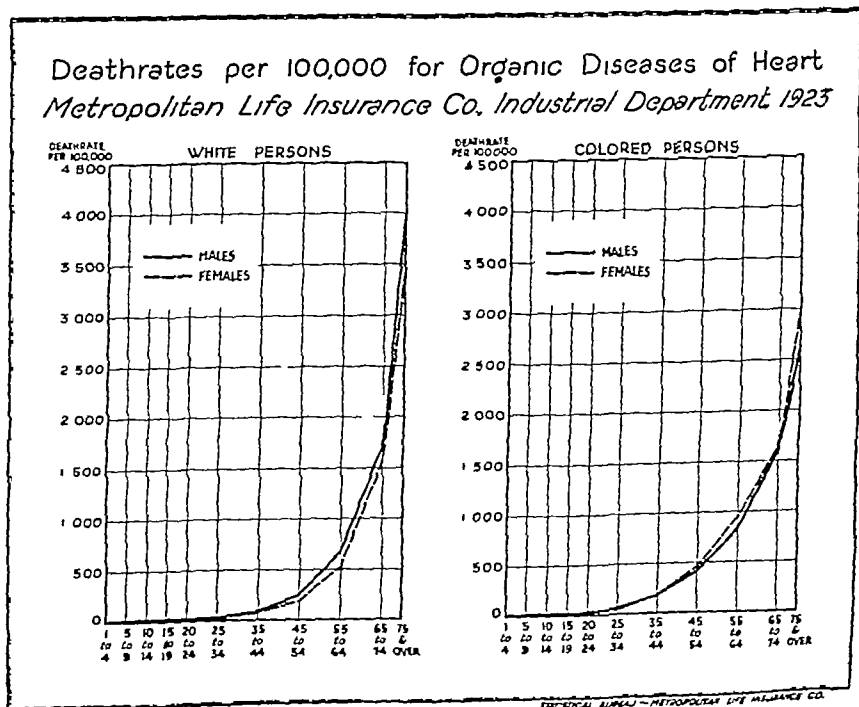
periods of life, the rates for colored people are about twice that for whites at the corresponding ages. It is also noteworthy that at some ages in adult life, the rates for colored females are higher than for colored males. It has been suggested that the higher prevalence of such diseases as malaria, typhoid fever and especially syphilis in the colored race, plays an important part in creating this excess of heart disease among them. But possibly, also, the figures presented are not all that they ought to be, because of the great difficulty in obtaining reliable statements of the causes of death on certificates. We shall always be troubled with our figures for heart disease until there are a larger number of autopsies and the standards of medical practice are generally raised.

TABLE 2

Death Rates per 100,000 for Organic Diseases of the Heart. Metropolitan Life Insurance Company, Industrial Department, 1923

Age period	White		Colored	
	Males	Females	Males	Females
All ages—one and over	113.6	122.1	190.8	217.4
1 to 4	6.3	6.2	17.1	10.3
5 to 9	10.3	10.8	17.5	10.8
10 to 14	19.8	23.2	28.9	16.0
15 to 19	27.6	23.9	28.4	19.3
20 to 24	23.9	25.2	27.6	38.1
25 to 34	39.6	32.4	68.0	58.7
35 to 44	86.6	70.7	180.3	184.7
45 to 54	253.3	184.9	424.6	470.4
55 to 64	681.3	535.6	831.9	948.8
65 to 74	1719.9	1545.4	1595.6	1641.1
75 and over	4060.8	3524.7	2600.1	3016.5

I have touched on the principal points in the mortality picture. I wish I could speak with as much assurance on the morbidity aspect of our subject. Unfortunately, that is impossible in the present state of our knowledge. We have made only the merest beginnings in collecting information on the incidence of heart disease in the community. Our very definitions are still vague. I should not have been able to make a presentation today if I had been kept to a literal interpretation of the title of this symposium. For, what is really a cardiac cripple? When does the condition justify such a designation in that shadow zone between the functional and organic heart case? Primarily, the difficulty lies in the fact that organic heart impairments ordinarily are not discovered in the early stages, and even then, there is no provision for systematic records of the after-history of the cases. This most valuable information, therefore, lies hidden away either in the memories of the one hundred thousand or more practicing physicians, or in their uncompiled and unanalyzed records. It is only recently that we have made a beginning, through the work of the cardiac clinics, to gather such information as we need on the morbidity of heart disease. It will always be a source of satisfaction to me to have had an opportunity to co-operate with Dr. Alfred Cohn in the preparation of the record forms used in these clinics. It is, indeed, fortunate that today we are able to tap this source of information from the unpublished work of Dr. Wyckoff, who has com-



piled and analyzed the records of a thousand patients in his service. These data are probably the only ones available at the present time, and I wish to acknowledge my great indebtedness to Dr Wyckoff and his associates who placed this material at my disposal for this occasion

In a previous paper, I have indicated that the number of persons suffering from definite organic heart disease approximated two per cent of the total population. This is a rough estimate. It is suggested by the findings of the life insurance companies in their routine examination of applicants for insurance, by the findings of the Life Extension Institute in their examinations, and by the results of others who have made physical examinations of large numbers of school children, employees in shops and factories and of other groups. This figure should, of course, be considered only a first approximation and will give place to a more definite one as further work is done on the records. It will serve, however, as our starting point. On this basis, there are well in advance of two million men, women, and children with organic heart lesions, and if the number of deaths annually from this group of diseases is in effect 200,000, we may infer that the average duration of a case of heart disease is about ten years. This will, of course, vary with the age at which the lesion occurs, with the type of lesion, the care which the individual receives and a host of other factors which bear on the condition. But, this figure of average duration will serve as a beginning to guide our discussion.

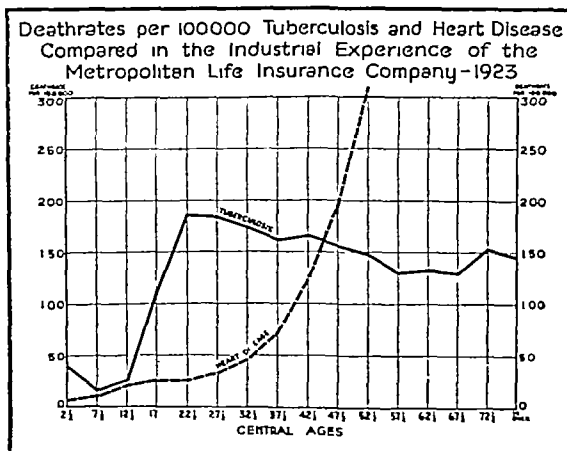
What are some of the outstanding findings in the tabulations of Dr Wyckoff? The thousand cases were distributed etiologically as follows: About one-fourth presented rheumatic heart disease, about two-fifths, arterio-sclerotic, about one-tenth, syphilitic, and about another one-tenth, heart disease of unknown origin. The remaining 15 per cent are accounted for by a mixture of odds and ends which are not so easily classified. The cases of rheumatic and unknown etiology are discovered, for the most part, at the earlier ages, the cases of arterio sclerotic etiology appear in the later age groups. The great presumptive importance of rheumatic fever as a causative factor is clearly indicated by the findings of Dr Wyckoff and his associates. It would be very interesting to find out what the relative duration of these cases of rheumatic origin is in contrast with the duration of cases of degenerative heart disease. The seriousness of syphilis as a primary causative agent is no surprise. Probably, the figure of ten per cent is a minimal value in view of the difficulty of determining in every instance the presence of the spirochete and the incompleteness of case histories. It is important, however, to observe that this type of heart disease is most prominent in the fifth and sixth decades of life. It is especially among the colored patients

that syphilitic heart disease is prominent, in this group, it accounts for about a third of the cases.

An equally valuable classification prepared by Dr Wyckoff and his associates is that showing the incidence of structural lesions in these 1,000 cases of organic heart disease. They found 88 per cent of the cases showing enlargements of the heart, among whom one in five had enlargement of the heart only. Hypertrophy was, by all odds, the commonest impairment. Mitral insufficiency was diagnosed in approximately half of all the cases. Mitral stenosis was present in 44 per cent of the cases, but, in nearly all of these, mitral regurgitation was also present. Aortic insufficiency was present in about 15 per cent of the cases, aortic stenosis in about three per cent, aortitis in 17 per cent, and aneurism in a little over one per cent. The following table is taken from Dr Wyckoff's report, with his permission.

TABLE 3  
Incidence of Structural Lesions in 1,000 Cases of Organic Heart Disease.

Structural Lesion	Males		Females		Both Sexes	
	No.	Per cent	No.	Per cent	No.	Per cent
Enlargement of Heart	342	54.2	341	34.1	684	88.4
Enlargement of Heart, only	137	13.7	66	6.6	203	20.3
Mitral Insufficiency	228	22.8	267	26.7	495	49.5
Mitral Stenosis	210	21.6	227	22.7	443	44.3
Aortic Insufficiency	178	17.8	68	6.8	146	14.6
Aortic Stenosis	23	2.3	6	.6	29	2.9
Aortitis	142	14.2	27	2.7	169	16.9
Aneurism	11	1.1	1	.1	12	1.2
Mitral Insufficiency and Stenosis	202	20.2	219	21.9	421	42.1
Mitral Insufficiency and Stenosis and Aortic Insufficiency	82	8.2	40	4.0	162	16.2
Mitral Insufficiency and Stenosis and Aortic Insufficiency and Sten	6	.6	6	.6	12	1.2



This report when it is published should receive the careful attention of all physicians as it is, in fact, the first attempt, to my knowledge, to collect a large body of information of an authen-

tic character in this field of heart disease prevalence. We have, heretofore, had any number of sketchy and loose statements of diagnostic findings. But, this series stands by itself in the authority of the examiners and the fullness of the records. This report should stimulate others in the field to collect similar case records and to tabulate and analyze them along comparable lines. A very great service could be rendered to this branch of medicine by spreading the use of these forms not only in clinics, but also among physicians in private practice.

I wish now to turn to a third source of information on the prevalence and significance of the heart diseases, namely, the records of the life insurance companies. A number of the larger companies have been for years liberal in their acceptance of certain types of heart cases for sub-standard insurance. The examinations for insurance are, of course, not made with that same thoroughness which characterizes the work of the cardiac clinics. But, the insurance applications do, nevertheless, make possible the classification of the heart findings of large numbers of people with a fair degree of accuracy. The heart defect most frequently found is mitral regurgitation. Hypertrophy of the heart without other heart signs is next in importance. Mitral stenosis, aortic stenosis and aortic insufficiency follow in order of frequency. This order is very much like that of Dr. Wyckoff's material, but, I doubt very much whether the examinations as conducted by insurance medical examiners in the field are of sufficient accuracy and refinement to find all the cases with heart lesions or to diagnose them correctly. Yet, the parallelism is very interesting. The medical directors of the life insurance companies are confronted with the practical problem of evaluating these lives and placing them in the several risk classes for which mortality rates and premiums have been computed. When insurance is granted, an excellent opportunity is afforded to the medical director of following the subsequent mortality experience on such persons.

A number of companies have, in this manner, collected considerable data on the after mortality of cases with mitral regurgitation which, I believe, will interest you. The experience covers a period of close to twenty-five years and is based on many thousands of persons. Taken altogether, the mortality rate is about two and a half times as high as that which prevails among normal persons accepted for standard insurance, age period being considered. Those cases where the murmur is slight but not transmitted have only a slight excess over normal mortality. The

presence of a well marked hypertrophy adds to the hazard, as does also the history of rheumatic fever or other acute inflammatory processes. You will all remember Dr. Mackenzie's very favorable prognosis of these cases. He felt that the insurance companies were losing a great deal of good business in not accepting these cases. But, our experience has shown, I am afraid, that his impressions were not correct, although it may well be that these cases of mitral insufficiency constitute the least impaired of the organic heart cases. In this connection, it is interesting to note that close to half of the deaths which occurred among the mitral insufficiency cases were from organic heart disease of one form or another. Cases of aortic stenosis and of intermittent heart disease gave an experience very much like that from mitral insufficiency, i.e., double mortality. In a few instances, the insurance companies have accepted risks affected with mitral stenosis, but the experience is uniformly bad, and the present practice is to reject such cases. The available insurance experience is, however, insufficient to give reliable results on the precise effect on longevity of these very serious impairments.

I have mentioned the practice of the insurance companies in this connection with a special point in mind. The medical directors of the insurance companies are keenly interested in the work of your clinics. As physicians they are, of course, very much concerned with the prevention of suffering and the postponement of death. But, as insurance men, they are also concerned with providing an equitable classification of the risks presented to their respective companies. They are all of them very anxious to provide protection for the families of persons affected with impairments, but, it is always necessary that such insurance protection be granted with no unfairness to those who are already insured. For this reason, the medical directors have been compelled to proceed cautiously with the acceptance of risks showing heart impairments. It is quite possible that the new movement for the study of heart disease will provide the very information which will make it possible for the companies to extend their operations to such cases and to offer insurance to lives which are not now accepted because of the dearth of information on the after mortality of such risks. There are large opportunities for co-operation between your heart clinics on the one hand, and the insurance companies on the other. I believe it would be a very profitable procedure for both groups to get closer together if for no more than to explore the opportunities for further research.

## A PROGRAM OF PROCEDURE IN THE PROBLEM OF THE CARDIAC CRIPPLE\*

By HOMER F SWIFT, M.D.,

NEW YORK CITY

**D**URING the past winter a committee of the New York Heart Association has been making a general survey of the special work among cardiac patients, and trying to devise plans for future work with these patients. At the meetings of this committee persons in the field of public health, and vital statistics, as well as those more specially concerned with the various phases of heart disease were consulted. The following observations and suggestions were derived in large part from the deliberations of this committee. They represent, therefore, not the opinions of one individual, but the ideas of many.

Statistical data concerning heart disease, or rather "heart diseases" compared with the falling death rates from most infections render it difficult to claim that much has been accomplished up to the present in diminishing the mortality from heart disease. This discouraging evidence immediately requires us to examine the reasons for the apparent lack of beneficial results from all of the efforts that have thus far been expended. Certain questions may be asked. Are the sources of our information reliable? Is it possible to analyze them in such a manner that they will give us some approximation of the truth? If not, what measures may be proposed in order to remedy these defects in our present sources of knowledge? Is it possible with our existing machinery to obtain reliable information, or must new methods be devised and adopted in order eventually to have more dependable guides to the efficacy of our prophylactic and therapeutic procedures?

The complicated nature of heart disease and the multiplicity of conditions covered by the term confuse the picture. For example, all vital statistics indicate that "organic diseases of the heart" is the largest single cause of death, and that the rate is apparently increasing from year to year. But "organic disease of the heart" is an all embracing term. Death rates from most infectious diseases have fallen steadily in the past few decades with the result that expectancy tables show the span of life to have been definitely lengthened, hence increased death rate from degenerative types of cardiac vascular disease is to be expected. In this group we are faced with the apparently paradoxical statement that both personal and general health measures calculated to prevent a disease may in the end lead to an increased statistical death rate from that disease. It is a question, therefore, whether this portion of

the problem, i.e., degenerative heart disease, does not belong in its broader aspects to the general field of public health, and in its narrower implications to the physiology and pathology of senescence.

The first requirement in any plan of procedure then, is the adoption of some simple form of classification of heart disease. Naturally the type of classification adopted differs according to the use to which it is to be applied. Thus the New York Heart Association is using a system in which the functional state of the organ is the primary consideration. This has proven most useful from the standpoint of treatment of the crippled heart. Provided the criteria of functional classification are correct, it enables physicians to adopt therapeutic measures which are directed towards moving the patient into a more favorable functional position. Obviously most cardiac cripples have irreparable heart failure just prior to death, hence from the viewpoint of vital statistics as well as from that of preventive medicine a functional classification is of relatively little value. If seems, therefore, advisable to adopt an etiologic system. Even with the evident difficulties of assigning a definite etiologic agent to all cases of heart disease, and with the probability of often encountering differences of opinion as to the relative importance of a number of different causative factors, it is still of value from practically every angle to attempt to determine the origin of the disease, or condition leading to the diminished functional state of the heart, and also to designate whether that disease is active, recurring, quiescent, or cured.

On this basis, the following classification of Heart Disease has been suggested

- I Infectious
  - a Rheumatic Fever
  - b Syphilis
  - c Other infections (type to be stated)
- II Degenerative and senescent.
- III Concomitant state in—
  - a Chronic Bright's disease
  - b Arterial hypertension
- IV Fatigue—Toxic states
- V Neurosis—so-called Functional Heart Disease.

In order to operate successfully the natural history of each of these forms of heart disease must be known, and the differences between them clearly emphasized. Information in respect to one is not equivalent to information in all. For example, we have sufficient knowledge of syphilis and enough methods of diagnosis and treatment to eradicate it, if all of the means at our disposal could be effectively utilized. It is safe to

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse, May 13 1925

predict then, that syphilis of the heart will be eventually eliminated through the thorough application of information already available. In respect to rheumatic fever, on the other hand, we have much to learn before we can begin to apply effective prophylactic measures. It may be useful to quote the remarks of a well known cardiologist concerning our lack of knowledge: "We do not know the cause of rheumatic fever and chorea, or the communicability of these diseases, the relationship of focal infections (tonsils, teeth, lymph glands, and intestinal tract) to rheumatic fever, the therapeutic value of the removal of these foci, the natural history of a large group of these patients followed over long periods of time, methods for preventing rheumatic fever, the best methods for handling these patients at various stages of their disease." The controversial nature of our knowledge of nephritis and hypertensive cardio-renal disease does not require special emphasis. This agnostic attitude is not necessarily pessimistic, nor does it prevent efforts at solution. On the contrary, honest recognition of deficiency in knowledge is the first step towards remedying our shortcomings. Numerous groups of workers are engaged in attempting to solve many of these problems. It goes without saying that every encouragement should be given to all these efforts, for more than one example might be cited in which the work of a single individual or small group furnished the method by which the larger problem was successfully solved.

In the meantime there are many lines in which co-operative effort would probably prove beneficial. Mention has already been made of the difficulty of obtaining much useful information from vital statistics because they reflect only unclassified mortality rates. More might be expected from morbidity returns. In this respect, although heart disease is recognized as the largest single cause of death, when we compare the lack of requirements of Boards of Health for physicians to furnish information in reference to its incidence with their efforts to record cases of diarrheas of infancy, dysentery, or chickenpox, our first impulse is one of surprise. If cardiac disease were made reportable on forms following well defined etiologic classification so that the relation of various predisposing factors to the actual circulatory disease could be determined, it is conceivable that after a number of years a mass of very useful information might be secured and the trend of the results of our therapeutic efforts might be determined. But the objection is raised that no immediate benefit could be expected from this information and that without this immediate benefit in sight, health authorities are loath to make demands for reports from practitioners, and are adverse to enlarge the Board of Health statistical departments. Our inability, therefore, to apply some

prophylactic measures as an immediate result of these reports prevents us, as physicians especially interested in cardiac disease, from urging the adoption of measures which would probably yield information of decided value in the future.

More limited groups of individuals from which morbidity figures may be obtained are insured persons, conscripts and school children. Statistics of insured workers, while of value, cover only a small group of cardiacs, for most patients with cardiac disease are, of necessity, excluded from the benefits of insurance. Morbidity curves and expectancy tables based on statistics of life insurance companies are, therefore, not applicable to the majority of cardiac patients. Morbidity rates among conscripts give us merely a single cross section in a limited group of the total population, they do not cover the early and late periods of life when cardiac disease is an important public health problem. Morbidity studies in school children permit of a slightly larger range in that the patients might be followed over a longer period, and are under certain control. Education is, however, the primary object of the schools, and although much is being done to improve the general health of school children the results of these efforts, in respect to heart disease, will not be made known unless there is a definite plan to correlate corrective and therapeutic efforts with a study of what follows their application. It must not be forgotten that the better nutritional states and housing conditions existing today in America, apart from any special prophylactic or therapeutic measures, may have much to do with improving the health of school children.

It is evident that there is no unanimity as to the best methods of treating cardiac school children. If they are considered from the standpoint of functional classification, treatment directed mainly towards lightening the burden of a crippled heart might be recommended. If, on the other hand, the child with heart disease is considered as having reacted in a peculiar manner to certain infections and as being a subject especially susceptible to reinfection, or to the re-awakening of latent infection, it seems probable that he would best be treated in a manner especially calculated to keep his resistance against infection at the highest possible level, as well as to guard against straining his crippled heart. The answer to the question as to the best course of treatment of cardiac school children cannot be reached by a single survey of these children, but requires the repeated observation over many years of different groups of patients from various social levels, treated in various ways. Hence, there should be added to the existing work on the study of cardiac disease in school children a definite plan for obtaining information on these points.

In smaller cities with a comparatively fixed



population and few schools this type of continuous investigation could be most advantageously pursued. The need for information along these lines is emphasized when we realize that, among school children, heart disease, chiefly rheumatic in nature, is the cause of three times as many deaths as pulmonary tuberculosis.

The Milbank Foundation is, at present, preparing to investigate the general public health problem in a relatively large district in New York City and in Syracuse, and of necessity heart disease must occupy a considerable portion of the programs. In this work the Milbank Directors and Heart Associations might be mutually helpful, for the former have the funds and the desire to obtain information that may be used in forming programs for future work and the latter has, through its Research Committee, a well considered plan as to how observations in reference to heart disease should be made and recorded. Already the records of many cardiac patients in the Bellevue-Yorkville district are documented on the Heart Association charts, and with these as a model nucleus, the Milbank cardiac investigations may be made to proceed much more rapidly than if the Milbank directors try to originate their own methods and forms. The cardiac clinics situated in the district should be urged to assist in this work, in order to demonstrate the mutual advantages of co-operation.

Studies among any special group are of necessity limited, either because of the restricted life of the investigating committee, or because the individuals under observation pass beyond the jurisdiction of the investigators. The picture obtained, although accurate, is more or less limited. Even were the supervision of cardiac school children perfectly organized our knowledge of the ultimate result of this special care would be largely lost unless plans were perfected for following them in the post school period.

A study of the various factors which are favorable, or unfavorable, to a patient with heart disease must be pursued for many years and must be made in all the places where the patient is found, viz, in his home and place of work, in the wards, the out-patient cardiac clinic and convalescent homes, and in the consulting rooms and bedside with private patients. The observations, moreover, should be made by physicians and social workers, who are specially trained in the interpretation of the signs and symptoms of heart disease and in the detection of unfavorable and favorable environmental influences. Indeed, hundreds of patients are observed daily in the various institutions of this country but the results of the observations are only of benefit, directly to the patient, and indirectly to the physicians, or group of physicians, having to do immediately with the patient. Our present state of uncertainty in respect to the solution of many practical problems is not that these have not been

considered, or worked upon, but rather in the failure to make known the results of the work already done. Again, each physician, or group of physicians, in an institution works in a more or less individual way, with but little consideration of how the observations are made or recorded elsewhere. The records of cardiac patients in a hospital, or clinic in many instances must correspond in size and form with the records of other classes of patients in that institution, rather than with the notes of cardiac patients in another institution. This has resulted in different groups of workers being less mutually helpful than would be possible under better circumstances. There is little common plan of procedure and hence, little common language. What Group A may do cannot be interpreted in terms of what Group B has done, because the two cannot compare directly their observations and results. How many more divergent points of view arise when the number of groups is increased by twenty to forty is obvious.

Another reason for our incomplete knowledge of the life history of cardiac disease is that at various times the cardiac patient is under different observers, in the wards of hospitals, in the out-patient cardiac clinic, in the convalescent home, and often under the care of a private physician. As a rule the observers in each unit have relatively little accurate knowledge of what has occurred to the patient while he was under the care of physicians in other institutions, or even in other parts of the same institution. In hospitals, employing a unit history in wards and out-patient department, the gap is bridged to a certain extent, but the convalescent home is practically always out of documentary touch with wards and out-patient clinics, and at best a functional classification is attached to the transfer cards as a patient moves from one observer to another.

For economic and administrative reasons, it seems necessary to divide the patients into classes according to the present scheme. It is conceivable that a special cardiac hospital, or cardiac unit, in a general hospital might be so arranged that the patients, no matter in what condition from acute illness through convalescence, were under one group of observers constantly and that from such a cardiac unit, much useful information would arise. Some cardiac clinics are at present so organized that the patients are under the direction of the same physician both in the wards and out-patient departments. It is easy to imagine the expansion of this type of work so that a special cardiac hospital were so staffed that the patients could be observed, treated and specially trained, all at the same time. In fact, model institutions of this general type have been most valuable in pointing the way to the best form of treatment of tuberculosis.

Today, however, we must face existing condi-

tions and make the best use of them. About seven thousand patients per year are now under the care of various groups of physicians in 48 different cardiac clinics in New York City. There is already a certain degree of co-ordination between many of these groups in that meetings are held and opinions and experiences interchanged, but it may be asked whether, with the present plan of procedure, we shall, at the end of five or ten years, have made much progress in the solution of any phase of the cardiac problem. A regrettable feature of the whole situation is that with the present lack of mutual co-operation, we shall be unable to determine either our rate of progress, or lack of progress, if such exists.

Heart Associations or physicians in other cities of the state might conceivably be able to co-operate more effectively than do those of the metropolis, for the size of the problem among millions of people makes organization complex and cumbersome. To the worker in smaller places we may recall that Trudeau did more than any metropolitan physician to point the way to proper treatment of tuberculosis, and Sir James MacKenzie, after experience both in the country and in London, selected St Andrews as a more favorable place to study the life history of chronic cardiac disease than he found in a London hospital. The recent work of Kaiser in following a large group of tonsillectomized children and comparing them with a similar group of unoperated ones, shows how a study of clinical material may help us form an opinion of certain prophylactic measures.

At this point we may digress a moment to indicate some benefits to be obtained from the study of the relation of tonsillectomy to rheumatic fever and cardiac disease. It may be that eventually among a group of tonsillectomized individuals there will be as large a proportion having rheumatic fever or cardiac disease as in a control group of similar size, but that in the operated patients the span of life and period of economic usefulness may be decidedly increased. In other words, the breadth of life may be measurable enlarged by our therapeutic and prophylactic procedures even though the eventual mode of termination may be the same.

To whom, then, must we turn for the eventual solution of many of the problems of cardiac disease? The answer seems obvious. To the physicians and special workers among cardiac patients. The organization of Heart Associations and of special cardiac clinics in various cities of the country is but an expression of the recognition of the necessity for co-operative effort. Eventually society which will furnish the financial support for these organizations will ask whether the expenditure of funds has been justified by results. At present no machinery exists which can give a satisfactory answer to this question. It,

therefore, behooves these Associations to make the obtaining of information in respect to various phases of heart disease a large part of their program.

Let it be immediately acknowledged that the making of accurate observations is a laborious task, and that the recording of these observations is still more laborious. The first work must be done and is being done by physicians and special workers, the second, may be facilitated to a large extent by trained secretarial assistants. At this point Heart Associations with sufficient funds at their disposal might well supply assistance to those institutions which are willing to help by studying their patients in a manner that would lend itself to co-operative documenting. After several years work, charts for such documenting have been elaborated by a special committee of the New York Heart Association.

The objection is often raised that these charts, as they stand today, are too long and too complicated. It was not to be expected that every space would be filled out for every case. Naturally a purely degenerative type of disease requires different treatment in practically all respects than an infectious type. Intelligent discrimination should be applied to history-taking and recording as well as to therapeutics. The blanks had to be so constructed that they lent themselves to the registering of information from all types of cardiac disease, also to the co-relating of this information from many points of view. They were prepared under the advice of statisticians for the statistical treatment of all types of cardiac disease. A little training and experience in their use has convinced more than one objector of their practicability and that time is saved and the records of different cases are more comparable than when each examiner is following his own individual plan. An analysis of 1,000 cases on them is now under way, and the experience gained in this work is immediately available for the extension of their use. In the survey of certain groups of school children and in the follow up of a large number of cardiacs these charts have proven most helpful.

There is today a tendency towards fusion of Heart Associations and Tuberculosis Associations. This has resulted in part from an effort to reduce to a minimum the number of public health organizations, for it seems that in many respects the same machinery and methods may be employed in the treatment of tuberculous and cardiac patients. But it should be kept in mind that the problems in the two conditions diverge at many points. The only positive information in reference to cardiac disease comparable to that concerning tuberculosis is in the diagnosis and treatment of syphilis as it involves the circulatory system. The treatment of rheumatic infections of the heart very probably rests upon the same general therapeutic principles that have

been elaborated for tuberculosis, but the final verdict remains for the future to render. As the Tuberculosis Associations take over the cardiac work, it is well for the directors to keep in mind that new problems are presented to them. In general, unqualifiedly proven methods of prophylaxis and treatment do not exist, nor is there statistical machinery to furnish positive information concerning many of these moot points. There should, therefore, be added to the work of all organizations having to do with the prevention and relief of heart disease a department the special function of which is to coordinate efforts in obtaining useful information in reference to circulatory diseases. The formation of special cardiac clinics and periodic examination of apparently well persons will afford many opportunities for detecting various types of heart disease much earlier than has been possible in the past. These opportunities also carry with them the obligation for giving proper advice concern-

ing specific as well as general prophylactic and curative measures. In diseases of the circulatory system entirely new problems will be presented to the physician, for in the past most of the patients have not applied for medical assistance until their cardiac capacity was diminished enough to prevent them from carrying on their daily tasks.

The urgency of providing means for furnishing answers to these questions is not, therefore, imaginary or over idealistic. It should not in any way interfere with work already in progress or diminish the efforts at present being expended in the treatment of patients with cardiac disease. A constant attempt to gather facts and correlate the results of our work would, on the other hand, place us in a more favorable position to advise our patients properly, to know whether our time and money were being most effectively expended, and finally, to project more intelligently our future plans.

## THE ORGANIZATION OF THE CARDIAC CLINIC\*

By JOHN WYCKOFF, M.D.,

NEW YORK CITY

THE term Clinic in the United States is used to designate two types of organizations. In Europe, and now increasingly here, a clinic is known as a unit, general or specialized, complete for the diagnostic study and treatment of disease, in both the ambulatory and bed phases. In this country, a clinic is more usually considered to be an outpatient dispensary for the diagnosis and treatment of ambulatory patients. The organization of a clinic, in this latter interpretation, is the subject of this paper.

Clinics may be more or less specialized. They may be general or have such a gross subdivision as General Medicine, or General Surgery, such divisions may be subdivided into clinics for the various specialties in medicine or surgery. In these, patients are studied, diagnosed, and treated for a particular disease or group of diseases. The group classifications may be anatomical, as in an eye clinic, etiological, as in a tuberculosis clinic, or by age groups, as in a pediatric clinic. Such classifications are of necessity, arbitrary. For example, the diseases of the eye spring from a variety of causes: trauma, acute infections, chronic infections, diseases of metabolism and others. When the disease of a single organ is due to an underlying cause, such as a chronic infection, other organs may also be affected, for example, a patient with a syphilitic choroiditis may also be suffering from tabes dorsalis, and the question at once

arises whether the patient should be treated in the neurological clinic, the eye clinic, or a syphilitic clinic. Furthermore, when groups are based upon structural classifications, they may call for different forms of treatment. In a neurological clinic, one may meet patients with diabetic neuritis, tic douloureux and muscle atrophies following acute anterior poliomyelitis, all neurological cases, they need for treatment, however, the expert care, one of a specialist in diseases of metabolism, another of a neurological surgeon, and the third of an orthopedist, beside the neurologist.

These well-known difficulties in the arbitrary division into groups of patients for diagnosis and treatment frequently give rise in the minds of thoughtful men and women, as well as those not so thoughtful, to questions as to the advisability of such specializations not only in public but also in private practice. Such criticism is useful. Arbitrary groups based on any form of classification, must not lose touch with other branches of medicine or surgery. There can be no specialty independent of others.

In spite of such criticism, based upon obvious defects of a group system, specialization continues to grow. It may be possible for an occasional superman to know the essentials of progress in all fields, but most of us cannot hope to do so. If patients are to get the benefit of the real advances of medicine, some physicians must work in groups, keeping in touch as much as possible with all fields, but keeping a particu-

\*Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse, May 13 1925

tions and make the best use of them. About seven thousand patients per year are now under the care of various groups of physicians in 48 different cardiac clinics in New York City. There is already a certain degree of co-ordination between many of these groups in that meetings are held and opinions and experiences interchanged, but it may be asked whether, with the present plan of procedure, we shall, at the end of five or ten years, have made much progress in the solution of any phase of the cardiac problem. A regrettable feature of the whole situation is that with the present lack of mutual co-operation, we shall be unable to determine either our rate of progress, or lack of progress, if such exists.

Heart Associations or physicians in other cities of the state might conceivably be able to co-operate more effectively than do those of the metropolis, for the size of the problem among millions of people makes organization complex and cumbersome. To the worker in smaller places we may recall that Trudeau did more than any metropolitan physician to point the way to proper treatment of tuberculosis, and Sir James MacKenzie, after experience both in the country and in London, selected St. Andrews as a more favorable place to study the life history of chronic cardiac disease than he found in a London hospital. The recent work of Kaiser in following a large group of tonsillectomized children and comparing them with a similar group of unoperated ones, shows how a study of clinical material may help us form an opinion of certain prophylactic measures.

At this point we may digress a moment to indicate some benefits to be obtained from the study of the relation of tonsillectomy to rheumatic fever and cardiac disease. It may be that eventually among a group of tonsillectomized individuals there will be as large a proportion having rheumatic fever or cardiac disease as in a control group of similar size, but that in the operated patients the span of life and period of economic usefulness may be decidedly increased. In other words, the breadth of life may be measurable enlarged by our therapeutic and prophylactic procedures even though the eventual mode of termination may be the same.

To whom, then, must we turn for the eventual solution of many of the problems of cardiac disease? The answer seems obvious. To the physicians and special workers among cardiac patients. The organization of Heart Associations and of special cardiac clinics in various cities of the country is but an expression of the recognition of the necessity for co-operative effort. Eventually society which will furnish the financial support for these organizations will ask whether the expenditure of funds has been justified by results. At present no machinery exists which can give a satisfactory answer to this question. It,

therefore, behooves these Associations to make the obtaining of information in respect to various phases of heart disease a large part of their program.

Let it be immediately acknowledged that the making of accurate observations is a laborious task, and that the recording of these observations is still more laborious. The first work must be done and is being done by physicians and special workers, the second, may be facilitated to a large extent by trained secretarial assistants. At this point Heart Associations with sufficient funds at their disposal might well supply assistance to those institutions which are willing to help by studying their patients in a manner that would lend itself to co-operative documenting. After several years work, charts for such documenting have been elaborated by a special committee of the New York Heart Association.

The objection is often raised that these charts, as they stand today, are too long and too complicated. It was not to be expected that every space would be filled out for every case. Naturally a purely degenerative type of disease requires different treatment in practically all respects than an infectious type. Intelligent discrimination should be applied to history-taking and recording as well as to therapeutics. The blanks had to be so constructed that they lent themselves to the registering of information from all types of cardiac disease, also to the co-relating of this information from many points of view. They were prepared under the advice of statisticians for the statistical treatment of all types of cardiac disease. A little training and experience in their use has convinced more than one objector of their practicability and that time is saved and the records of different cases are more comparable than when each examiner is following his own individual plan. An analysis of 1,000 cases on them is now under way, and the experience gained in this work is immediately available for the extension of their use. In the survey of certain groups of school children and in the follow up of a large number of cardiacs these charts have proven most helpful.

There is today a tendency towards fusion of Heart Associations and Tuberculosis Associations. This has resulted in part from an effort to reduce to a minimum the number of public health organizations, for it seems that in many respects the same machinery and methods may be employed in the treatment of tuberculous and cardiac patients. But it should be kept in mind that the problems in the two conditions diverge at many points. The only positive information in reference to cardiac disease comparable to that concerning tuberculosis is in the diagnosis and treatment of syphilis as it involves the circulatory system. The treatment of rheumatic infections of the heart very probably rests upon the same general therapeutic principles that have

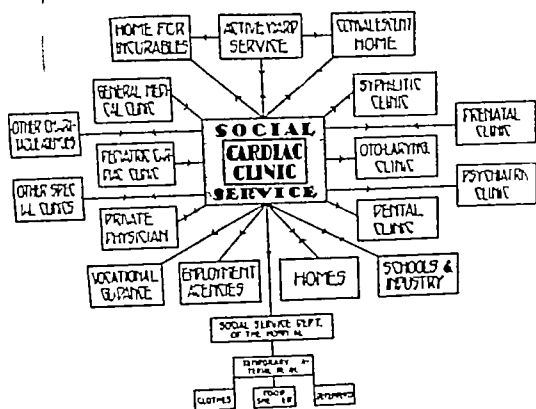


FIG I

Diagram to show the relation of a cardiac clinic to outside agencies, the connecting line of liaison maintained between the social service part of the clinic

**General Medical Clinics**—The relationship to the General Medical Clinic must be particularly close. Heart disease is a part of general medicine, while the reasons for a special clinic are, I think, obvious, the clinic should keep in close contact with the General Medical Clinic, from which it should receive many of its patients.

**Bed Service**—The relationship to the bed service should also be a close one. Under ideal conditions, the physician in charge of the heart cases in the ward should be in charge of the cardiac clinic. In the ward, one sees but a small cross section of the cardiac's life. There one learns the course and treatment of heart failure, and sees the active types of heart disease, but it is in the ambulatory clinic that one learns the course of chronic heart disease, its management and treatment. If there is a ward service connected with the cardiac clinic, members of the resident staff should have duties in the clinic as well as in the ward. Nothing prevents premature discharge of cases of heart failure or of active heart disease from the ward service so well as a staff which serves both in the ward and in the clinic. Patients referred from the ward to the clinic, or from the clinic to the ward, should be accompanied by a transcript of the essentials of their record while under observation, unless there is a unit record system.

**The Pediatric Cardiac Clinic**—In talking with physicians in charge of adult cardiac clinics, one finds agreement that a difficult problem in keeping touch with cardiac patients is at the time when such patients graduate from the pediatric cardiac clinic. There are many reasons for this. Patients who are under the care of one group of physicians and social service workers dislike a change under any circumstances, particularly so when they are suddenly thrown into a group between the ages of fourteen and sixteen, and at this time many of the patients are in Class 1 and free from symptoms. They have had heart

disease for a number of years and have done well, they frequently have little fear of the disease. Among patients of the usual clinic type, they are beginning to break away from parental guidance and have not yet developed a sense of responsibility, and for these reasons the clinic frequently loses track of these young people, a group for whom probably more constructive work can be done, particularly in the field of vocational guidance, than for any other type. At Mt Sinai Hospital in New York, Dr Marcus Rothschild is handling this problem by the formation of an adolescent cardiac clinic. This clinic takes the children at sixteen and keeps them until eighteen. He is also in charge of the adult clinic. The children are graduated from the children's clinic to the adolescent clinic and here, though they come in contact with a new doctor and social service worker, the patients are only a little older and many of them their old friends. In this environment, they are happier, and when, two years later, they graduate into the adult clinic, with the same staff and social service worker, their continued attendance is much more likely.

**Department of Health**—Little is known as to the rôle which scarlet fever, diphtheria and measles play in causing chronic heart disease. It would be well if patients who, while in the communicable disease hospital, develop signs or symptoms of heart disease, should be discharged to a cardiac clinic for further observation and treatment.

**Psychiatric Clinic**—The psychiatric clinic is frequently an aid to the cardiac clinic, not only to find the cause of certain cardiac neuroses and to attempt to lead the patient out of his troubles, but also in cases of organic heart disease, to differentiate clearly between symptoms due to heart disease and those of neurogenic origin.

**The Pre-Natal Clinic and Obstetrical Service**—A cardiac clinic receives many cases from a pre-natal clinic, as heart disease is sometimes first discovered during a pregnancy, and itself must refer many of its younger women to such a clinic when they become pregnant for observation during pregnancy, and for confinement. With close co-operation between these two clinics and the obstetrical service, we believe many lives of mothers and babies are saved.

**Syphilitic Clinic**—In an adult clinic, there are always a number of cases of syphilitic heart disease. It is frequently more convenient to have their anti-luetic treatment given in a syphilitic clinic. However, there should be close co-operation between the two if the patient is to derive the greatest possible benefit. A cardiac clinic should also have referred to it from the syphilitic clinic any cases of syphilis having organic heart disease.

**Otolaryngological Clinic**—If there is no otolaryngological department in the cardiac clinic,

lar eye on newer methods of diagnosis and treatment in some limited field, moreover, in working with large numbers, a distinct economy of time and effort is effected by handling in groups patients with the same or similar disease calling for more or less uniform methods of diagnosis, management and treatment, and I believe this is particularly true of heart patients. In opening, I have tried to point out some of the dangers of specialization, so that we may take heed to avoid them in our consideration of the organization of a cardiac clinic

The first clinic in this country for ambulatory cardiacs was established in 1911, by Dr Hubert V Guile, in Bellevue Hospital. It was begun because the Social Service Department of the hospital felt that the number of returns of cardiac patients to the wards could be diminished if the patients could, upon discharge, be cared for in a clinic less crowded than the General Medical Clinic, and manned by physicians who would have time to become interested in the special problems of the heart patient

#### FUNCTIONS OF CARDIAC CLINIC

The functions of a cardiac clinic, briefly stated, are to keep the ambulatory patient, with organic heart disease, in the best possible health for as long a time as possible. To do this properly, two separate and distinct processes must be carried out

- 1 A diagnosis must be made

- 2 Treatment must be instituted and maintained

Not only should a first, or working, diagnosis be made, but each time that treatment is changed or continued it should be only because the facts upon which the original diagnosis had been made have been reviewed, their correctness considered, and the question as to whether the status of the patient has changed

**Diagnosis**—A complete diagnosis should consist of a cardiac diagnosis and a diagnosis of factors influencing the heart condition, both medical and social. The cardiac diagnosis should be made under the following heads: Etiological, Structural, Pathological-physiological, and the patients should be classified as to amount of cardiac reserve. Under "other medical diagnosis," should be considered any other change of structure or functions, its cause and its bearing on the heart condition. The social diagnosis should include home environment, habits, financial status, responsibilities, and occupation

**Treatment**—The matter of treatment also demands subdivision

- 1 *Medical treatment* of the heart itself is undertaken with the idea of increasing or preventing the loss of cardiac reserve by

- a Treating the cause, or etiologic treatment
- b Treating the changes in structure (a rare possibility)

- c Treating changes in the pathological physiological condition, such as controlling the ventricular rate in auricular fibrillation with digitalis, or by reinstituting regular sinus rhythm in a patient with auricular fibrillation with quinidine

- 2 *Treatment of other purely medical conditions*, other than cardiac, which influence the heart

- 3 *Social treatment* Alleviating or eradicating improper home environment and bad habits, helping to relieve financial handicaps, and removing responsibilities, and aiding in the modification or change of occupation.

**Treatment Plan**—After the diagnosis has been made, the physician and social service worker should, in conference, decide upon a treatment plan in which cognizance is taken of all diagnoses and all forms of treatment indicated

With a very few patients, one individual working alone can accomplish a great deal if he works hard, is resourceful, and uses all the agencies at his command. But, as the number of patients increases, he needs help, and as soon as he has even one person to help, there must be organization or there will be duplication of effort. Such organization must be considered in two ways

- 1 The relation of the clinic to outside agencies

- 2 The internal organization of the clinic itself

Outside agencies related to the cardiac clinic must be classified as

- 1 Those that refer patients to the clinic

- a For diagnosis

- b For diagnosis and treatment of their heart condition

- 1 Referred completely

- 2 Referred for only cardiac treatment, returning to original agency for treatment or care of another sort (e.g. Pre-Natal Clinic)

- 2 Agencies to which the clinic refers patients

- a For diagnostic procedures

- b For medical therapeutic procedures

- c For social care or management

If the cardiac clinic is a part of a general hospital, many of these agencies may be a part of the hospital, but we shall consider them as outside agencies, as we are thinking of the cardiac clinic as a unit by itself

The number of such outside units with which the clinic must co-operate and keep in touch varies. I will discuss briefly the agencies with which one clinic is co-operating, as fairly representative of the connections a cardiac clinic in a city should have. I think it is fair to say as a usual thing, it is best if a cardiac clinic be maintained as a part of an out-patient department in a general hospital, so that all the clinical and laboratory relationships and opportunities for consultations on which efficient cardiac work may depend are represented

the physician and she should take up the case with the physician, making suggestions as to aid. She should not undertake such aid without the direction of the physician, except in emergency. On the other hand, the technique of such work should be left in her hands, she should be trained to do such work efficiently, and should usually not be interfered with in carrying it out. Notes of her observations and her activities should appear on the clinic chart. They should not be kept in a separate file in the social service department of a hospital, but should be entered directly on the patient's chart, as they are a definite part of the history and necessary for complete and correct diagnosis.

In small clinics, she may have to act as file clerk, but in large clinics (although she must have free access to the charts), this should not be part of her duties. She is a specially trained worker who, presumably, is paid in proportion to her training and should not be required to waste hours of time doing work which an unskilled worker may do. Her time during clinic hours should be spent interviewing patients and talking over the problems of the patients with the doctors in charge, and in consultation with the doctors making her plans for work during the following week.

*The Internal Organization of the Clinic*—The primary objects of the organization are

- 1 To make as complete and correct diagnosis as possible
  - a By determining certain facts in the clinic
    - History given by the patient
    - Results of physical examination, including X-ray and electrocardiography, if available
  - b By having available facts learned from without the clinic
  - c The grouping of these facts together in some permanent form and uniform manner so that the physician in a brief time can correlate and interpret the observations
- 2 To assure intelligent treatment in the clinic and prompt reference to proper outside agencies for treatment
- 3 To facilitate the follow-up of these cases both in the clinic and at home so that diagnoses may be checked and the results of treatment noted

That such observations may be made, set down, and treatment instituted, the clinic must have

- 1 A certain minimum of physical equipment
- 2 An organized system of records
- 3 A staff

*Equipment*—A minimum physical equipment as outlined by the Committee on Cardiac Clinic, of the New York Heart Association, should consist of

Proper waiting room and examining room

Files, furniture and stationery

Thermometer, scales, sphygmomanometer

Facilities for routine urine examination, blood counts, and the collection of blood for chemical and serological examinations

While not an absolute necessity, facilities should be available for fluoroscopy by the physician in the clinic, and for teleoroentgenographic and electrocardiographic examinations. In adult clinics, an ophthalmoscope should be available.

*The Record*—Since heart disease is chronic and observations are made frequently over a considerable period of years, and as memory is short, it is essential that all observations should be written down upon a record. They should be noted as briefly as is consistent with accuracy and the system of notation should be as uniform as possible. First, as to the location of information of the chart, so that one knows where to turn to find such information, and second, as to nomenclature, so that as far as possible, similar observations and procedures will always be described in the same way. Furthermore, from the standpoint of the cardiac problem as a whole, all cardiac clinics should use the same record form, the same nomenclature and criteria for diagnosis, otherwise it will be impossible to gather together the data from all clinics for statistical study. The necessity for statistical study cannot be overstressed. Many fundamental questions concerning heart disease can be answered by no other means. Modern medical principles of treating the patient as a whole require that all the records of each out-patient be filed together. A central record system needs good administrative management in order to be effective, but it is far superior to the old plan in which each special clinic had its independent record filed by itself. If such a record system is used, all cardiac diagnoses must be indexed and cross-indexed if they are to be of real use as a source of information.

*Staff*—The clinic staff should consist of the Medical Staff

Social Service Staff

Technical Assistants (if laboratory work is carried on in the clinic)

Clerical Assistants

The duties of the Medical Staff are to take the medical histories, make physical observations, interpret and correlate the facts so obtained with facts brought to them from laboratories, other clinics, the patients' homes and places of work and outside agencies, from these to arrive at a diagnosis, and institute treatment. They should be responsible for the proper entry of all observations on the chart, though the actual making of the entries should be done by clerical assistants. In large clinics, their work may be more specialized, one or more acting in a supervisory capacity, others attending to details. They should



there must be close connection with such a service, both ambulatory and bed, not only for tonsillectomies in patients with diseased tonsils, but to search for diseased accessory sinuses, middle ears and sometimes mastoids, and to undertake the proper means for their cure

*Dental Clinic*—The same relation obtains with a dental clinic. Large cardiac clinics may find it saves much trouble to have a dentist in attendance

*Laboratory*—Besides the routine laboratory examinations done in the clinic, a connection should be made with a laboratory to make special examinations when they are indicated. X-ray and electrocardiographic facilities should be arranged for in this manner if they are not available at the clinic itself

*Convalescent Home*—The convalescent home refers patients to the clinic whom it has received from the ward service. The clinic should be able to send many patients direct to the convalescent home for periods of rest as prophylactic against heart failure. The clinic should keep in mind that a convalescent home is not a refuge for the terminal cases, only patients who may have reasonable hope of having their cardiac reserve increased by convalescent care should be sent to the home. This matter cannot be overstressed. Every worker in a heart clinic is constantly being pressed to do something for the heart patient who is passing into that state of markedly diminished cardiac reserve, where he has symptoms of failure when at rest and where his limitation of effort is so great that he is only able to sit up in a chair or possibly walk to his meals. Such patients are usually discharged from medical service of hospitals. They break down at once in the usual tenement, the clinic worker knows if they are readmitted to the ward they will be discharged again in a short time, and it is a great temptation to send them to a convalescent home. At such a home, they may be able to live within their reserve for several months, but after that time they become bed cases. They should never be sent to a convalescent home. Such homes, as said before, should be rigidly reserved to give the needed rest to the cardiac with some future

*Home for the Permanently Disabled*—A great need, and most difficult to meet, is the disposition of patients who have become permanently disabled. A home for these cases should be available to a clinic. Each year, a number of its patients quietly slip into the class which needs such an institution. Refuges of this sort should be called hospitals, never homes for incurables

*Employment Agencies*—It is frequently necessary to obtain employment for patients or change the employment of those at work. This branch of the work is important and delicate. Patients must be fitted to their occupations with the greatest care. Judgement must be used by all

agencies. The physician must know, as far as possible, the physical potentialities of his patient, the social service worker his past history as to reliability, honesty and willingness to work, the employment agency the character of the work, the effort it entails, and its hygienic aspects. Too hurried and inconsidered placements of heart patients in industry result in failures of the patients to make good, which of course increases the difficulties of the employment agency in placing other patients, it may also result in the physical breakdown of a misplaced cardiac, and entail a long period of convalescence. In large cities, a single agency securing employment for all cardiacs would be more efficient than several bureaus working independently

*Vocational Guidance*—Young cardiacs should, as far as possible, be guided into a life work which will require a minimum of physical effort and little exposure. For such occupations patients need training and the cardiac clinic should have the co-operation of an agency giving vocational guidance and training

*Private Physicians*—Private physicians who refer patients to the clinic, should give information concerning the past history of their patients to the clinic, and the clinic, on its part, should be scrupulously careful to let the physician know of the progress of his case

We have enumerated and briefly described the outside agencies with which a cardiac clinic must co-operate, if this is to be done successfully, a close liaison must be maintained between the patient, those agencies and the clinic. The details of their coordination is the duty of the Social Service Department of the clinic.

*Social Service Department*—What his staff is to the commanding officer in the army, the social service worker should be to the chief of a cardiac clinic: intelligence, liaison, operations and, in smaller clinics, possibly supplies—though this should not be the duty of this department. The social service worker should have available information concerning the physical and mental condition and home environment of the patients; data concerning their education, industrial relationships, finances, and willingness to co-operate. Such a worker should be in touch with all agencies of possible help to the cardiac, and should keep the physician informed as to new developments in such agencies

As directed by the physician, she should carry out relief for the patients. Whether or not a special type of relief is to be instituted is the problem of the physician, the technique of the procedure should be left to the social service worker. There is a tendency in many clinics not to observe these distinctions of function. The social service worker is not trained or expected to know the physical potentialities of any case, but because of her close contact with the patient she should learn of his needs in greater detail than



*Distancing*—Regularity of attendance and a complete follow-up system is essential if the best results are to be obtained. In clinics in large cities, this is impossible to accomplish unless the patients admitted to the clinic are limited to localities accessible to the clinic. Patients living in districts nearer other clinics should not be admitted, but should be referred to the other clinics, and regular patients moving into other districts should promptly be transferred, each of course, with a transcript of his record. It is a great temptation not to do this, particularly as the patients dislike the transfer, but unless it is done, the social service worker's time quickly becomes so taken up in traveling that she is unable to accomplish her work, the patients become irregular in their attendance because of the distance to the clinic and they do badly. One further word about regularity of attendance: Patients who, through lack of interest and carelessness persist in clinic non-attendance, except when they feel ill, and after several warnings, should be dropped from the clinic and only re-

admitted when they give evidence of willingness to co-operate.

The organization which I have discussed has as its chief purpose the relief of the patient. There are two by-products which go with such relief, if it is efficiently done: the first is clinical research, and the second the education of the clinic staff. Dr. Dublin has pointed out this afternoon the paucity of data at hand concerning the fundamental problems of heart disease. For this data to some extent, we must look to the cardiac clinics. New physicians coming into the clinics must be given an opportunity to learn not only physical signs, but the progress of heart disease and the results of treatment instituted. These two by-products of the clinic are accomplished, I believe, in direct proportion to the amount of accurate detail which appears on the record chart and, since that is essential if the patient is to be properly diagnosed and treated, the three desired objects, proper care of the patient, research, and education of the clinic staff, are dependent on each other.

## Deaths

BRASLAW, ABEL, New York City, New York University, 1889; Fellow American Medical Association, Member State Society. Died October 19, 1925.

BROWNELL, WILLIAM HENRY, Utica, New York University, 1882, Fellow American Medical Association, Member State Society, Physician Faxton Hospital. Died August, 1925.

CARR, WILLIAM, New York City, Bellevue Medical College, 1872, Fellow American Medical Association, Member State Society, Consulting Oral Surgeon Bellevue Hospital. Died October 15, 1925.

COX, CHARLES NEWTON, Brooklyn, University of Pennsylvania, 1883, Fellow American Medical Association, Fellow American College of Surgeons, American Laryngological, Rhinological and Otolological Society, American Otolological Society, Member State Society, Brooklyn Pathological Society, Consulting Laryngologist and Otolologist Bushwick Hospital, Consulting Otolologist Long Island College and St. Mary's Hospitals. Died October 8, 1925.

DELPHEY, EDEN VINSON, New York City, College of Physicians and Surgeons of New York, 1889, Fellow American Medical Association, Member State Society, New York Academy of Medicine, American Electrotherapeutic Association. Died October 22, 1925.

GRIBBON, HENRY ALEXANDER, Poughkeepsie, University and Bellevue Medical College, 1899, Fellow American Medical Association, Fellow American College of Surgeons, Member State

Society, Alumni Association Post-Graduate Hospital, Attending Surgeon Vassar Brothers and Samuel Bowne Hospitals. Died October 18, 1925.

HEYMAN, MARCUS BABCOCK, New York City, New York University, 1890, Fellow American Medical Association, American Psychiatric Association, American Public Health Association, New York Society for Clinical Psychiatry, New York Neurological Society, New York Academy of Medicine, Member State Society, Consulting Physician U. S. Veterans' Hospital No. 81 and Broad Street, Superintendent Manhattan State Hospital. Died October 7, 1925.

KUDLICH, HERMANN F., New York City, Vienna, 1869, Member State Society. Died September 26, 1925.

METZGER, JULIUS I., New York City, College of Physicians and Surgeons of New York, 1882, Member State Society. Died September 29, 1925.

MILES, GEORGE WILLIAM, Oneida, Starling, 1879, Fellow American Medical Association, Member State Society. For many years Secretary of the Madison County Medical Society. Died October, 1925.

NEWLAND, FRANK H., Clifton Springs, Cleveland Homeopathic, 1902, Member State Society. Died September 16, 1925.

SEELEY, JENNIE GRAY, Ithaca, Syracuse, 1903, Member State Society. Died September 4, 1925.

be relieved, as far as possible, from work that can be done by lay workers. Another duty of the medical staff, helped by the social service worker, is to enlist the intelligent co-operation of the patient. This can be done best by educating him as to his limitations and explaining to him as far as possible the reason why he is handicapped.

The duties of the Social Service Staff have already been described.

If laboratory work is carried on in the clinic, some of it may be done by the technical assistant, e.g., the electrocardiographic technician, the interpretation of their observations is, of course, the function of the Medical Staff.

Clerical assistants, either paid or volunteer, should be used for filing and indexing histories, filling in such data as name, address, age, sex, etc., and intelligent volunteers can easily be trained to make observations as to temperature, height, weight, certain measurements, vital capacity, etc. They should also enter on the charts, from dictation, the results of physical examinations, in short, do any work that does not require the special training of a physician or social service worker.

While the subdivision of the labor of the clinic should allow the trained experts to conserve their time, it will defeat its purpose unless there is proper coordination. To function properly

- 1 All workers in the clinic must have well defined duties
- 2 These duties should be performed in proper sequence so that
  - a It becomes a clinic routine.
  - b The latest data may be obtained before treatment is instituted. A record should be kept of all their observations and instituted activities

Figure 2 shows the internal organization of one clinic following these general principles.

The subdivision into certain groups for medical observation and treatment, is a detail which would vary in different clinics. On paper, this organization may look complicated. However, after the second or third visit of a patient to the clinic, the patients proceed from station to station without direction, they are handled without hurrying, quickly, and without long waits. Frequently, ninety patients are cared for in two and a half hours. It will be seen that upon the first visit the patient has his history taken, a general physical examination is made, laboratory specimens collected and temporary medical treatment is instituted. During the ensuing week, a home visit is made by the social service department, and social, economic and industrial facts are obtained. On his return visit, the patient is electrocardiographed and fluoroscoped, a tele-roentgenogram is taken, and he has a nose and throat examination. On his third visit, a dental

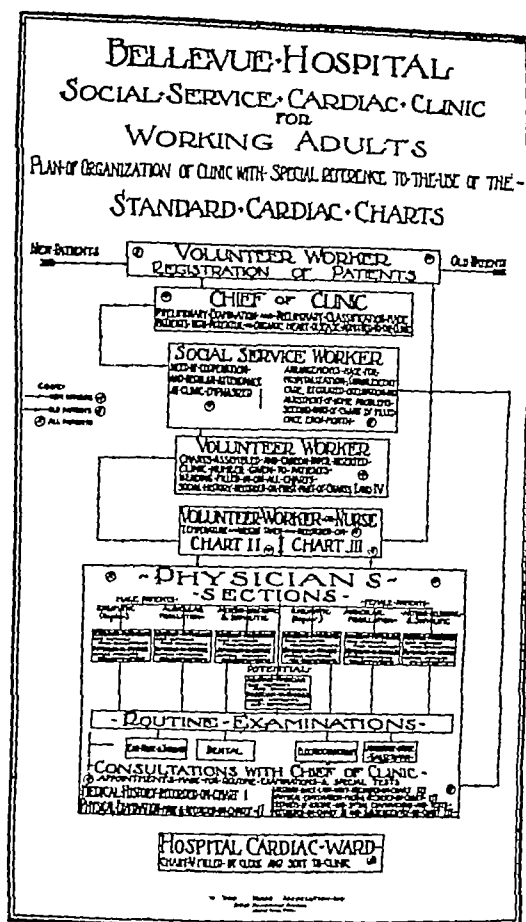


FIG II

Diagram showing the internal organization of one cardiac clinic, illustrating the point that all workers have well-defined duties which are performed in a regular sequence.

examination is made, the data of the previous examination is upon his chart and the physician, with the social service worker, is then able to make a plan based upon careful study of the patient.

It is necessary that patients report regularly. They should be requested to return at definite dates, some weekly, others every two or three weeks, or even less frequently. All active patients should be required to report at least every three months. In our clinic, appointments are made for definite dates, but as yet not for a definite hour. The chief social service worker has a record kept for her by volunteer workers as to the dates of appointments and after each clinic night knows what patients have failed to keep their appointments, these patients are at once written to and asked to come to the clinic the week following. If they do not appear, a home visit is made the next week to determine the cause of non-appearance.

While it is without the province of the Academy to run any sort of a school or post-graduate teaching, its power for good in stabilizing this work and distributing a great fund of information to those contemplating study here, places it in an enviable position

The plans which are proposed for an easier access to the library and an even better co-operation between fellows who wish to secure books and literature from the librarian are most commendable. The last edition of the *Academy Bulletin* suggests this in greater detail

There may still linger in the minds of some a doubt as to whether the most fortunate site for the Academy is its new location? Matrimony offers the same problem and after all maybe it is merely a matter of adjustment

We are reasonably sure that all who have contributed in both time and money to the new Academy will take a civic pride in supporting its upkeep

Any metropolis growing as rapidly as New York cannot make plans anticipating a distant future. We outgrow them almost before they are realized, and the idea of erecting any building in perpetuity must ever be a dream

So the men of the city and state again join in congratulations and thanks to their fellow officers who have been instrumental in establishing the New York Academy of Medicine in new and better quarters, together with the privilege and opportunity for greater good to the whole medical profession

---

## THE DISTRICT BRANCH MEETINGS

We have attended all the District Branch meetings, and have enjoyed every one of them, but we dare not try to judge which one was the best. Each carried out some feature of its program better than the others, and by combining the excellent features of all the programs, we can visualize the ideal meeting

We are aware that any system of forecasting has its limitations. Consider the town in which the meeting shall be held. The Branch meeting whose attendance showed the greatest per cent of increase over that of last year was held in the most inaccessible place, but automobiles triumphed over the limitations of time and space, and physicians evidently thought that the beauty and repose of a mountain hotel are more seductive than the allurements of a great hospital in a large city where the falling off of attendance reached its highest point

The meeting in the mountain hotel was characterized by sociability. The members brought their wives, and there was time for getting acquainted with one another. The whole atmosphere of the place tended toward sociability, and the corridors with their attractive window seats and divans invited acquaintances and friendships—and those, after all, are among the most valuable products of the District Branch meetings

The best assembly room was that which was equipped with a stereopticon, and could be darkened readily. The visual method of imparting information is the most effective, for the eye is more than equal to the ear as an avenue of entrance of ideas to the brain. Speakers like to use lantern slides to illustrate their talks, and great is the satisfaction of both speaker and audience when the pictures are shown clearly

We might make a whole long editorial on

the use of lantern slides in association with a medical lecture, but we will only say that the model set of slides which we saw was made up of diagrams and letters which were so large and plain that they could be easily read from any part of the assembly room

The best program of the Branch Societies gave abundant time for the presentation of the activities of the State Society. One of the essential features of a Branch Society meeting is the presence of the President and other officers of the State Society, and the opportunity to hear and meet the officers is deeply appreciated by the members. The most satisfactory program divided the time about equally between State Society problems and scientific subjects

The ideal District Branch meeting had one of the major activities of the State Society on its program. Graduate education is a subject which is of vital interest to every County Society, and it had been formally recommended to the Branch Societies by vote of the Committee on Public Health and Education. Three District Branches listed the subject on their programs

Another subject which had been recommended by the Committee on Public Health and Education was the movie films on Gastric Ulcer and on Tuberculosis. Four Districts listed the films on their programs

The time available for each meeting was limited. If every ideal feature had been adopted by the committee of arrangements, one day's time would not have been sufficient to carry out the program. Every program gave evidence of careful planning, and the best evidence of the value of the meetings is that those in attendance regretted the shortness of the hours

# EDITORIALS

The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

Editor-in-Chief—ORRIN SAGE WIGHTMAN, M.D.,

New York

### COMMITTEE ON PUBLICATION

E. ELIOT HARRIS, M.D., *Chairman*

New York

WILLIAM H. ROSS, M.D.

Brentwood

DANIEL S. DOUGHERTY, M.D.

New York

Executive Editor—FRANK OVERTON, M.D. Patchogue

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

*President*—NATHAN B. VAN ETTEN, M.D. New York  
*First Vice President*—WILLIAM H. ROSS, M.D. Brentwood  
*Second Vice President*—FREDERICK H. FLAHERTY, M.D. Syracuse  
*Speaker*—E. ELIOT HARRIS, M.D. New York  
*Vice Speaker*—GEORGE M. FISHER, M.D. Utica  
*Secretary*—DANIEL S. DOUGHERTY, M.D. New York  
*Assistant Secretary*—HOWARD GILLESPIE MYERS, M.D. New York  
*Treasurer*—CHARLES GORDON HEYD, M.D. New York  
*Assistant Treasurer*—JAMES PEDERSEN, M.D. New York

**COUNSEL**  
GEORGE W. WHITESIDE, Esq., 27 William St. New York  
Telephone, Broad 1744

**ATTORNEY**  
ROBERT OLIVER, Esq., 27 William St. New York

**EXECUTIVE OFFICER**  
JOSEPH S. LAWRENCE, M.D. 51 Chapel Street, Albany

### SECTION OFFICERS

*Medicine*  
*Chairman*—L. WHITTINGTON GORHAM, M.D. Albany  
*Secretary*—WARDNER D. AYER, M.D. Syracuse

*Surgery*  
*Chairman*—EDWARD S. VAN DUYN, M.D. Syracuse  
*Secretary*—GEORGE E. BRILEY, M.D. Albany

*Obstetrics and Gynecology*  
*Chairman*—ALFRED C. BECK, M.D. Brooklyn  
*Secretary*—NATHAN P. SEARS, M.D. Syracuse

*Pediatrics*  
*Chairman*—ROGER H. DENNETT, M.D. New York  
*Vice Chairman*—ARTHUR W. BENSON, M.D. Troy  
*Secretary*—JOHN AIKMAN, M.D. Rochester

*Eye Ear Nose and Throat*  
*Chairman*—EUGENE E. HINMAN, M.D. Albany  
*Secretary*—JAMES W. WHITE, M.D. New York

*Public Health, Hygiene and Sanitation*  
*Chairman*—ARTHUR D. JAKES, M.D. Lynbrook  
*Secretary*—LEO F. SCHIFF, M.D. Plattsburg

*Neurology and Psychiatry*  
*Chairman*—CLARENCE O. CHENY, M.D. Utica  
*Secretary*—THOMAS K. DAVIS, M.D. New York

### CHAIRMAN, STANDING COMMITTEES

*Arrangements*—EDWARD R. CUNIFFE, M.D. New York  
*Legislation*—HENRY L. K. SHAW, M.D. Albany  
*Public Health and Medical Education*,  
CHARLES A. GORDON, M.D., Brooklyn  
*Scientific Work*—ANDREW MACFARLANE, M.D. Albany  
*Medical Economics*—WILLIAM WARREN BRITT, M.D. Tonawanda

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex President and the Councilors of the District Branches.

*First District*—JOHN A. CARD, M.D. Poughkeepsie  
*Second District*—JOSEPH S. THOMAS, M.D. Flushing  
*Third District*—CHARLES P. MCCABE, M.D. Greenville  
*Fourth District*—HORACE M. HICKS, M.D. Amsterdam  
*Fifth District*—NELSON O. BROOKS, M.D. Oneida  
*Sixth District*—GEORGE H. FOX, M.D. Binghamton  
*Seventh District*—WILLIAM I. DEAN, M.D. Rochester  
*Eighth District*—HARRY R. TRICK, M.D. Buffalo

For a list of the Officers of the county medical societies, see October 15 JOURNAL, advertising page XVIII.  
For list of District Branch Officers, Standing Committees and Special Committees, see October 15 JOURNAL, advertising page third cover

## LAYING THE CORNER STONE OF THE NEW YORK ACADEMY OF MEDICINE

On October 30th, the New York Academy of Medicine will lay the cornerstone of the new building to be erected at 103rd Street and Fifth Avenue

THE MEDICAL JOURNAL OF THE STATE OF NEW YORK wishes to tender the congratulations of its organized membership

This occasion should be a source of satisfaction to the officers and Fellows of the Academy who have striven so unselfishly these past years to provide a fitting home for the advance of medicine in our great metropolis

The choice of a site, the enlistment of financial assistance from the Carnegie and Rockefeller Foundations and the campaign of raising funds from the membership itself all constituted problems of no mean dimensions

These have been met and successfully solved and now the dream of many years is in the process of being realized

The work of the Academy is primarily one of education. It is fortunately divorced from any political ambition and must necessarily defer matters of this character to the County and State Societies, where they more properly belong

New York has become a great medical center. A clearing bureau is as essential to it as an admission ward to a great hospital. Correlating the medical clinics, providing meetings and sections for every specialty in medicine, and opening its great library to the public and the profession are the outstanding features of its usefulness



# LEGAL



By GEORGE W. WHITESIDE, Esq  
Counsel, Medical Society of the State of New York

## THE GOVERNMENT OF A PROFESSION

To punish the erring members of the legal profession who stray from the paths of rectitude has long been the policy of the Bar Association in New York City. The Committee on Grievances has afforded the aggrieved client a forum wherein he needs no lawyer to plead his cause, and has furnished the lawyer complained against a tribunal composed exclusively of lawyers, who are expert in applying standards of professional honor to the transaction presented for their scrutiny.

This Committee has gained the confidence of the public and of the profession. It is composed of nine unpaid members of the Association, who assume the onerous and unpleasant responsibility of judging their brother lawyers, to the end that public confidence in the profession may not be shaken by failure of retributive justice to the unscrupulous and unworthy member. It is not a mere gesture or an abstract declaration of professional principles that this committee makes. They take specific complaints and dispose of them.

The nine members of this Committee, in the year 1923-24, held forty-nine meetings, which is about an average of a meeting a week. They had brought to their attention in that period, twelve hundred and thirty-four complaints against attorneys. They actually tried fifty-nine cases, and in twenty-nine of these cases requested that disbarment proceedings against the accused attorneys in the Appellate Division be instituted. As a result of their work in the year, the Appellate Division disbarred four lawyers, suspended five for periods ranging from three months to one year, censured one, excused one, and dismissed the proceedings in one case. This large number of complaints so considered covered a broad field. In three hundred and eighty-six cases attorneys were charged with negligence, carelessness, bad advice and collusion against their clients' interests, in two hundred and twenty-six instances they were charged by clients as a result of disputes over fees, one hundred and seventy-three complaints dealt with alleged conversions of money, subornation of

perjury was charged in fifty-nine cases; the use of threats and blackmailing tactics in thirty-nine cases, and improper advertising in thirty-eight cases. These instances cited indicate the type of matters that this Committee considered during that year. This activity was supported, during that time, by three thousand two hundred and twenty-four members, who paid dues of \$182,-655 00, an average slightly under \$60 00 a year per member. The Committee doing this work spent \$19,319 49.

Suppose there had been no such body functioning in the legal profession. Where would all of this professional dirty linen have been washed? How many innocent lawyers accused in twelve hundred and thirty-four complaints would have had their names dragged before the public and their professional reputation besmirched? How many of the guilty would have been punished? Was it worth the money that was spent during that one year and the time of the nine members of that Committee to accomplish the results so essential to the public interests, so important to the profession and so vital to the individual? There are very few cases brought against lawyers in the courts for their alleged shortcomings and there is little publicity that unfavorably affects the profession—suing lawyers does not seem to be a very popular procedure. Has the activity of this Grievance Committee made unnecessary the institution of many such suits against lawyers by aggrieved clients? Has that Committee afforded a fair and inexpensive forum for the aggrieved client to have his grievance justly considered? Has not that Committee done much to elevate the standard of professional honor and save the weak and erring by timely warning from falling from the height of recognized professional responsibility to the depths of professional degradation?

Similar work is done by other bar associations throughout the state.

Is there any food for thought by the medical profession in what the legal profession has thus done and is continuing to do?

## THE PSYCHOLOGY OF MEDICAL INSTRUCTION

The most efficient practical means of imparting instruction to physicians is by means of the programs of medical societies. There are three principal methods of imparting instruction through the programs:

- 1 The spoken lecture
- 2 The visual method in which lantern slides, or diagrams, or other visual helps are used
- 3 The clinical, in which cases are shown, or pathological specimens are exhibited, or vivid case histories are read

The essential features of these three methods are employed in the printed pages of medical periodicals and books.

The spoken lecture reaches the brain through only one avenue—the ear through which words and ideas must go in single file. The visual method adds the broad avenue of the eye, through which ideas may pass in groups, and may pause, or turn back, or resume their entrance at any desired rate. The

use of lantern slides and diagrams not only aids the listener, but they compel the speaker to prepare and arrange his thoughts systematically, and to adapt his words to the concrete images which are seen by the eye.

The spoken and the visual methods are usually impersonal and arouse few or no emotions. In distinction to these two methods the clinical demonstration is personal in a double way. The listeners are always interested in a suffering human being, and if, in addition, they have a similar case in their own practice, the case at once takes on a vital personal meaning to the doctor himself.

A clinical program for a county society is by far the most efficient form of teaching, and the next in value is a talk illustrated with lantern slides and diagrams. A stereopticon is a necessary part of the outfit of a county medical society.

How many county societies own stereopticons?

---

## CASE HISTORIES

The importance of case histories is becoming realized more and more. Histories of cases may have a medico-legal value, and they are necessary for medical progress, and for the good name of both doctors and hospitals.

History writing is one of the most unpopular of all the routine activities of a hospital physician, and our medical surveys have revealed widespread difficulties in getting first-class records made. The leaders in the medical profession insist that histories of their cases shall be written, but the hospital authorities throughout the State would like to see their histories improved.

To most doctors writing medical histories is as irksome as writing articles for the medical journals. We medical editors can appreciate the feelings of the superintendents and managers of hospitals in which histories are not completely written.

There is nothing inherently difficult in writing a good case history. The American College of Surgeons does not require that histories shall be kept to the last detail, as is required in some of the large city hospitals.

Possibly the memory of writing useless details during their interne days is a factor in keeping doctors from writing full histories.

Many are the means adopted by hospitals to secure histories. Some post the names of delinquent doctors, but it often has little effect. One of the most effective means is that of requiring that full histories shall be written before a patient is discharged. The doctor quickly hears from a patient who is told that the reason that she can't get her clothes and go home is that the doctor has not completed his history of her case.

The hospital trustees have a responsibility to provide the means for writing histories. A history clerk is almost indispensable. She will waylay the doctors and get the required facts. She will typewrite the cases so that they can be read, and she will file and index the cases so that they can be utilized in future years.

The American College of Surgeons is doing an excellent piece of public health work in establishing a standard of histories that shall be maintained as a prerequisite to the recognition of the hospitals.



# MEDICAL ECONOMICS



As the members of the Committee on Medical Economics attend medical society meetings and get the opinions and reactions of the members, they are encouraged by the response to the committee's program that was announced on page 942 of the Journal of October first

The subject of periodic examinations of apparently well persons was presented before the Eighth District Branch on October 7th, and aroused enough interest so that several of the county presidents in this district have asked the committee to repeat the discussion before their societies, and help them to arrange for definite programs of action

The medical profession has been so busy with the routine of caring for the sick and disabled that it has given little attention to the well and able-bodied individual. But now so many people are demanding that they have a thorough inventory taken occasionally that the doctors are really taking note of it and are inquiring where they can get a good blank for this purpose. The American Medical Association published a blank and many physicians have been using it. Several states have adopted their own blanks, while many of the counties in this state have endorsed the movement and adopted blanks of their own. The particular form of blank used is of minor importance so long as it contains all the headings and sub-divisions, and will lead the doctor to make a thorough examination. The value of having a good blank and being familiar with it is that one may proceed with a complete examination much more quickly by having a definite routine and always following it. The use of a standard form is desirable because by recording methodically observations as to physical and functional conditions of persons passing through their hands, physicians will acquire increasing skill and keenness in detecting early evidence of preventable and curable conditions, and also because by the general employment of a thorough and complete method of inquiry by physicians the laity will learn to appreciate the importance to their own health of good medical examinations and to expect attention to details of personal hygiene on which continued health so often depends.

There are two points to be emphasized. The first is that we want to get the idea across to the laity, "*Go to Your Family Physician First*." This has been done in many cities and counties by putting on a Health Week Campaign.

The Medical Societies of Onondaga, Albany, and Monroe Counties, and in Yonkers, have recently made the Health Examination campaign

a part of their regular program of public health education, and in each case have taken further steps to work out the details of the campaign with the co-operation of other agencies, particularly local committees on tuberculosis and public health.

The members of the Onondaga County Medical Society voted not only to promote health examinations, but to initiate the campaign by a health examination clinic with its own members to be examined, as was done in Brooklyn, thus setting a good example for the rest of the Community. The Onondaga Health Association is co-operating in this enterprise.

The Albany County Medical Society unanimously adopted resolutions, urging periodic examinations, and appointed a Committee to develop plans in co-operation with other agencies.

The Yonkers Academy of Medicine recently endorsed the health examination campaign and appointed a Committee which will act jointly with a Health Examination Committee of the Yonkers Tuberculosis and Health Association, and a campaign program has been adopted for operation the first of the year, including moving picture publicity, lantern slides, pamphlets, poster exhibits, and newspaper publicity.

At a meeting of the Monroe County Medical Society, a resolution was unanimously passed making the Health Examination movement a part of its program and authorizing the appointment of a special Committee.

The following statistics are of interest in connection with the Health Examination Campaign as carried on during the past 18 months by the Rochester Tuberculosis Association.

Twenty thousand health examination leaflets and 18,000 folders were distributed to industrial plants, including the Eastman Kodak Company, and at the Rochester Industrial Exposition, 1,500 were distributed in the towns and villages, 15,000 pay envelope cards were distributed to employees in smaller plants, and to hotels and lunch rooms, 2,000 posters were distributed to 297 factories, 375 special letters were sent to food handlers, 450 letters to managers of factories, and 316 form letters to physicians in the city. The film, "*Working for Dear Life*" appeared in 17 moving picture houses 140 times, before 35,000 people, 25 employment managers were interviewed, 37 health talks were given and 2 talks by radio by the Chairman of the Health Examination Committee. Two sets of 150 street car cards advertising health examinations were used one month each in the street cars. As a

## BREAKING OF X-RAY APPARATUS

The plaintiff, a woman about 55 years of age, had suffered a right Colle's fracture and had come to the defendant physician for treatment. To aid him in his examination and diagnosis he ordered an X-ray to be made and arrangements were made to meet the patient in the X-ray department of a hospital with which the physician was connected and had the right to use their X-ray apparatus.

At the appointed time the physician met the patient at the hospital and took one X-ray picture of the wrist. He then proceeded to prepare the apparatus for the taking of a second picture, the patient's arm in the meantime lying upon the X-ray table. While adjusting the apparatus one of the control cables broke causing the X-ray tube to fall upon the patient's injured wrist. The fracture was treated by the physician with a subsequent good result, the patient procuring a functioning wrist with some slight impairment in

flexion. Thereafter the patient instituted an action against both the physician and the hospital, charging them with negligence in the taking of the X-ray and claiming that by reason of the breaking of the X-ray apparatus and part falling upon her injured wrist the condition at the site of injury was aggravated, causing her great pain and suffering and permanent disability.

The action came on for trial and at the close of the plaintiff's case was dismissed as against the defendant physician. The trial was continued as against the hospital and submitted to the jury which found in favor of the hospital. The plaintiff thereupon appealed to the Appellate Division which affirmed the judgment in favor of the physician, but reversed the judgment as to the hospital ordering a new trial. The matter was thus favorably terminated in favor of the defendant physician.

## CLAIMED NEGLIGENT OPERATION RESULTING IN LOSS OF KIDNEY

A physician being unable to collect his bill for services rendered in the performance of an operation for the removal of a stone from the kidney, instituted an action against the patient, in which action, as a means to avoid the payment of the bill, the patient interposed a counterclaim of alleged malpractice charging that the physician negligently performed the operation, as for many days after the operation there was a continued bloody discharge resulting in pyelitis and subsequent bilateral pyelitis. The patient further claimed that by reason of the surgeon's negligence it was necessary for him to submit to three additional operations causing the loss of the patient's left kidney.

When the patient sought advice and care from

the physician he was suffering from stones in both kidneys and disease of both kidneys. An operation was performed upon the right kidney and a stone removed therefrom. As in almost all cases where an operation of this nature is performed, there was some bleeding. The operation upon the right kidney was successful and relieved the condition as, at the time of the institution of this action the right kidney was converted into a healthy and good functioning organ.

When the case was about to be reached for trial and the physician pressed his action to recover for the services rendered, the defendant withdrew his counterclaim of alleged malpractice and paid the physician for the services which had been previously rendered.

## UTERINE TUMOR—X-RAY BURN

The plaintiff in this action had been examined by a gynecologist and referred to an X-ray therapist for treatment for a uterine tumor. It was charged that he failed to use due and proper care in his endeavor to cure the plaintiff, in that on the day specified he negligently administered the X-ray, causing her to be burned, which condition would not have resulted had care and skill been used in the administration of the X-ray. The husband also joined in the wife's action, seeking to recover damages for the loss of his wife's services.

The dates of treatment and the dosage administered to the plaintiff were as follows:

Date	Spark Gap	Distance	Filter	Time	Place
May 25	9"	10"	3 mm.	6 min	Over lower abdomen
June 3	9"	10"	3 mm.	6 min	Buttock and sacrum
June 12	9"	10"	3 mm.	6 min	Abdomen anterior

No further X-ray therapy was administered. When the patient returned to defendant on July

10th there was a small area of redness on the abdomen, and on July 10th, 20th and 22nd he administered light treatment by holding over the reddened area a 100 Watt tungsten lamp for a few minutes at a time. There was no break or peeling of the skin and no ulceration. The defendant had advised the patient to return and to continue the light treatment, but the plaintiff did not return after July 22nd.

It was claimed by the patient that a portion of her abdomen was severely burned. However, about the time of trial a physical examination disclosed that there was a slight area about the size of a quarter on the abdomen which showed a slight discoloration, but no other injury.

The action finally came on for trial which lasted three days, and after the introduction of testimony by both sides the case was submitted to the jury, which rendered a verdict in favor of the defendant.





# MEDICAL SURVEY



## NUMBER 17—MONTGOMERY, FULTON AND HAMILTON COUNTIES

**EDITOR'S NOTE**—The information on which this Survey is founded was obtained principally from Dr J S Walton, District State Health Officer and President of the Montgomery County Medical Society, Dr H B Riggs, President of the Fulton County Medical Society, Dr H M Hicks, President of the Fourth District Branch, and Dr Charles Stover of Amsterdam

Montgomery County extends for 30 miles on both sides of the Mohawk River, beginning on the west side of Schenectady County. It has an area of 398 square miles, and a population of 57,928. It has one city—Amsterdam—with a population of 33,524, and nine villages with a total population of 12,350. The largest village—Fort Plain—contains 2,747 people. The county has 12,054 people living outside the cities and villages.

**Physicians**—There are 56 physicians listed in Montgomery County, according to the Directory of the Medical Society of the State of New York, of whom 34 live in Amsterdam, and 24 in ten centers in the rest of the county. The proportion of doctors in the city is 1 to 1,000 of population, and outside the city it is 1 to 1100.

**County Medical Society**—The Montgomery County Medical Society has 51 members, or 91 per cent of all the doctors listed in the county. This is an exceedingly high percentage, and shows a deep interest in medical matters on the part of the physicians of the county. The Society holds monthly meetings which are well attended.

The city of Amsterdam is the center of Montgomery County, medically and geographically. Its doctors are active in medical affairs, and are qualified and equipped to take good care of practically every medical condition that arises, without calling for outside help. The doctors are within easy reach of medical centers in Schenectady and Albany, and they take pride in conforming to the standards of the doctors in the larger cities.

The high standards of medical practice are reflected in the activities of the County Society. Monthly meetings are held, and also the monthly staff meetings of the two hospitals in Amsterdam are in fact clinical meetings of the doctors. The Montgomery County Medical Society has been active in post-graduate medical work since the year 1919, when the Board of Supervisors established a county laboratory with a full-time director and pathologist. This step aroused the

interest of the doctors, and they put on a series of lectures on pathology for which a fee was charged. This course was so well attended and received that the physicians have planned other courses for which fees will be charged. The County Society is thus one of the pioneers in graduate education work.

**Hospitals**—Montgomery County has three hospitals.

1 St. Mary's, Amsterdam	50 beds
2 Amsterdam City, Amsterdam	75 beds
3 Tuberculosis Sanatorium	50 beds

The county has three beds for each 1,000 of population, but provision is being made to double the capacity of St. Mary's.

The two hospitals in Amsterdam are well organized with open staffs. Over two-thirds of the physicians of Amsterdam are listed on the staffs of both hospitals. Each holds monthly staff meetings which are practically meetings of the County Medical Society. The hospitals have adopted a system by which the nurse in charge of each case is authorized to look after its history, and to be persistent in asking the doctor for the necessary items of information. The names of the doctors who do not comply with the requests of the nurses are posted, and as a final resort no patient is discharged until the doctor has completed the history. The result is that the doctors have acquired the habit of writing histories. Each hospital has a training school for nurses.

**Public Health Work**—The official public health work of Montgomery County is done by 10 health officers, of whom 9 are members of the County Society, and 8 have had special courses of instruction. Each health officer outside of the city of Amsterdam serves an average of 2,700 people.

The county maintains a tuberculosis sanatorium with 50 beds, in charge of a full-time superintendent, Dr W A Bing. Clinics are held at regular intervals, and the work is well organized.

A lay county tuberculosis committee is active. It supports an executive secretary and uses most of the Christmas seal money in the support of a summer camp for undernourished children.

The county maintains a public health laboratory in the Amsterdam City Hospital, with a branch in St. Mary's Hospital, and another in the County Sanatorium. The director, Dr J A Dickson, has brought the work up to a high stage of efficiency. He and his staff are at the service of physicians at all hours to give intra-

special feature, a Balopticon was installed in several store windows showing 24 health slides. Articles urging health examinations have appeared periodically in the press.

The second point to be emphasized is that general practitioners should be prepared to take care of their patients when they come.

The public is becoming educated today to demand a scientific and up-to-date attitude on the part of the physician. The present transportation facilities do not require people to employ the doctor around the corner. If they don't get service at home, they go elsewhere. After all, service is what we have to sell, but it must be scientific. The public is willing to pay for the kind of service it demands. It is up to us to render that service and charge for it.

We hear much about the passing of the family doctor. Don't be alarmed. The passing of the slipshod, unscientific bunk dealer is a reality. But the well trained, properly equipped, experienced general practitioner has a field today greater than ever before. He is a good diagnostician. He sees his patient as a whole. He knows his peculiarities and circumstances. He can decide when to refer him to a specialist and when to protect him from the danger which is threatened by a narrowly specialist point of view.

He is not only a physician, but a friend and counselor. He not only knows the normal but he knows the effect upon health of diet, exercise, mental attitude, recreation, family and social life.

His care of cases of typhoid fever, diphtheria, scarlet fever, tuberculosis and malaria has been materially reduced by sanitation and preventive medicine. Social medicine, free clinic, school and industrial medical service tend to encroach upon the field of the general practitioner. But what of such diseases as cancer, diabetes, diseases of the kidney, heart and blood vessels and other organic diseases? They seem to be increasing, or at least not decreasing. Early diagnosis seems to be the step in combating these maladies and early diagnosis cannot be made without examining apparently well individuals. What better plan can one suggest than to advise every individual to go on his birthday and have a competent physician make a thorough physical examination, and have an inventory of his physical assets and liabilities? In this way the early de-

tection of some organic disease or some definite physical impairment of which the person is unaware is brought about. Errors in environment, hygiene and personal habits may be corrected and through this the span of life, which is now about fifty-eight years, will be materially increased.

During the last decade, many agencies, such as health departments, voluntary health organizations, life insurance companies, hospitals, clinics, industrial concerns and individual physicians have been taking more and more interest in the proposition of Periodic Health Examinations of apparently well people.

With the slogan, "Have a Health Examination on Your Birthday," the campaign of the National Health Council started July 4, 1923, and has gained such momentum that its effect is felt by every ethical physician doing general practice in this state and in many other states in the Union.

It is quite natural that insurance companies should be the first to put the idea to practical test because it offers a definite plan for the preservation of human life.

Taking advantage of the publicity given by the National Health Council and the natural attitude of the lay mind which is always looking for some way to avoid employing a physician, numerous health laboratories have commercialized the idea and are flooding the mails with their circulars advertising that for fifteen dollars per year they will make four urinalysis and tell each person just what to eat and how to live indefinitely.

It is high time that organized medicine in all of its branches took definite steps to meet the demands created by this nation-wide campaign.

How can the medical profession be prepared to meet this great change that is coming?

1 The members of the medical profession should each one have a health examination. In what better way can we visualize this important step and show our patients that we practice what we preach?

2 Every County Society should endorse the movement and put on a regular periodic health examination campaign in which the idea is carried to the laity by a proper publicity program. This should be under the direction of the Public Health Committee.

W. WARREN BRITT, *Chairman,*  
Committee on Medical Economics



# DISTRICT BRANCHES



## THE FIRST DISTRICT BRANCH

The First District Branch of the Medical Society of the State of New York is composed of three metropolitan counties—New York, Richmond and Bronx—and five other counties—Rockland, Orange, Westchester, Putnam, and Dutchess. This Branch held its annual meeting on the afternoon of Wednesday, October 14th, in the Vassar Brothers Institute, Poughkeepsie. The President, Dr. John A. Card, presided, and 50 members were present.

Dr. N. B. Van Etten, President of the Medical Society of the State of New York, described the activities of the State Society, and emphasized the civic duties of the physicians. He gave statistics showing the evolution of the civic duties of physicians, especially in regard to the problems of insanity and nursing. Anyone hearing his address would get a new insight into the broad field of influence which doctors should have in community affairs.

Dr. Daniel S. Dougherty, Secretary of the State Society, gave an inspirational address, combining apropos stories and good advice in a most happy way. He urged the leaders of the county societies to report the activities of the societies in the State Journal in such a way that the local newspapers would abstract the news from the Journal.

Dr. Orrin S. Wightman, Editor-in-Chief of the NEW YORK STATE JOURNAL OF MEDICINE, described the plans for making the Journal so interesting and useful that doctors outside the State would want to subscribe to it.

Dr. Wightman also described the Periodic Health Examination campaign which is being conducted by the New York County Medical Society, and announced the forthcoming publica-

tion of the series of lectures on what to look for in making an examination. Abstracts of several of the lectures were published in the Journal early last Spring.

Dr. Joseph S. Lawrence, Executive Officer of the State Society, described the opportunities of the District Branch leaders in promoting indemnity insurance, increased membership, and sociability and friendships among the members of the county societies.

The scientific address of the day was given by Dr. William Francis Campbell, of Brooklyn, Past President of the State Society, on the subject, "The Hernia Problem and Workmen's Compensation," and illustrated his lecture with lantern slides. Dr. Campbell spoke especially on traumatic hernia, and said that it was an extremely rare condition. Nearly all hernias are of slow onset and are the result of a failure of the congenital peritoneal sac to close firmly. A particular strain or an injury was usually given as a cause for a hernia when a patient first notices it, but Dr. Campbell said a hernia was to be considered traumatic and compensable only when six conditions were present:

- 1 The force is adequate to produce the hernia
- 2 The descent of the hernia follows immediately after the injury
- 3 Severe pain comes on at once
- 4 Prostration is at once marked
- 5 A physician is called within twenty-four hours
- 6 The employer is notified within twenty-four hours

The movie film on Gastric Ulcer was then shown, and was followed by the film on Tuberculosis. See page 1012.

## THE SECOND DISTRICT BRANCH

The Second District Branch of the Medical Society of the State of New York comprises the four counties on Long Island. The physicians of the Island are closely united and cooperative. They meet one another frequently in the medical center, Brooklyn, and they have published their own medical journal, the Long Island Medical Journal, for nineteen years. They have had their common organization, the Associated Physicians of Long Island, for over twenty-six years, or longer than the re-organized Medical Society of the State of New York has existed. The same

men who are deeply interested in the Second District Branch are also leaders in the Associated Physicians. The two organizations, therefore, held a joint meeting on Tuesday, October 13th, in the Hempstead Country Club, Hempstead, Nassau County.

The meeting began at 4:30 with a brief business meeting of the Associated Physicians at which the president, Dr. A. D. Jaques, of Lynbrook, Nassau County, presided. This was followed immediately by a meeting of the Second District Branch at which the president of the Branch, Dr. Joseph S. Thomas, of

venous injections and perform other expert services. He also secures numerous autopsies, and preserves the diseased organs. The collection of pathological specimens is rapidly growing, and is at the service of the County Medical Society for Graduate Education teaching.

Clinics are held in Amsterdam in Tuberculosis, child welfare, and venereal diseases. A dental clinic is held in the schools.

The schools of Amsterdam employ a full-time medical inspector, a dental hygienist, and five health teachers who are registered nurses. Public health nurses are employed in the county as follows:

Amsterdam schools	5
Amsterdam public health	4
Amsterdam Metropolitan Life Insurance Co	1
County Tuberculosis	1
Village schools	4
Total	15

## FULTON COUNTY

Medical conditions in Fulton County are similar to those in Montgomery County.

Fulton County adjoins Montgomery on the north. The two counties form a square with an artificial boundary line running east and west. Communication between the two counties is easy and extensive, and the physicians have cordial relations.

Fulton County has an area of 516 square miles, and a population of 44,927. It contains two cities, Gloversville, population 22,075, and Johnstown, with 10,908 population. There are only two villages, and their combined population is 1,782. The population of the county outside the cities and villages is 9,264.

**Physicians**—There are 46 physicians listed in Fulton County,—30 in Gloversville, 11 in Johnstown, and 5 in the rest of the county. There is one physician to every 975 inhabitants of the county.

The civic and medical center of Fulton County is Gloversville, which is about 12 miles from Amsterdam. While the physicians of the two cities are on friendly terms, yet those of Gloversville are independent medically, and have sufficient local talent to take care of their own cases, as do the physicians of Amsterdam.

**Hospitals**—Fulton County has two hospitals:

1 The Nathan Littauer Hospital, Gloversville	55 beds
2 The County Tuberculosis Hospital	35 beds
Total	90 beds

Fulton County has 2 beds for each one thousand of population.

The Nathan Littauer Hospital employs a history clerk, and its staff holds monthly meetings. It has a laboratory with a pathologist in charge, and plans are under way to make the facilities and standards conform to those of the State

Department of Health. This hospital conducts a training school for nurses.

**County Medical Society**—The Fulton County Medical Society has 37 members, which is 80 per cent of the physicians listed in the county. It holds monthly meetings, at which nearly all the papers were given by local men.

The County Society has voted to assume the direction of the Child Welfare clinics throughout the county. Plans are nearly perfected by which the County Society will assign physicians to the several towns, and it is expected that the Town Boards of Health and the State Department of Health will provide the funds to pay the doctors honorariums for examining the children.

**Public Health Work**—The official public health work of Fulton County is done by 9 health officers, of whom 7 are members of the County Society, and 7 have had special courses of instruction. Each health officer outside of the cities serves an average of 2,200 people.

The county has a tuberculosis sanatorium with a superintendent on part time. A County Tuberculosis Committee supports a summer camp for undernourished children.

Gloversville maintains regular clinics in tuberculosis, child welfare and venereal diseases.

**Public Health Nurses**—The following public health nurses are employed in Fulton County:

Johnstown school	2
Johnstown Red Cross	2
Gloversville Public Health	2
Gloversville school	2
Gloversville Metropolitan Life Insurance Co	1
Gloversville Red Cross	1
County Tuberculosis	1
Total	11

## HAMILTON COUNTY

Hamilton County has an area of 1,700 square miles, and extends from Fulton County northward 60 miles into the heart of the Adirondack Mountains. It has a permanent population of 3,970, which is increased many fold during the summer. There is one incorporated village in the county, Speculator, pop 600, and the only place reached by a railroad is Raquette Lake in the extreme northwest corner.

Eight doctors live and practice in the county. The towns of Indian Lake, Long Lake, and Speculator each has given its local doctor a salary of from \$1,200 to \$3,000 for acting as health officer and as physician to the poor.

While there are few doctors in the county during nine months of the year, many doctors go there in the summer and practice among the summer residents.

Hamilton County has no County Medical Society, but some of the doctors have joined the societies of the neighboring counties.

slup in health matters that are now being done by lay organizations

Dr Charles Stover, of Amsterdam, told of the post-graduate plans of the Montgomery County Medical Society. He said that interest in post-graduate medical work began in 1919 with the establishment of a laboratory in the City Hospital, which was soon taken over by the Board of Supervisors. A competent pathologist was employed and a course of lectures was given by Dr Kellar of the Bender Laboratory, Albany. The doctors of Montgomery County are now forming a class of thirty, each of whom will pay \$25 toward honorariums for doctors who will give a series of lectures and clinics. Dr Stover spoke highly of the graduate education plans of the State Medical Society, but said that Montgomery County would continue the plans which had been formed before the State Committee was functioning.

A luncheon was served to the physicians and their wives at noon in the basement of the church, and the afternoon was devoted to the following scientific program.

"A New Type of Obstetrical Forceps," Dr Lyman G. Barton, Plattsburg

"A Lantern Slide and Moving Picture of the Use of the Forceps," Dr W. S. Caldwell, New York City

"The Theory of Circus Movement and Its Application to Auricular Flutter and Fibrillation," Dr Carl R. Comstock, Saratoga Springs

"Fractures—Principles and Treatment, With Lantern Slide Demonstration," Dr David Wilson, Amsterdam

Exhibition of a movie film on Tuberculosis, prepared by Dr Gregory Cole, New York City

The physicians were shown pathological specimens from the County Laboratory, prepared by the pathologist, Dr James A. Dickson.

In the evening a popular meeting was held at which the tuberculosis movie film, prepared by Dr Gregory Cole, was shown. The reel on "Working for Dear Life," prepared by the Metropolitan Life Insurance Company, was also shown. Dr H. J. Hawk, Superintendent of the Mount McGregor Sanatorium, Saratoga County, addressed the meeting on the value of health examinations. About 400 persons were in attendance.

## THE FIFTH DISTRICT BRANCH

The Fifth District Branch of the Medical Society of the State of New York is noted for its excellent meetings. This year's annual meeting was held on Friday, October 9th, in the Marcy Division of the Utica State Hospital. The President, Dr Nelson O. Brooks, of Oneida, and the Secretary, Dr William J. McNeerney, of Syracuse, recorded. Over 100 members were present, although the day was rainy and the roads were slippery.

Morning and afternoon sessions were held with an hour's intermission for luncheon, which was given through the courtesy of Dr Richard H. Hutchins, Superintendent of the Utica State Hospital. The meetings were held in the Assembly Room of the Hospital, which was equipped with a stereopticon containing a reflecting attachment for projecting writings and pages of books.

The members were welcomed by the superintendent, Dr Richard H. Hutchins, who described the development of the Marcy Division of the Utica State Hospital since ground was broken for it six years ago. He spoke of the efforts of the State authorities to provide hospital room for the ever-increasing number of the insane, and said that a more promising method of meeting the situation was to detect the earliest signs of insanity while the disease was in an incipient stage and curable. The staffs of the hospitals were holding clinics for incipient cases with great success, but it was necessary to take a

further step and instruct family physicians in the recognition and treatment of conduct disorders and "nervous" conditions for which the patients nearly always consult their family doctors when the symptoms become annoying. Dr Hutchins offered the facilities of the Hospital to those doctors or groups who would like to study the fundamentals of psychiatry.

Dr Clarence O. Cheney, Assistant Superintendent of the Utica State Hospital, described the good results of treating cases of general paresis with malarial germs inoculated into the blood, and the production of a transient fever. He also mentioned the good results from the use of trypanemine in three-grain doses once a week intravenously. Dr Cheney said that the malarial germs produced a shock which arouses the defensive mechanism of the body to clear up the cortex of the brain from the intercellular inflammation which is the pathologic condition in the early stage of general paresis. The doctor showed several cases of general paresis which had been treated with malarial organisms with very great improvement.

Considerable time was devoted to a description of the various activities of the State Medical Society. Dr N. B. Van Etten, President, described the fundamental conditions which confront the State Medical Society, and showed how the Society was broadening its activities in order to take its proper place among the great civic forces of the State.

Flushing, presided. One hundred members were present.

Dr Daniel S Dougherty, Secretary of the Medical Society of the State of New York, spoke on the business methods of the State Society, and urged the District Branch to support the proposed amendment to the by-laws of the State Society establishing a board of trustees to control the expenditure of the one hundred thousand dollar income of the Society. On motion the meeting voted unanimously in favor of the proposed amendment.

Dr Joseph S Lawrence, Executive Officer of the State Society, spoke on the opportunities of the President of the District Branch to bring the local problems of the county societies to the attention of the Council of the State Society.

Dr Orrin S Wightman, Editor-in-Chief of the New York State Journal of Medicine, spoke of the plans for increasing the field of usefulness of the Journal.

At six o'clock, the members sat down to a social supper, after which Dr N B Van Etten, President of the Medical Society of the State of New York, read a carefully prepared paper on the opportunities for service which are before the State Society.

The scientific program was then carried out, and consisted of an exhibition of the two movie films on Gastric Peristalsis and Gastric Ulcer, which had been prepared by Dr Gregory Cole. These remarkable films showed the X-ray appearance of the stomach in motion in both normal and pathological conditions. Physicians are familiar with X-ray photographs of the stomach, but Dr Cole has "animated" the pictures so that they show the peristaltic waves in a remarkably clear manner. Physicians generally are surprised at the depth of the peristaltic constrictions and the rapidity of their travel down the whole length of the stomach. The two films require nearly an hour to show, and they convey information far more vividly and truthfully than hours of description and still pictures could show.

The films end with an outline of what constitutes a surgical condition and what is medical, and the finale is an animated cartoon of a fist encounter between a surgeon and an internist over the treatment of a case.

The meeting was highly interesting, and the response of the members to the speakers was remarkably enthusiastic.

#### THE FOURTH DISTRICT BRANCH

The annual meeting of the Fourth District Branch of the Medical Society of the State of New York was held on Thursday, October 8th, in the Emanuel Presbyterian Church, Amsterdam. The President, Dr Horace M Hicks, presided, and 75 members were present. The meeting was opened with a brief prayer by the pastor, Rev Lewis A Galbraith.

Dr Hicks in his president's address, spoke of the social and civic duties of a doctor who is well educated in science and well read in literature. The doctor could encourage the rural farmer to improve himself mentally, and also could help him in his problems with soils, fertilizers, insects, and other problems of the farm.

Dr N B Van Etten, President of the State Medical Society, gave an address on the activities of the State Medical Society, and its component district and county societies. He showed the great progress that has been made in the societies during the last five years, and said that he considered himself fortunate to be president at this time when the society was being carried on by five doctors for every one who was at work five years ago.

Dr Daniel S Dougherty, Secretary of the State Society, took "Service" as the subject of an inspiring address. He spoke of the necessity of trying to please the patients, and urged the

doctors to cultivate a manner which inspired confidence and yet is scientific. He said that a patient whom he sent to an eminent specialist was dissatisfied because the doctor had only a chair, a table, and a book case in his office, and the patient was delighted with another doctor who examined her for half an hour with electric lights and mirrors, for he "did a lot for her." Another patient felt that Dr Dougherty was neglecting her because he looked into her ear with only a speculum and head mirror, while another doctor had looked into it with fourteen different instruments. The doctor spoke of the value of an up-to-date equipment, and of the need for a thorough physical examination of every new case.

Dr Dougherty emphasized the need of supplying every county secretary with clerical assistance, for he has to write letters, address envelopes, and do other clerical work which a stenographer could readily do. He had found that county societies always provided the money, even by raising dues, whenever the secretaries had asked for the means to increase the field of usefulness of the secretary.

Dr J S Lawrence, executive officer, spoke on means for increasing the interest in county societies, and suggested four meetings a year as the minimum, and the assumption of the leader-

Superintendent of the City Hospital, said the specimens would be available for use by the Committee on Public Health and Education in the Graduate Courses

The half day scientific program was as follows

"The Differential Diagnosis of Pain in the Right Lower Quadrant of the Abdomen," Dr Harold Blaisdell, Jamestown

"The Surgery of the Handicapped Patient" Dr William D Johnson, Batavia

"Some Solved and Unsolved Problems in Gall-Bladder Surgery," Dr E R McGuire, Buffalo

"The Acute Leukemias," Dr Nelson G Russell, Buffalo

"A Resume of Recent Researches in Cancers," Dr Burton T Simpson, Buffalo

A buffet luncheon was served at noon by the courtesy of the Erie County Medical Society

About fifty members sat down to a subscription dinner which was held in the early evening in the lobby of the City Hospital

The evening program consisted of the moving picture, "Working for Dear Life," and the lantern slides and lectures on "Have a Health Examination on Your Birthday" Dr Britt explained that these were shown for the information of the doctors of the Eighth District Branch, and to show them what could be done in each community to promote Periodic Health Examinations by the doctors themselves

The following officers were elected to serve for two years President, Dr George F Cottis, Jamestown, First Vice President, Dr Thomas J Walsh, Buffalo, Second Vice President, Dr Francis E Fronczak, Buffalo, Secretary, Dr William Warren Britt, Tonawanda, Assistant Secretary, Dr Russell H Wilcox, Tonawanda, Treasurer, Dr Fitch H VanOrsdale, Belmont

## COLUMBIA COUNTY MEDICAL SOCIETY

The annual meeting of the Columbia County Medical Society was held at The Worth House, Hudson, on Tuesday, October 6, 1925 President Charles L Nichols presiding

Members present Drs Collins, Diefendorf, Edwards, Galster, Harris, King, McCormick, Mambert, Maxon, Nichols, Noerling, G W Rossman, C G Rossman, Skinner, Taylor, Van Hoesen, Wheeler, Whitbeck

Dr McCabe, president of the District Branch, and Dr MacFarlane, of Albany, were guests of the Society

The minutes of the semi-annual and special meetings were read and approved as read

The following officers for the ensuing year were elected

President, Henry J Noerling, vice-president, John P Ruppe, secretary and treasurer, Charles R. Skinner, Censors, Louis Van Hoesen, Clark G Rossman, William D Collins, Nathan D Garnsey, Frank C Maxon, delegate to State Society, John L Edwards, alternate, Charles L Nichols

Treasurer's report showing a membership of 35 and a balance in the treasury of \$160.93 was read and accepted

Application for membership of Dr John P Ruppe was reported favorably by the Board of Censors and was unanimously accepted

The secretary was instructed to deposit with the state librarian a record book of the society, dating back to 1806, and recording the meetings of the society from 1806 to 1862

In response to a communication from Dr McKay, of the State Department of Health, the society indorsed the work of the Division of Maternity, Infancy and Child Hygiene in holding periodic clinics throughout the county for preschool children

Adjourned for lunch

The meeting resumed after an excellent luncheon, with President-elect Noerling presiding, listened to an interesting address by President Nichols

Dr Andrew MacFarlane, of Albany, outlined the program of the State Society relative to Post Graduate Medical Education After considerable favorable discussion the Society decided to adopt the suggestions of Dr MacFarlane, and the secretary was instructed to communicate with Dr Gordon relative to starting a course of lectures in the near future

The officers of the Society were directed to arrange for a joint meeting of Albany, Berkshire and Columbia counties next year

The following committees were appointed by President-elect Noerling for the coming year

Legislative Maxon, Garnsey, Van Hoesen, Oliver and Collins

Public Health and Post-Graduate Medical Education Whitbeck, Mambert, Nichols, Diefendorf and Harris

Dr Frank Overton, Executive Editor of the State Journal of Medicine, made a plea that the county secretaries should send accounts of their society meetings to the State Journal, and also send the accounts to their local newspapers, for the activities of the doctors were of great civic interest

Dr Joseph S Lawrence, Executive Officer of the State Society, described the opportunities of the District Branches in coordinating the work of the county societies

Dr Herman G Weiskotten, Dean of the Syracuse Medical School and member of the Committee on Public Health and Medical Education, described the plan for graduate education that was proposed by the State Society

The following scientific program was carried out

"Diagnosis of Cancer of the Stomach with Special Reference to Acid Values," Dr I Harris Levy, Syracuse

"Surgical Procedures in Acute Perforation of the Stomach," Dr Gilbert D Gregor, Watertown

"Relief Measures During Labor," Dr Henry W Shoenek, Syracuse

The following officers were elected for two years President, Dr Charles D Post, Syracuse, First Vice President, Dr Page E Thornhill, Watertown, Second Vice President, Dr Augustus B Santry, Little Falls, Secretary, Dr William J McNerney, Saratoga, Treasurer, Dr Frank E Fox, Fulton

### THE EIGHTH DISTRICT BRANCH

Every District Branch meeting has a character of its own Dr Harry R Trick, President of the Eighth District Branch, carried out the excellent idea of devoting a morning session of his meeting to a discussion of the activities of the State Medical Society, the afternoon to a scientific program, and the evening to a social dinner and a semi-popular meeting with the exhibition of moving pictures and lantern slides The meeting was held on Wednesday, October 7th, in the Buffalo City Hospital, with about one hundred members present

Dr N B Van Etten, President of the Medical Society of the State of New York, described the activities and aspirations of the Society He said that the policies of the Society are in a state of rapid evolution, and that two important questions which are coming up this year are a novel medical practice act, and a more comprehensive system of defense against malpractice suits He told of the immense amount of detailed investigation and planning which had been done by the leaders during the past summer, and of their efforts to keep the members informed through the Journal, addresses and conversations

Dr Daniel S Dougherty, secretary of the State Society, gave a practical talk on the work of the secretaries of the societies of both the State and the counties It is the work of the secretary to be familiar with every phase of the work of the Society, and to see that the activities are conducted in an orderly way and through regular channels Dr Dougherty spoke of the need of harmony, toleration, and standardization in the societies and especially in the State organization with its augmented income and its increased number of active workers on its various committees

Dr W W Britt of Tonawanda, Secretary of the Eighth District Branch and Chairman of the Committee on Economics of the State Medical

Society, told about the plans of the Committee He said that the Committee had sent a questionnaire to the Presidents of all the county medical societies, asking what subjects they would recommend for consideration Nursing was the first choice, but since that subject is being handled by a special committee, Dr Britt's Committee would emphasize the second subject that was to be recommended—that of periodic health examinations

Dr Britt said that the fundamental need in the promotion of health examinations was a standard form for making and recording the examinations He exhibited various forms and also samples of the literature sent out by the Metropolitan Life Insurance Company and other organizations that are interested in health examinations

The meeting of the Eighth District Branch voted to recommend that the Committee on Economics prepare an examination blank and submit it to the next house of delegates to be adopted as the standard form for the whole State

A novel feature of the meeting was an exhibition of pathological specimens and X-Ray photographs prepared by Dr W F Jacobs, pathologist for the City Hospital A number of these specimens and pictures were exhibited at the meeting of the Medical Society of the State of New York, at Syracuse last May The pathological specimens are preserved in their natural colors, and are sectioned or opened in order to bring out the points to be emphasized There were gall bladders with gall stones looking like ladies' purses full of pearls, hearts with areas of muscle degeneration, and coronary thrombi, gastric ulcers with thickened walls, and perforations, and colons with intussusception The specimens were prepared with special reference to their value in teaching students Dr Goodale,



# BOOK REVIEWS

**AN INTRODUCTION TO DERMATOLOGY** By SIR NORMAN WALKER. Eighth Edition. With ninety plates and eighty illustrations in the text. William Wood and Company, New York, 1925 Price, \$7.00

This book of slightly more than 350 pages is practically a reproduction of the lectures given by the author at the University of Edinburgh, and is, therefore, rather elementary in type as the title suggests

The introductory section deals with the structure and function of the skin, as well as general diagnosis and treatment of skin diseases. After this, instead of following the classification laid down by Hebra, the author has rearranged the text in a manner which seems easier to grasp. He considers first Anomalies of Sensation, next, Anomalies of Secretion, and then in Section 4 treats with the Inflammations, including toxic eruptions. These Inflammations have been subdivided into those of the Surface Epidermis, and of the Deep Epidermis. The section also includes the Infective Inflammations in which he combines both the bacterial and parasitic infections.

Beginning on page 161 he has devoted about ten pages of the text to giving the Distribution of the Commoner Forms in Dermatitis, not in tabulated form, but in an easy, descriptive style, with suggestions on treatment. This latter statement will also hold true in regard to his handling of the individual dermatoses throughout the text.

There are incorporated in the book eighty illustrations in black and white and ninety-two really excellent plates, all but a few of which are in colors. These colored plates practically constitute a skin clinic.

The book is of the type desired by students or physicians not too far advanced in the knowledge of Dermatology. The treatments advised are generally conservative. E. ALMORE GAUVAIN

**SURGICAL CLINICS OF NORTH AMERICA.** Volume 4, Number 5, October, 1924 (Portland-Seattle Number). Published every other month by the W. B. Saunders Company, Phila. and London. Per clinic year (6 issues), cloth, \$16.00 net, paper, \$12.00 net.

The surgeons of the North West are the contributors to this number. Not unlike the clinics in any other part of the country, we find here a great variety of most interesting clinical cases, and a display of the highest type of surgical skill.

HERMAN SHANN

**SURGICAL CLINICS OF NORTH AMERICA.** Volume 4, Number 6, December, 1924 (Lahey Clinic Number). Published every other month by the W. B. Saunders Co., Phila. and London. Per Clinic Year (6 issues) Cloth, \$16.00 net, paper, \$12.00 net.

This volume is designated as the Lahey Clinic Number. The bulk of the number is contributed by Dr. Lahey of Boston, who deals with all possible varieties of thyroid disease. Every aspect of thyroid disturbance is thoroughly discussed, and the indication for various operative procedures are given in detail. Excellent illustrations accompany the text. A number of articles are contributed by the co-workers of his clinic. HERMAN SHANN

**THE THEORY AND PRACTICE OF THE STEINACH OPERATION WITH A REPORT ON ONE HUNDRED CASES** By DR. PETER SCHMIDT (Berlin) and an Introduction to the English edition by J. JOHNSTON ABRAHAM, C.B.E., D.S.O., M.A., M.D., F.R.C.S. (Eng.) 12mo of 150 pages. London, William Heinemann, 1924. Cloth, 7s. 6d.

One reason for this book's favorable impression on the reviewer is because the sponsor in the introduction states the efficacy of the Steinach operation to be a moot question. This is refreshing after so many writers on the subject have insisted that the procedure is a cure-all and a never failing nonesuch.

In the introduction and in a general survey in Chapter I, the endocrinology of the sexual glands is described, along with brief mention of various writers and their accomplishments. Also there is a summary of experiments in castration, spaying, homoplastic and autoplasmic grafts, and masculinization and feminization results.

To one personally unacquainted with any patients who have undergone the procedure the benefits claimed, even in as modest a book as this, are a little startling. A few of the troubles disappearing after the Steinach operation are languor, backache, mental exhaustion, baldness, sight and hearing defects, impotency, hypochondria, loss of weight, cardiac insufficiency and arrhythmia, and certain urinary difficulties. One wonders why auto-rejuvenation is not seen after epididymitis either in old men or under-par younger men. Epididymitis of gonorrheal or other cause is not rare, and in some patients at least, complete obstruction must take place, but rejuvenation has never followed in the experience of this reviewer. Despite the propaganda in the subject of rejuvenation applicants for the operation are rare. The list of disorders that these patients suffer belong in the real of the internist rather than to the genito-urinary specialist.

The operation is simple and safe. We are apt to hear more on it from those interested in the general condition of the old than from those doing work only in limited fields.

This book is interesting and presents the subject in a good manner free from the usual blatant exaggerations. GRAY PHILLIPS

**ELEMENTARY MORPHOLOGY AND PHYSIOLOGY FOR MEDICAL STUDENTS.** A Guide for the First Year and a Stepping-stone to the Second. By J. H. WOODGER B.Sc. Octavo of 528 pages, illustrated. New York, Oxford University Press, American Branch, 1924. Cloth, \$4.20.

The author, in his work justifies its publication on the assumption that premedical education is inadequate. The book begins with a foreword to the student in which the author implores the student to observe for himself, to be individual, and not to be a follower.

The rest of the book is devoted to the subject in hand. It begins with animal organization, its physiology, tissue and the cell are discussed. - Animalculae of lowest form are investigated and gradually those of a higher scale.

The text contents are described clearly and concisely. The subject matter is treated accurately and interestingly. There is a short bibliography at the end with an excellent index.

One may say that it is a splendid book fulfilling the author's desire to depart from the usual and make the young premedical student an investigator. S. R. SLATER.

(Continued on adv page xxvii)



# THE DAILY PRESS



We have frequently discussed the use of the daily press in imparting medical instruction to the people. We have thought out loud and have expressed our opinions of the medical items that have appeared in the newspapers. Our attitude has been one of dissatisfaction.

We have had very little occasion to criticize the editors of the newspapers. The editors have nearly always printed what has been given to them, and have usually preserved the style of the items.

We have frequently realized the difficulty in finding in a news item that feature which makes it live news. An item must appeal to the particular paper. An epidemic in Buffalo does not excite the people of Montauk Point, and few people care whether or not a treater of horses is called by the title of doctor. We have pointed out that nearly all publicity is built around persons. Anything that affects a well-known person, or a considerable number of persons in a community, is live news.

We have also frequently suggested that doctors themselves have the power to secure the publication of almost any kind of medical information that they desire. They hold the key to medical publicity.

The publication of medical items in the newspapers is a duty for county medical societies to assume. A committee on medical publicity would be valuable in every county society.

A county society that adopts the plan of appointing a committee on publicity will probably have difficulty in securing the personnel to serve on the committee. Most doctors have an aversion to writing—why that is so, is incomprehensible. Are the high schools and colleges failing to teach their students to write? We believe so, but the supply of doctors during the next ten years will continue to be averse to writing. If we had our way, we would compel every medical student to devote one of his summer vacations to reporting for a newspaper. He would then know what constitutes medical news, and how to secure its publication in the newspapers. Yet in spite of all this every county society can find two or three doctors to serve on a publicity committee.

What would be the duties of a publicity committee? The committee would have an exceedingly broad field, but for a starter, we will suggest only one duty—that of giving news of the meetings of the county medical society to the local newspapers.

Every meeting of a county society has something of special interest to the people of the county. The scientific papers may not appeal to the public, but a doctor can make such an application if he does a little thinking. But nearly every society discusses something of great public interest—health examinations, a new medical practice act, pure milk supplies, a venereal disease clinic. These and dozens of other topics may be developed in the account of the meeting.

The names of the local men who attended the meeting are always available. Surely they are of as much importance as the names of the women who attended the card party of the village thimble club.

Another legislative program is about to be announced, and its success will depend largely upon popular support. Possibly the neglect of newspaper publicity in the past has been a great factor in the failure of the proposed medical practice laws. It is the duty of physicians to see that their local newspapers are supplied with local medical items that will influence the people to support the proposed act. Possibly the legislative committee could take charge of the medical publicity in the newspapers of the county, but a publicity committee should be appointed.

The pages of this JOURNAL will contain explanations of the Medical Practice Act and arguments for its passage. Points that are brought up against the bill will be discussed and answered, and the bill will be explained from every standpoint. All this material will be available for the committees of county societies to use in their publicity campaigns.

One of the most effective means of publicity for the Medical Practice Act will be to reprint extracts from the JOURNAL in the local newspapers. These extracts can be made into live news if their relation to the local doctors is brought out. The very fact that a local physician takes the trouble to go to a reporter or editor is evidence of a local interest which can be turned into news. Probably the editor will ask the doctor what the item has to do with the town in which the paper is printed? It is work of the doctor to discover the local application of the extract, and give it a human interest.

The daily newspapers are ready to assist the doctors in promoting a high standard of medical practice, the local doctors must tell their local editors how to render that assistance.

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL 25, No 24

NEW YORK, N Y

NOVEMBER 15, 1925

## RESULTS OF SURGICAL TREATMENT OF CANCER\*

BY G W CRILE, M D

CLEVELAND OHIO

WHATEVER the changing aspects of the cancer problem, as far as its etiology is concerned, as to its prognosis one fact remains unchanged, namely, that cure depends upon the early complete removal of the primary focus of the cancerous process. There is no problem, therefore, regarding the treatment of cancer, that is, as to whether or not the cancer should be removed, if its location is such that its removal is anatomically possible. There is, however, a divergence of opinion as to the method of removal, centering principally about the relative merits of surgery and of radiation therapy.

The increasing knowledge of the effects of radiation, in particular the recent advances in the application of deep X-ray therapy, have aroused widespread discussion as to the relative values of radiation and of surgery in the treatment of cancer wherever situated. The settlement of this problem must depend upon the careful sifting of the clinical data provided by the experience of surgeons and radiation therapists. It is only by a comparative study of the end-results of these different methods of treatment that a final decision can be reached as to the method of choice in the treatment of cancer of any organ or part.

Already such studies have led some of us to prefer radiation in the treatment of cancer in certain organs and tissues, although even in such cases we cannot consider our judgment as final, but hold ourselves in readiness to reverse our present practice if later evidence appears to contravert our present conclusions.

It has seemed best to me, therefore, in my presentation today, to offer the present opinion of my associates and myself regarding the preferred method of treatment of carcinoma of certain organs and tissues of the body as based upon our combined experience in 4,108 cases of cancer, among which 3,414 have been treated by

surgery or by radiation or by a combination of both.

*Cancer of the Skin*—For carcinoma of the skin radium therapy is usually the most efficient treatment except in the case of a pigmented mole which metastasizes early and should always be excised.

*Carcinoma of the Buccal Surfaces*—Carcinoma of the head and neck shows one great advantage over cancer of the other organs and tissues, namely, cancer of the jaw, tongue, cheek and lips is rarely disseminated to other parts of the organism. In a recent study of the literature pertaining to cancer of the head and neck we found that among 4,500 reported necropsies, in only 1 per cent were secondary foci found in distant organs or tissues. The collar of lymphatics about the neck forms an almost impassable barrier through which cancer rarely penetrates and every portion of this barrier is readily accessible to the surgeon. Within the lymphatic collar, however, metastases are rapidly disseminated, although cancer of each part of the head seems to follow a law of its own as far as its primary extension is concerned. This fact provides the key to the treatment of cancer of these parts, the prime requisite being the complete removal of the lymphatic glands which are related to the site of the cancerous growth.

*Early cancer of the mucous membrane of the gums or cheeks* does not demand excision of the glands. Good results in these cases are usually obtained by the use of the electric cautery. Radium therapy is the preferred method of treatment in early cases of *cancer of the lip*. In late cases the cancer should be excised by means of a V-shaped incision, the scar of which is no more noticeable than that produced by radium.

The most efficient method for destroying an early *cancer of the tongue* is electric coagulation or cauterization with the actual cautery. Radium would suffice to destroy the growth, but the radium burn is exceedingly painful.

\* Read at the Annual Meeting of the Medical Society of the State of New York, at Syracuse May 12 1925

**PRACTICAL CLINICAL PSYCHIATRY FOR STUDENTS AND PRACTITIONERS** By EDWARD A. STRECKER, A.M., M.D., and FRANKLIN G. ERAUGH, A.B., M.D. Octavo, 375 pages, illustrated Philadelphia, P. Blakiston's Son and Co., 1925 Cloth, \$4.00

Although this book is written for practitioners and students of medicine, it contains much of interest to the laity, because of its most interesting contents and its simplicity of style, rendering it readily comprehensible to one unfamiliar with strictly technical terms. It might even be of value to the layman, from the fact that it is capable of erasing from the popular mind the idea that any one suffering from mental symptoms is immediately locked up, innumerable papers having been duly signed, and then forgotten. In the present day, such is far from the case. In this book we discover to what extent there have been accomplishments along these lines, and it seems the more remarkable, the institution of psychiatry as yet being very young. The chapters on "Methods of Examinations" and those on various types of psychoses are very interesting, and more and more do we feel, as we read on, what a delicate thing is this new science—thus dealing with mental phenomena. It is an excellent book for the student because the subject is so very clearly and carefully dealt with in its details and because it is explicit and interesting in examples.

F. C. E.

**GYNECOLOGY FOR NURSES** By M. J. SEIFERT, A.B., M.D., F.A.C.S., Attending Surgeon and Gynecologist, Columbus Hospital, Chicago. D. Appleton and Co., New York, 1925.

There is urgent need of a textbook of Gynecology for Nurses. The volume under review does not, however, fulfill all the requirements of a textbook for nurses, chiefly for the reason that it has too much information that is surgical and medical and not enough nursing.

The author has covered well the subject of gynecology and, best of all the practical side of the subject is excellently given. With few exceptions the opinions expressed are those of a general surgeon doing good gynecology. It would seem, however, that such a text would be better suited for medical students than for nurses for after all the nurse is to care for the case—doing what she can to make the patient comfortable. Diagnosis and therapeutics are strictly medical and not nursing problems.

H. B. MATTHEWS

**LECTURES ON GONORRHOEA IN WOMEN AND CHILDREN** By J. JOHNSTON ABRAHAM, C.B.E., D.S.O., M.A., M.D. F.R.C.S. 12mo of 142 pages, illustrations London, William Heinemann, 1924 Cloth, 7s. 6d.

In this book of 136 pages the author has given a brief description of the immediate and remote manifestations of gonorrhoea in women and children. The author claims that the subject of gonorrhoea in women is still strangely neglected in England and this fact is true as far as this country is concerned. He has therefore given in this book the methods of examination of a female patient with a history suggestive of a gonococcal infection, the symptoms usually complained of in this infection, and finally he has put forward certain lines of treatment for the early curable stages of the disease, which can be followed out successfully without any special apparatus beyond those found in every doctor's cabinet and without any skill beyond that possessed by the average practitioner.

It is a book that should be read by everyone who attempts to treat this neglected and difficult subject.

PHILIP GOLDFADER.

**MEDICINE. AN HISTORICAL OUTLINE.** By M. G. SEELIG, M.D. 12mo of 207 pages. Baltimore, Williams and Wilkins Co., 1925 Cloth, \$2.25.

This octavo of 207 pages, including an index, with 198 illustrations, is just what the title indicates, a historical outline of medicine, or, perhaps better, a flying sketch of the important periods of medical history. There is a somewhat ornate foreword by Fielding Garrison, and the author of the book gives sufficient warrant for writing it in his preface. The context covers eight lectures, including primitive and early Oriental medicine, the Greek and Graeco-Roman era, the Middle Ages, the sixteenth, seventeenth, eighteenth and nineteenth centuries.

Prof. Seelig has woven a story of medical history which ingeniously combines chronology with theory and the great personalities associated with them in a manner calculated to both interest and stimulate students of medicine in high degree. He shows evident grasp of the subject, and the facts presented make clear the interdependence of the true growth of medical science and our increasing knowledge of the sciences in general, together with the steady improvement of instruments of precision.

Withal there is a human touch in the book, which vivifies and lends a charm to it, making it read almost like a novel. Medical students and practitioners alike should possess, read and re-read this little book, until it becomes an integer of their gray matter. In so doing they will be led to further study of a subject which can only lead to a broader vision of and respect for the profession of their choice.

J. M. VAN COTT

**PREPARATION OF SCIENTIFIC AND TECHNICAL PAPERS** By SAM F. TRELEASE and EMMA SAREPTA VULE. 12mo of 113 pages. Baltimore, Williams and Wilkins Co., 1925 Cloth, \$1.50.

This book contains many technical suggestions of value to the scientific writer. The list of medical periodicals quoted is poorly chosen and inadequate. This book may prove helpful to scientific writers, but we believe it does not cover the subject of medical writing as completely as it should. This may not have been intended by the writers.

FREDERIC DAMRAU

**FROM INFANCY TO CHILDHOOD. The Child from Two to Six Years** By RICHARD M. SMITH, M.D., Assistant Professor, Child Hygiene, Harvard University. The Atlantic Monthly Press, Boston, 1925.

Chapter I gives timely advice to parents, urging periodic examination of children between two and six years.

Under Diseases, the care of "Croup" may give a false sense of security to an inexperienced mother, if she understands that "Syr. Ipecac in 10-drop doses" will cure croup, "which may recur for two or three nights." The book does not warn the reader against diphtheritic croup. This treacherous disease may be mistaken for the harmless catarrhal laryngitis to which the author apparently has reference. One must realize the possible consequences from the delay to administer antitoxin, should the case prove to be diphtheria. Indeed it is very unsafe to leave the differential diagnosis of croup to any lay person, when one realizes that it not infrequently taxes the ingenuity of an experienced physician.

In discussing "Swallowing of Foreign Bodies" the author misses an opportunity by not warning against the things that make it possible for any baby to either swallow or aspirate a foreign body. Certainly this accident is 100 per cent avoidable. Not a word is uttered against this carelessness on the part of parents or nurses.

Books of this class have no place in the modern nursery unless they discuss the prevention and avoidance of avoidable accidents and preventable diseases.

The mother or nurse may read this book with some benefit.

HARRY APPEL

month in 6, and yet in many of these cases emaciation and exhaustion as a result of dysphagia were already marked

*Carcinoma of the Breast*—Our total series of 1300 operations on the breast includes 752 operations for malignant tumors. We have follow-up data in 530 cases in which a radical operation was performed, of these 145 have lived for five years or more. Of these 530 cases, 356 were treated by surgery alone, with 128 five-year survivals, 174 by surgery plus radiation, with 17 five-year survivals.

In this discussion I shall summarize our present point of view regarding the treatment of cancer of the breast by the brief statement that the early radical operation is the only method to be employed, and that excepting in manifestly inoperable cases the patient should be given the benefit of the doubt and radical operation performed.

As to the role of radiation there is not a sufficient uniformity in the reported results to form any final basis for judgment. It is certain that radiation by itself alone cannot be compared with surgery, and our own statistics have definitely proven that intensive post-operative radiation is distinctly contraindicated.

*Carcinoma of the Stomach*—As in the case of cancer of the esophagus, a cancer of the stomach is characterized by a rapidity of growth, and an extent of lymphatic involvement so that the "dead line" of inoperability is reached very early in its progress. A period of a few weeks may be sufficient to carry the patient from an operable to a completely inoperable condition and consequently in the majority of cases the patient comes to operation too late for possible cure. When operable, as in the case of carcinoma elsewhere, resection with the widest possible excision of the growth is the indicated procedure. Blood transfusion, saline injections, nitrous oxid analgesia, the application of hot packs and divided operation may suffice, however, to carry through many patients in whom the prognosis appears to be hopeless, but in whom the anatomical possibilities of operation have not been passed.

In many cases the diagnosis of cancer is made when the lesion is an ulcer. The relation between ulcer and cancer of the stomach remains to be finally established, but it is probable that cancer is preceded by ulcer in not more than 10 per cent of the cases. Even this low percentage is sufficient, however, to warrant the removal of the ulcer by operation.

Our series includes 393 cases of carcinoma of the stomach among which 310 have been operated upon—3 per cent of our total number,

1009—of operations on the stomach. Follow-up data are available in 130 of these cases among which 11 have passed the five-year period. Of these 130 cases resections were made in 23 with one five-year survival, gastroenterostomy in 61, with 6 five-year survivals, exploratory in 43 with 3 five-year survivals, and radiation therapy only was done in three with one five-year survival. The question may well be raised regarding the pathological diagnosis in the last cited groups. We can say only that the clinical signs and the exploratory operations gave every evidence of an inoperable condition in each.

*Carcinoma of the Gall Bladder*—Carcinoma of the gall bladder is usually associated with cholecystitis and consequently in most cases the disease has extended into the liver and adjacent deep structures before the malignant condition is recognized. For this reason the prognosis is extremely unfavorable, even after a radical operation. Our records include 54 cases of carcinoma of the gall bladder, among which 43 were operated upon. Among these we have no records of any five-year survivals.

*Carcinoma of the Intestines, Sigmoid and Rectum*—Radiation is of little avail in the treatment of lesions of the abdominal viscera. For cancer of the small intestine—which is of very rare occurrence, of the cecum, the transverse colon, the descending colon, or the sigmoid, surgical treatment is indicated. The operative management as in cases of carcinoma of the stomach being directed to the utmost conservation of the resources of the patient, and as in the former case, transfusion, saline infusions, divided operation and nitrous oxid analgesia, may suffice to carry through the apparently hopeless patient.

For the treatment of cancer of the rectum on the other hand, the combination of radium with deep X-ray therapy promises to supplant surgery, for the rectum is readily accessible for the implantation of radium and many portals of entry are available for deep X-rays.

*Carcinoma of the Uterus*—I doubt whether a wider diversity of opinion regarding treatment exists in any field of surgery than in the treatment of carcinoma of the uterus. Up until within the last year or two this could be said regarding carcinoma of the cervix also. During the past few years, however, the accumulation of statistics in regard to the value of radiation therapy of carcinoma of the cervix has developed to such a degree that its pre-eminent value appears to be established. In the case of carcinoma of the cervix as in the case of carcinoma of the Rectum, we are turning over all of our cases to radium and deep X-ray therapy, and for the same reason, that is, there

Cancer of the tongue calls for the complete removal of the glands of the neck on both sides if the lesion extends toward the midline, while cancers of the buccal surface, which metastasize rarely and usually only on the side of the lesion, demand a less radical operation. In advanced cases, however, no matter where the primary lesion, a wide regional block excision is demanded. Since we adopted this plan, which involves excision of the sterno-mastoid and of both jugular veins, together with the larynx, we have rarely missed securing a permanent cure with any case which has not progressed beyond the lymphatic plains of the neck.

Our statistics include 107 cases of carcinoma of the buccal surfaces, of which 75 have been treated. We have follow-up data regarding 24 of these cases, in which a radical operation was performed, of these seven have lived for five years or more.

*Carcinoma of the Larynx*—Intrinsic carcinoma of the larynx is even more protected from metastases than carcinoma of the group of organs which we have just discussed. Surgical treatment—laryngectomy—is definitely indicated. Although there are a few who advocate the use of radium in early cases, the general trend of opinion is adverse to its use. The only argument in favor of radium as against surgery would appear to be escape from mutilation, but the mutilation is so slight and the patient so soon becomes adapted to the loss of voice that these do not seem to be valid arguments in favor of radium, whereas the practical certainty of cure provided the carcinoma is entirely intrinsic should lead one unquestionably to accept the dictum that surgery is the one method in these cases.

The postoperative application of the X-ray, however, is of value in that it may serve to check any extension of the growth providing some extrinsic focus may exist.

Extrinsic cancer of the larynx, however, presents a different problem, and surgical treatment in these cases should always include a block dissection of the gland-bearing area. In inoperable cases of extrinsic cancer of the larynx in which only tracheotomy can be attempted, radium is of value as a palliative measure. On the other hand, it should be borne in mind that extrinsic cancer of the larynx is even more accessible than cancer of the tonsil or cancer of the pharynx, and my own experience has included cases in which an apparently hopeless extension of the growth has been followed by complete recovery. In one case the growth involved not only the larynx but in addition, all of the tissues between the juncture of the posterior and the middle third of the tongue were involved and removed as well as the upper region of the

trachea and the upper end of the esophagus. This patient has lived without recurrence for six years since the second operation.

Our series includes 79 cases of carcinoma of the larynx, among which 64 were operated upon. We have follow-up data regarding 26 of these patients, of whom 2 have survived for more than the five-year period.

*Carcinoma of the Thyroid*—In our total series of 6,427 thyroidectomies there has been a carcinoma of the gland in 139 cases. It is significant to note that in about 95 per cent of these cases the carcinoma was due to a degeneration of a foetal adenoma, and inversely that approximately 10 per cent of all foetal adenomata seen at operation are cancerous. For these reasons I believe that a foetal adenoma should always be removed. Iodin has no effect upon a foetal adenoma, and moreover in these cases iodine often produces myocarditis and hyperthyroidism. A malignant foetal adenoma is always removed if possible, otherwise it is treated with radium. A foetal adenoma is the easiest of all types of goiter to remove. Simple adenoma is generally multiple, foetal adenoma is usually a well defined tumor and is present on one side only. A patient with an inoperable carcinoma of the thyroid gland will live without radiation for about one year. As for the length of life with radiation, there is no basis upon which to found a final judgment. Sometimes the mass disappears, in other cases, radiation does not seem to do any good. In cases in which the patient is suffering from obstruction and resultant partial asphyxiation, a decompression operation will serve to give temporary relief, the operation being followed by radiation. In such cases an acute myxedema may develop but this myxedema is readily met by the administration of thyroid extract.

In our series of cases of carcinoma of the thyroid which received surgical treatment we have follow-up data regarding 53 patients of whom 15 have lived for more than five years since operation.

*Carcinoma of the Esophagus*—Carcinoma of the esophagus, in contradistinction to carcinoma of the larynx, is one of the most hopeless among malignant conditions. The cases usually are presented too late for any surgical procedure to be of value. Radium and deep X-ray therapy, however, present some basis for hope, especially in the earlier cases, although the progress of the disease in these cases is always exceedingly rapid. Thus in the records of the Cleveland clinic among 31 cases of carcinoma of the esophagus, the duration of symptoms had been less than 10 months in all, but 5 cases, less than 6 months in 18, less than 3 months in 11, less than 1

persons who become afflicted with cancer will die from this disease. Of course, this includes all the types of malignancy. It is thus quite evident that our present methods of treatment are not all that could be desired. You have just listened to the foremost authorities upon the present status of treatment by the best methods available at this time. It is but natural that they would stress the possibilities in their respective lines—I believe it would not be amiss if I were to call your attention to the limitations.

**Surgery**—Surgery is definitely limited. In the first place, the question of operability is always to be considered, and even this varies, according to the skill and judgment of the surgeon. Thus, we can see that cancer, in its relation to surgery, may be divided into two great groups, *viz*, first, those cases which are operable, and second, those which are not, either because of the extent of the lesion or for any other reason. Experience shows us that in certain types of cancer, a very large number are past the operative stage when they present themselves to the surgeon for treatment.

It is clear, then, what the limitations of surgery are. Theoretically, every case in group one should be cured if the patient has the services of a competent surgeon, but this ideal state of affairs does not exist, as is proven by surgical statistics. I believe that two factors are largely accountable for our present results. First, either the surgeon fails to differentiate between the mechanical operability and the therapeutic operability, or secondly, at the time of operation, imperceptible metastatic cells are present. So we have added to the group of inoperable cases, the recurrent ones.

**Radiation**—Personally, I do not accept any difference between the mechanism which brings about the results obtained in the use of radium, from those obtained from X-rays. It resolves itself into the question of either the availability or the most convenient method of application. So these two agents may be considered together, under the caption, "Radiation Therapy."

It was thought, when radiation was first introduced as a method of treatment for cancer, that the inoperable and recurrent cases would be taken care of, but it soon became apparent that this method of treatment had its limitations. The majority of inoperable and recurrent cases did not respond to radiation treatment as it had been hoped they would. However, there is thus much to be said for radiation—by its application a malignant neoplasm may be made to disappear. We know that it has the *potentiality* of destroying or nullifying cancer cells. Unfortunately, we are unable, as yet, to explain the mechanism of this action. Is it a caustic action, or is it a specific one, either on the cancer cells themselves, or on their environment? Up to the present time,

we have been working with radiation in a purely empirical way, obtaining results without a definite knowledge of its mode of action. Should it transpire that this agent has a specific action on cancer cells, the outlook for future results, by using this method of treatment, is very bright.

A lead in this direction that is promising is being followed at our Institute. It is a well-known fact that the presence of oxygen is necessary for the growth energy of normal cells, but it has been found that cancer cells will multiply in the absence of this element. The energy is derived from the fermentation of sugars. The ability to convert sugar into lactic acid seems to be a property of the cancer cell. That this occurs has been demonstrated in our laboratory by our biological chemist, Dr. Cori, both on tumor-bearing animals and on humans. We are working, at present, to determine if radiation has any action upon this particular process.

I do not believe that comparisons should be made between the relative value of surgery and radiation in the treatment of cancer. The possibilities and limitations of surgery should be recognized and applied to appropriate cases. Radiation cannot be finally judged until we learn definitely the exact mechanism of its action.

I would, with your permission, change the title of my paper to the following one: "Present Status of the Treatment of the Cancer Problem." Aside from the question of etiology, the most vital cancer problem today is this—what can we do to decrease the mortality of the 70 per cent. It may be conceded, that the majority of cases of localized cancer can be cured with either surgery, radiation or diathermy. Then the apparent answer to this problem is, to get them in the early stages. Much can be done and is being done by the education of the laity. We have a valuable agent in the American Society for the Control of Cancer to help us disseminate knowledge, which is valuable to persons who have early or precancerous lesions. We should stand firmly behind this society and lend it our aid.

But the responsibility is not entirely limited to the laity, for the records of some of the cases which appear at our Institute, show distinct evidence of procrastination and lack of a complete examination, upon the part of the physicians who were consulted first. This is particularly true of rectal examinations.

It seems to me that if the early diagnosis of cancer were given as much prominence on the curriculum of our medical colleges as is given to appendicitis and tuberculosis, we would materially improve our statistics.

Another more difficult problem, which as yet we have not solved, is to obtain some dependable method for the early diagnosis of deep-seated cancer. The need for this stands out in regard to gastric malignancy, which, as you know, shows

are so many portals of entry for the X-rays and the cervix is so readily accessible for radium implantation that the entire invaded region may be reached without endangering the abdominal viscera. As for carcinoma of the fundus, however, we still advocate vaginal hysterectomy in all cases.

**Cancer Within the Genito-Urinary Tract**—In general, reliance must still be placed upon surgery for the treatment of carcinoma of the genito-urinary organs. In some cases carcinoma of the kidneys in children will be reduced by deep X-ray therapy, but the radiation must be followed later by surgery. In the case of deep seated bladder tumors, radium has seemed to prevail in certain cases, but here also the results are still too uncertain for radiation to be used routinely. Postoperative radiation is employed in many cases, but more because it is hoped that it may be of avail than because of any definite results.

In conclusion, according to our experience our present judgment regarding the treatment of cancer of the organs discussed in this paper may be summarized as follows:

1 *Skin*—Radiation, except in cases of pigmented moles which should be excised.

2 *Buccal Surfaces*—Mucous membranes of mouth—excision. Early cancer of tongue, electric coagulation or actual cautery, early cancer of lip, radium, late cancer of tongue or lip, excision plus block dissection of glands.

3 *Larynx*—For intrinsic carcinoma, laryngectomy plus postoperative radiation, for extrinsic carcinoma, block dissection plus radiation if operable, tracheotomy plus radiation if inoperable.

4 *Thyroid*—Thyroidectomy plus radiation if operable, decompression plus radiation if inoperable, prevention by excision of foetal adenomata.

5 *Esophagus*—Gastrostomy for feeding plus radiation.

6 *Breast*—Radical operation. The value of radiation is still *sub judice*.

7 *Stomach*—Resection if operable, gastroenterostomy if inoperable.

8 *Intestines and Sigmoid*—Colostomy plus radical operation if operable, colostomy plus radiation if inoperable.

9 *Rectum*—Colostomy plus radiation.

10 *Uterus*—For fundus, radical operation, for cervix, radiation.

11 *Genito-urinary Organs*—Operation plus post-operative radiation in selected cases.

#### RESULTS OF SURGICAL TREATMENT

	Total Cases	Treated by all methods	Heard from	Survival Period Five years or over
Total series of cases of carcinoma	4108	3414		
Buccal Surfaces	107	75	24	7
Larynx	79	64	26	2
Thyroid		139	68	15
Esophagus	55	31		
Breast	829	752	530	145
Stomach	393	310	130	11
Small Intestine	16	12	3	2
Gall Bladder	54	43		
Large Intestine and Rectum	429	347	96	11
Uterus	525	472		
Cervix			24	8
Fundus			25	7
				208

## THE PRESENT STATUS OF THE TREATMENT OF CANCER\*

BY BURTON T. SIMPSON, M.D.

BUFFALO, N. Y.

### Introduction

WHEN we consider that the only reliable methods available today for the treatment of cancer are surgery, radium, X-ray and diathermy, we cannot help but feel, after listening to the excellent presentations covering these methods of treatment, that there is very little which has not been thoroughly covered by the previous speakers. I think you will also agree that there is not much left for me to discuss. I might, however, take up the question of diathermy, had not Dr. Wyeth handled this subject so well, last year, at the Rochester meeting. It

was my understanding, when I was invited by your chairman to take part in the symposium, that I was to open the discussion of the papers given. But when I received the program I found, much to my surprise, that a subject had been assigned to me, and I could not help but feel that, undoubtedly, the three preceding speakers would be sure to cover all that is to be said concerning the treatment of cancer.

However, as the honor has been conferred upon me to read a paper, I will try to avoid a repetition of the facts already told you, and will endeavor to bring to your attention some information which may be of interest to you.

Statistics show that 70 out of every hundred

\* Read at the Annual Meeting of the Medical Society of the State of New York, at Syracuse, May 12, 1925.



## X-RAY IN CANCER THERAPY \*

BY BERNARD F SCHREINER, M D, F.A.C.S

BUFFALO, N Y

**F**OLLOWING the discovery of X-rays in 1895 by Professor Roentgen, Herbert Jackson constructed an X-ray tube with a focusing spot for the cathode stream, using platinum for the anode. Numerous experimenters devised ways and means for utilizing these rays for photographing bones. It was during this period that the observation of the effect on skin was noted, namely, dermatitis and sometimes severe ulceration, which was the common X-ray burn in the early work. Shortly after the discovery of X-rays by Roentgen, Schiff and Freund making use of this information, suggested the value of X-rays in the treatment of disease. From 1896 to 1906, great optimism prevailed and it was during this era that physicians subjected their patients as well as themselves to the deleterious effects of X-rays, which for a time caused this valuable means of combating malignant disease to fall into disrepute. From 1906 to 1912 a few investigators like Pusey, Pancoast, Stelwagen, Pfahler, and others in this country, and Schiff, Freund and Holzkecht in Europe, persisted in their efforts at perfecting technique which would prove of value.

During a period from 1908 to 1912 an interrupterless transformer was given to us by Snook, while others were making improvements in the old gas tubes. In 1914, Dr Coolidge, of the General Electric Company, perfected the Coolidge tube. These contributions to science did as much as any other discovery in the development of X-ray therapeutics. With the improvement in the apparatus and tubes, physical and biological measurements were introduced by various physicists and Roentgenologists, among whom were Kroenig, Friederich, Duane, Dessauer, Stenström, Holfelder, Sabouran, Holzkecht and Kienbock, so that the treatment of cancer has become more or less standardized in this way.

Our present use of X-rays in combating cancer may be divided into three methods

1 Unfiltered X-rays

2 Low voltage X-rays with aluminum, zinc or copper filters

3 High voltage X-rays with heavy filtration

Our methods of treatment must necessarily be limited according to the biological effects as well as the physical measurements. In the use of unfiltered X-rays in the beginning, they were used empirically, the dose depending on the erythema of the skin. At the Institute unfiltered X-rays<sup>1</sup> were used after a period of empiricism, followed by physical measurements which were

made by means of photographic paper calibrated on the biologic effect as expressed by erythema. It is necessary to standardize the conditions under which X-rays are given, namely, as to voltage used, milliamperage, distance, filtration, time and size of fields. Unfiltered X-rays are of value in the treatment of all superficial lesions, such as basal cell epitheliomata,<sup>2</sup> pigmented naevi, epithelioma of the lip,<sup>3</sup> and penis.<sup>4</sup> Basal cell epithelioma can be healed in 95 per cent of the cases as they present themselves at the Institute by means of a full erythema dose of unfiltered X-rays. One or two treatments usually suffice. In the treatment of pearl forming or prickle cell epithelioma, such as occur on the lip, skin and penis, we have had a primary healing in 75 per cent of the primary cases, of which 50 per cent are apparently permanent. It is often necessary to administer from two to three times the erythema dose on a lesion, being careful to block off the surrounding tissue (with leaded rubber) depending on the thickness of the lesion.

Low voltage X-ray, 140,000 volts, using 2½ mm aluminum or 25 mm copper, at a distance of 20 to 30 cm is of value in attacking lesions situated not more than 3 cm below the skin. The use of low voltage X-rays at the Institute is much curtailed in view of the great flexibility of the high voltage X-rays as to time and distance required for treatment. Low voltage X-rays with aluminum filter or copper filter can be used in the prophylactic treatment of breast cancer following operation as well as in the routine treatment of fibroids providing the patient is not too thick.

The use of high voltage X-rays has been standardized at the Institute and is very flexible, thereby conserving a great deal of time and delivering as much as 50 per cent, 10 cm below the skin. This apparatus is using 200,000 volts, 30 milliamperes, 5 mm copper, distance varying from 30 to 80 cm, size of field from 6 x 8 cm up to 20 x 20 cm, time factor varying accordingly, 6 minutes up to 30 minutes for various distances.

In the treatment of cancer by X-rays, three important factors suggest themselves

1 Is it possible to annihilate a cancer cell or a malignant tumor cell by one large dose of radiation?

2 Is it more efficacious to divide a known quantity of X-rays over a given period of time in the hope that cells which are in various stages of mitosis can be destroyed?

3 Is the effect of X-rays in the healing of cancer due entirely to action on malignant tumor

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse May 12 1925

the highest mortality of all types of cancer. An immense amount of research has been done on this aspect of the problem. In a recent review of this work, made at our Institute, we analyzed and checked up over fifteen methods, which had been brought forward in more recent years, for the early diagnosis of cancer. It was found that none of them was thoroughly dependable. However, every effort is being made to find such a test, by nearly all cancer research laboratories throughout the world.

Even if we educate the laity to seek advice early, stimulate the internist to be more keen in his examination, we will always have with us those cases which are insidious and impossible of early diagnosis, and also the recurrent cases, which are due to indiscernible metastases.

Today, these cases are one of our urgent problems. How are they handled? Either they are sent to the radiologist to see what he can do, or morphine is prescribed, to make the patient as comfortable as possible until he dies. It is my opinion that, at the present time, it is unwise to treat advanced cases with radiation. It is sure to cause the patient increased suffering, and the possibility of a cure is almost nil. Also, experiments carried on in our laboratory with primary mouse tumors, show definitely that morphine decreases the resistance of the animal against its tumor growth. This, too, has been borne out by our clinical experiences.

I believe it is a mistake to abandon the inoperable cancer patient. He should have the same careful medical care that any other person with a chronic disease gets. Not only should attention be paid to elimination, diet, tonics, local treatment, etc., but stress should be laid upon the psychic management of the patient. In this way much suffering could be obviated and life prolonged.

The ideal treatment of cancer would be the intravenous administration of some substance which would be inimical to cancer cells and harmless to normal ones. That there is some possibility of a hope for such an agent is shown by the work of Wassermann. He found that a combination of selenium and eosin, introduced into the circulation of tumor-bearing animals, would cause the tumors to disappear. However, the difference between the fatal dose for the tumor cells and the normal cells was so slight, that for every mouse that was cured, nine were killed. Therefore, it is clear that this method could not be put in practical application. Nevertheless we are continuously working along these lines, trying out empirically organic compounds, aniline dyes, hormones, etc.

Before closing, I wish to call your attention to one phase of the cancer problem, which is of much importance, but which has seemingly been neglected. That is, the danger of palpating breast tumors. This, I think, is the chief factor in the unfavorable results which we obtain in the surgical treatment of cancer of the breast.

Mortality from cancer of the breast is second only to that of cancer of the uterus in the female. Considering the following facts, it ought to be one of the most favorable types of cancer for cure. For it is discernible early, easily accessible and susceptible to complete removal. Why, then, is the mortality from this type of malignancy so high? The answer is, that premature metastases have been established by massage.

Experimentally, in breast cancer of white mice, we can produce at will early metastases by massaging the tumor. Strains which normally do not show metastases until the sixth or eighth month, can be made to have them at the third month by manipulating the tumor frequently for a few days.

Let us take a hypothetical example. A woman discovers a "lump" in her breast. She has heard that this is a very serious thing and naturally becomes alarmed. She continually feels of this lump to make sure that it is there. Often she asks her husband, or one of her friends, to feel of it. This, of course, amounts to massage. After a time, she goes to her physician, who makes a "thorough examination." Certainly, if he does his duty, he advises immediate consultation of a surgeon, who, in turn, adds his palpation to the tumor. Thus we see that in the natural history of most breast tumors, there is considerable handling before the lesion is removed, and often indiscernible metastases have been established, although the patient is considered a favorable early case.

It would seem to me, that there should be instituted a widespread educational attack upon this aspect of breast cancer. The danger of manipulation should be brought home, not only to the laity, but also to the medical profession. It should be impressed upon the latter that it is not always necessary to make a definite clinical diagnosis of cancer. The presence of a tumor in the breast, whether it be malignant or not, is sufficient evidence to justify an immediate operation.

It is evident that the unfavorable results obtained in the treatment of cancer of the breast are due to premature metastases. These, most probably, are brought about by excessive handling of the tumor by the patient, and very often by a too vigorous examination by the physician.

constant a degree of saturation over a period of ten or more days, hoping thereby to produce better results in the various types of cancer we are called upon to treat. That this coincides, although somewhat empirically, with the knowledge that we are obtaining by persistent investigation, is borne out clinically and by observations made by Murphy and myself

In April, 1918, a case of metastatic carcinoma of the breast, which was considered hopeless, was subjected to the removal of a metastatic nodule, with the patient's consent. This nodule was divided into three portions, the idea being to ascertain, if possible, the amount of radiation necessary to destroy tumor cells so that they could not be implanted. One part was subjected to a full erythema dose of unfiltered X-rays. A small incision was made in the skin over the abdomen and the tumor tissue inserted subcutaneously. One piece was used for control and was buried in another place beneath the skin. A third piece of tumor which was not radiated was implanted underneath the skin in an area which had been subjected to a full erythema dose of unfiltered rays. The result was that the control piece of tumor grew. The tissue which was radiated and then inserted in the body did not grow, nor did the tissue which was not radiated but planted in the radiated site grow. The significance of this observation, although only on one case, was not impressive enough at the time, so was not followed up. Little was thought about this until Murphy's work on animals which showed that transplanted tumor in radiated sites did not grow. This position brought us to the realization that the beneficial results from X-rays in the treatment of cancer cannot alone be attributed to the effect of the rays on the tumor cells themselves, but rather as a combined effect in which there must be a biological reaction in the normal tissues as well as the cancer cells. These facts have impressed themselves on us so that our investigations are now being pushed along the lines of trying to maintain such a state of affairs as exists in a given erythema dose by trying to prolong these effects by division of a known quantity of X-rays over a given period of time. This seems promising although we are not yet ready to set the exact time interval between the division of the dose and whether or not the end results will be more gratifying.

## Conclusions

I We believe that the subject of X-radiation is in its infancy and leaves much work to be done before drawing absolute conclusions as to the merits of this form of cancer therapy

II These investigations should be carried on by competent clinicians in conjunction with physicists so that careful data can be accumulated on these points

III While many people are inclined to be pessimistic in so far as the value of X-rays in the treatment of malignant disease is concerned, we have ample proof that no other known form of therapy can accomplish in certain cases what radiation can

IV Radium and X-ray therapy have a fundamental principle in common, that it is necessary to think in the same terms no matter whether one agent or the other is used, or a combination of the methods

## BIBLIOGRAPHY

- 1 Dosage One and Two Centimeters Under the Skin from Unfiltered X-rays. By K. Wilhelm Stenström. *Jour. Cancer Research*, Vol. VIII, No. 1, April 1924
- 2 Diagnosis and Treatment of Basal Cell Epithelioma, With a Report of 59 Cases. By Bernard F. Schreiner, M.D., F.A.C.S. *Amer. Jour. Surgery*, January, 1919
- 3 Contribution to the Treatment of Cancer of the Lip by Irradiation, With a Report on 136 Cases. By Bernard F. Schreiner, M.D., F.A.C.S. *Jour. Cancer Research*, Vol. VIII, No. 2, July, 1924
- 4 A Study of Eighteen Cases of Epithelioma of the Penis. By Bernard F. Schreiner, M.D., F.A.C.S. *Jour. of Radiology*, October, 1921
- 5 Consideration of Assumed Causes of Roentgen-Ray Intoxication and Injuries. By Bernard F. Schreiner, M.D., F.A.C.S., and K. Wilhelm Stenström, Ph.D. *Amer. Jour. of Roent. and Radium Ther.*, Vol. XI, No. 5, pages 451-454
- 6 Consideration of Body Dose in Radiation Therapy. By K. Wilhelm Stenström. *Amer. Jour. Roent.*, 1923, X, 140
- 7 Summary of the Clinical Results After Irradiation of Cancer of the Cervix Uteri. By Bernard F. Schreiner, M.D., F.A.C.S. *Amer. Jour. Roent. and Radium Ther.*, Vol. XII, No. 4, pages 367-370
- 8 A Practical Method for Applying X-Rays 120-150% of the Skin Dose to the Tumor Without Injury to the Skin. By Bernard F. Schreiner, M.D., F.A.C.S., K. W. Stenström, Ph.D., W. Mattick, M.D., *Acta Radiologica*, Vol. IV, No. 15, VIII 1925

cells or the reaction of normal tissues in overcoming the diseased process, or both?

During the period of 1914 to 1922, there were many opinions held by numerous investigators as to the possibility of eradicating cancer tissue by the so-called massive doses. Much was said and written, especially by the German school, as to the annihilation of malignant disease by one massive dose which, as experience has shown, has proven a great disappointment in many forms of malignant disease, notably breast cancer. It was proposed after careful observation that certain types of tissue were highly sensitive to radiation, whether X-rays or radium (Regaud). From this was promulgated the so-called cancer dose. We all know that certain cells in the sexual organs, ovary and testicle, are destroyed by about 35 per cent of the so-called erythema dose. Other tissues, such as lymphoid tissue, succumb to 60 to 70 per cent of the erythema dose. Basal cell epitheliomata heal with approximately a full erythema dose, 100 per cent. We believe pearl forming epitheliomata require a little more radiation, at least 120 per cent. Carcinoma cells have been put down by various observers as 110-130 per cent, sarcomas, spindle cell, giant cell, ranging from 110-140 per cent of the skin dose, while certain types of myxosarcoma require even more, 150 per cent (?).

High voltage X-rays, as ordinarily employed, give one an opportunity of delivering from 24 per cent to 50 per cent of the skin erythema dose at 10 cm depth by adjusting the size of the field to various distances with a variation of the time factor. In this way one is enabled by one or more fields to administer doses up to 120 or even 150 per cent beneath the skin, depending on the portals of entry and area of the body to be treated. Along these lines have been developed extreme variations in methods of technique which have resulted in some improvement of the results in the treatment of cancer, but have left much to be desired. The idea that prevailed in this sort of treatment was to deliver one massive or so-called "knock-out" dose to the cancer, but it was soon discovered that unfortunately the effect on the organism was profound. There were many untoward symptoms<sup>3</sup> which denoted extreme degrees of disturbance of the metabolism, patients often succumbing to toxemias a few days to a few weeks after radiation. After a short time it was plainly seen that this method of radiating cancer subjects was doomed to failure as the treatment was as bad, if not worse, than the disease.

About three years ago, Wintz, the German investigator, called our attention to the importance of the amount of radiation absorbed during a given treatment. At this time Dr Karl Stenstrom, the physicist at our Institute, proposed a unit of body dose,<sup>4</sup> the following factors being

employed the amount of radiation which is absorbed in a field 10 x 10 cm x 5 cm thick from an erythema dose. This was designated as our standard and called 100 AX. All radiations from that time on were calculated as to the amount of radiation absorbed during a given treatment. This unit of body dose was adjusted to the weight of the patient with the result that we have learned the number of AX units per pound of body weight beyond which it is dangerous to push any further radiation, 15 AX on breast and chest cases and not higher than 20 AX per pound body weight on abdominal cases. From that time on we noticed a gradual decrease in the amount of sickness and depression following the X-ray treatments and apparently as good if not better results from the standpoint of the tumor. With these factors in mind, there developed a method called three-field arrangement for attacking tumors 3 to 5 cm below the skin. This enables one to deliver 120 per cent or even more of the skin dose into the tumor without injury to the skin with a corresponding low body dose. The application of this method has also proven useful in tumors of extremities and stomach cancer. The publication of this method will appear shortly by Drs Stenstrom and Mattick.<sup>5</sup>

Keeping the problem of body dose before us, a large number of our cases have been treated by combined methods. For example, in cases of cancer of the uterus,<sup>7</sup> rectum, naso-pharynx, pharynx and mouth, as well as metastatic tumors which are accessible to either the implantation of emanation or the insertion of radium tubes, the dose is calculated so that the sum total of radiation approximates 130 per cent of the skin dose, 3 to 5 cm from the tubes or seeds implanted. This treatment is given during a period of one week to twelve days. Other developments with high voltage X-rays in cases with extensive neoplastic involvement have been calculated so that we can deliver more radiation to the tumor over a longer period of time in the hope of destroying cells which are in various stages of karyokinesis and at the same time giving the organism or the body a fair chance to recuperate from the assault of the large amount of radiation absorbed. This idea was promulgated in our minds by a careful study of the literature as to the effects of X-rays in the production of erythema as observed by Miescher and ourselves, that an erythema dose given in one sitting would produce slight flushing of the skin within twelve hours, with subsidence and then recrudescence of the erythema about the twelfth or fourteenth day which would persist for a period of a week or more and gradually diminish with another exacerbation at the end of six weeks or two months.

Experiments are being carried on with the idea of finding out how much radiation can be given in a certain length of time, maintaining as near

of thousands of examinations, these have conclusively proved that minor abnormalities frequently exist without detection and that the remedy if promptly applied has a very sound economic value to the individual. Naturally the medical profession in the same unselfish spirit which has characterized its work from the beginning is willing to take on this added responsibility in the early correction of abnormalities.

There is much food for thought in the undertaking. The average physician needs only to make a thorough physical examination correlating his data on a blank accepted as standard, this to be carefully filed for future reference. As to conditions which require the advice of a specialist, it is to be assumed that a general practitioner would not be an expert in examining eyes but a simple test with a careful questioning of the patient would indicate if trouble existed and the patient is naturally referred to a specialist. A conscientious general physical examination can be done by every physician, including tests of blood and urine, blood pressure, etc. There is

no mystery in this. Assuming a patient to be well without examination just because the physician chanced to know the family and forbears of the individual, would be a palpable error.

It is assumed that those general practitioners wishing to take up this work will acquaint themselves with a proper method of procedure so that they will not omit questions or examinations which are essential to an accurate and complete examination.

The movement for better health has reached national proportions and the American Medical Association having been convinced that it is time that the country united as a whole in some organized way, has invited interested groups to meet in Chicago in November when the present methods will be better standardized.

The future of Periodic Health Examination is essentially dependent upon the interest of the medical profession, a cooperation on the part of the public, and an intermediary who shall take care of the publicity necessary to awaken a general interest in the need of it.

## TANGIBLE RESULTS FROM POST GRADUATE LECTURES

Physicians like to see tangible results from any activity which they promote or support, and especially do they like to see their patients pleased. The principal justification for an activity is the tangible results which it produces.

There is need that physicians should take intensive courses of study in medical centers, but only a minority of physicians can afford the time and expense to take them. The duty of the State Medical Society is to the great mass of average doctors who compose its membership. The State Society at present should seek to raise the standard of practice for the many as well as to set a high standard for a few.

The Committee on Public Health and Medical Education is reporting that as the result of reading the report of one of the lectures sponsored by the State Medical Society, the medical staff of a hospital in a distant part of the State appointed a committee to propose a standard method of managing the toxemias of pregnancy

in that hospital (see page 1038). This result is both tangible and practical, and is the kind that should follow the State Society lectures. On the other hand, the lectures should be such that frequent opportunities for practical results may follow—and this means that the lectures should be on topics which a doctor will be likely to put to frequent use.

A specialist in obstetrics would have found very little that was new in the lecture to which we refer. All its information had been set forth in medical literature with which specialists were familiar. The originality and peculiar value of the lecture consisted in the choice and presentation of facts which can be put to practical use at the bedside, and which the average doctor would not otherwise have learned. The teacher who brings a new fact to the attention of many doctors does a piece of work whose value ranks with that of the discovery of the fact.

## A NEW DEPARTMENT

With this issue of the JOURNAL we are introducing a Department called "Medical Progress," which will appear in each issue and will consist of abstracts of the more important articles appearing in the current medical journals of this country and of Europe. We are fortunate in having secured the assistance of Dr. Thomas L. Stedman, formerly Editor of the *Medical Record*, who will have editorial charge of this Department.

In preparing the material for this section the aim will be to select for comment and review such articles as embody the latest advances in the various branches of medicine and surgery, or those which contain novel ideas and suggestions of actual value to the physician or surgeon in his daily practice. The new Department will thus be an essential part of the comprehensive plan for Graduate Education which has been instituted by the Medical Society of the State of New York.



# EDITORIALS



The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

Editor-in-Chief—ORRIN SAGE WIGHTMAN, M.D.,

New York

### COMMITTEE ON PUBLICATION

E. ELIOT HARRIS, M.D., *Chairman*

New York

WILLIAM H. ROSS, M.D.

Brentwood

Executive Editor—FRANK OVERTON, M.D. Patchogue

DANIEL S DOUGHERTY, M.D.

New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

*President*—NATHAN B VAN ETEN, M.D. New York  
*First Vice President*—WILLIAM H. ROSS, M.D. Brentwood  
*Second Vice President*—FREDERICK H FLAHERTY, M.D. Syracuse  
*Speaker*—E. ELIOT HARRIS, M.D. New York  
*Vice Speaker*—GEORGE M. FISHER, M.D. Utica  
*Secretary*—DANIEL S DOUGHERTY, M.D. New York  
*Assistant Secretary*—HOWARD GILLESPIE MYERS, M.D. New York  
*Treasurer*—CHARLES GORDON HEYD, M.D. New York  
*Assistant Treasurer*—JAMES PEDERSEN, M.D. New York

*COUNSEL*  
GEORGE W WHITESIDE, Esq., 27 William St. Telephone, Broad 1744 New York

*ATTORNEY*  
ROBERT OLIVER, Esq., 27 William St. New York

### EXECUTIVE OFFICER

JOSEPH S LAWRENCE, M.D. 51 Chapel Street, Albany

### SECTION OFFICERS

*Medicine*  
*Chairman*—L. WHITTINGTON GORHAM, M.D. Albany  
*Secretary*—WARDNER D AYER, M.D. Syracuse

*Surgery*  
*Chairman*—EDWARD S. VAN DUYN, M.D. Syracuse  
*Secretary*—GEORGE E. BEILBY, M.D. Albany

*Obstetrics and Gynecology*  
*Chairman*—ALFRED C. BECK, M.D. Brooklyn  
*Secretary*—NATHAN P. SEARS, M.D. Syracuse

*Pediatrics*  
*Chairman*—ROGER H. DENNETT, M.D. New York  
*Vice Chairman*—ARTHUR W. BENSON, M.D. Troy  
*Secretary*—JOHN AIKMAN, M.D. Rochester

*Eye, Ear, Nose and Throat*  
*Chairman*—EUGENE E. HINMAN, M.D. Albany  
*Secretary*—JAMES W. WHITE, M.D. New York

*Public Health, Hygiene and Sanitation*  
*Chairman*—ARTHUR D. JAKES, M.D. Lynbrook  
*Secretary*—LEO F. SCHIFF, M.D. Plattsburg

*Neurology and Psychiatry*  
*Chairman*—CLARENCE O. CHENEY, M.D. Utica  
*Secretary*—THOMAS K. DAVIS, M.D. New York

### CHAIRMAN, STANDING COMMITTEES

*Arrangements*—EDWARD R. CUNIFFE, M.D. New York  
*Legislation*—HENRY L. R. SHAW, M.D. Albany  
*Public Health and Medical Education*,  
CHARLES A. GORDON, M.D., Brooklyn  
*Scientific Work*—ANDREW MACFARLANE, M.D. Albany  
*Medical Economics*—WILLIAM WARREN BRITT, M.D. Tonawanda

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex President and the Councilors of the District Branches.

*First District*—JOHN A. CARD, M.D. Poughkeepsie  
*Second District*—JOSEPH S. THOMAS, M.D. Flushing  
*Third District*—CHARLES P. MCCABE, M.D. Greenville  
*Fourth District*—HORACE M. HICKS, M.D. Amsterdam  
*Fifth District*—NELSON O. BROOKS, M.D. Oneida  
*Sixth District*—GEORGE H. FOX, M.D. Binghamton  
*Seventh District*—WILLIAM I. DEAN, M.D. Rochester  
*Eighth District*—HARRY R. TRICK, M.D. Buffalo

For a list of the Officers of the county medical societies, see October 15 JOURNAL, advertising page xviii.

For list of District Branch Officers, Standing Committees and Special Committees, see October 15 JOURNAL, advertising page third cover

## PERIODIC HEALTH EXAMINATION

A public interest has been aroused in the matter of Periodic Health Examination which bids fair to claim a local, State and national interest. There has been so much said about it and so much propaganda has been forthcoming that it has gathered unto itself a certain air of mysticism. There is nothing mysterious about it. Public agencies of every character have long striven to conserve public health.

The idea that a healthy community is a great economic asset to the State is well founded. Our City and State Boards of Health have slowly but surely improved the health of the community. Their work which started in a determination to reduce the death rate has grown into the broader field of disease prevention.

A most remarkable piece of constructive work was accomplished when public laboratories were

established and an ample supply of anti-diphtheritic serum, tetanus serum, anti-rabic serum and various other preventative and curative serums were offered through these public sources.

The State has likewise demonstrated a commendable interest in the health and welfare of the rural districts. Public Health Centers have been established and demonstrations given to impress upon the people the fact that their health and well-being was a vital requirement for good citizenship.

We now reach another advance and this comes as a challenge and responsibility to the licensed physicians of the State. The idea that a Periodic Health Examination would disclose enough data to prevent the development and advance of definite diseases has been well established. Outside statistical agencies have collected the results



## MEDICAL PROGRESS



**Sympathectomy in Angina Pectoris**—About four years ago Jonnesco reported in *La Presse Medicale* a case of angina pectoris occurring in a man of 38 years, in which he resected the left cervical sympathetic nerve with the superior middle and inferior cervical and the first thoracic ganglia. The result was an apparent cure, the patient reporting, four years after the operation, entire freedom from his previously agonizing pain. The object of the operation was to suppress the pain by interrupting the transmission of impulses from the cardio-aortic plexuses, though of course the condition previously exciting the attack was not thereby removed. This first success encouraged a repetition of the operation by Jonnesco, Tuffier, and others, until at the present time the number of reported cases is such as to establish the justifiability of the measure for the relief of true angina pectoris in properly selected cases.

This aspect is discussed by Samuel A. Levine and Francis C. Newton in the initial number of the *American Heart Journal*, October, 1925, 1, 1. They confirm reports submitted by others showing that cervical sympathectomy affords striking relief in certain cases, and stress the point that the proper selection of cases ought to diminish markedly the immediate surgical mortality, and also give to those operated upon a reasonable expectation that they may live for an appreciable length of time to enjoy their improved health. The writers emphasize the absolute necessity of an accurate diagnosis before operation is undertaken, and especially insist that cardiac infarction be not confounded with angina pectoris. Furthermore the study of each patient should indicate that there has not been any congestive heart failure, that the musculature of the heart is satisfactory, and preferably that there is no valvular disease. The authors give a detailed report concerning seven patients who were selected for sympathectomy. They were all alive three months to two years after operation. Three were rendered absolutely free from anginal attacks and have remained so, three continued to have typical anginal attacks but were nevertheless considerably improved, in that it required a greater effort to bring on the attacks. In one case there was no change whatever. It is urged that cases be reported in detail so that it will be possible to form a judgment as to the type of patient to be operated upon.

A warning against the inclusion of the stellate ganglion in this resection of the sympathetic has,

however, recently been uttered by Danielopolu and Marcu (Paris correspondence of the *Lancet*, October 24, 1925, cci, 5330). In the authors' experiments the myocardium was first weakened by occlusion of the coronary arteries and then the superior thoracic ganglion was excised. The modification resulting therefrom in the electrocardiogram was regarded by them as of very serious clinical import, indicating a blocking of the cardiac motor fibres. The operation proposed by Danielopolu and Marcu in place of the Jonnesco procedure consists in excision of the cervical sympathetic, sparing the superior cervical and first thoracic ganglia, resection of the vagus and all its branches which supply the thorax, and resection of the rami communicantes uniting the inferior cervical and first thoracic ganglia to the lowest cervical and first dorsal nerves. The advantage of this operation is that, while a large number of cardio-aortic sensory fibres are resected, the important afferent fibres which pass through the stellate ganglion remain unimpaired.

**The Surgical Treatment of Mitral Stenosis**—H. S. Souttar (*British Medical Journal*, October 3, 1925, ii, 3379) reports a case in which he operated for mitral stenosis, and takes the occasion to illustrate the technique he has adopted. In a girl, aged 15, with a history of chorea and mitral stenosis, with many relapses and increasing failure of compensation, rest in bed made it appear that the heart was unable to reestablish compensation, and it was therefore decided to attempt to relieve the stenosis by surgical means. Under intratracheal anesthesia, a curved incision was made along the fourth intercostal space, up along the middle of the sternum, and onward along the first left intercostal space. On the outer side of this area, a short horizontal incision was made along each of the three ribs exposed, and through these incisions the ribs were divided. When the flap was turned outward an area of the chest wall about five inches square was exposed. The chest wall was divided a little within the line of the original incision by cutting through the muscles and costal cartilages, the flap so formed was turned outward, the pleura being included with it. After waiting five minutes for the rapid action of the heart to subside, the pericardium was opened by a vertical incision three inches long, in the center of which the left auricular appendage came prominently forward. Two sutures were passed through the upper and lower margins of the appendage, so that it could be readily drawn forward. As the heart was beating very

## PROBLEMS OF ORGANIZED MEDICINE

The Medical Society of the State of New York is often confronted with new problems for whose solution the public looks to physicians. Modern life requires a complex adaptation to new conditions which arise out of civilization itself. The means of rapid travel, for example, bring increased opportunities for the spread of infectious diseases, such as influenza, and the human race is still engaged in a constant struggle for existence.

While physicians are marvellously well trained to deal with individual cases of sickness, they as individuals can do little to combat the extensive causes of sickness which arise from communal origin. Doctors must have the assistance and support of the great mass of people before they can control such conditions as malaria and hookworm. These problems must be solved by organizations of physicians cooperating with society.

Social and philanthropic organizations have provided the means for studying public health and for spreading an extensive propaganda for the prevention of diseases and the promotion of vigor and long life. These organizations have individual physicians as advisors, but to the great mass of physicians they often seem visionary and impractical because the average physician acts on his own individual initiative and deals principally with sick persons as individuals. The physician of today has his hands full in dealing with individuals who come to him, each seeking relief from his own infirmity.

The individual physician is not able to solve community problems in medicine because he is only an individual and his voice does not reach beyond the limited circle of the comparatively few who employ him. But an organization of physicians can speak with an authority which is denied to the individual doctor.

Physicians generally are acutely aware of their opportunities to do public service, and to advance the cause of community health. There is a very real field for the practice of civic medicine by medical organizations as distinguished from individual physicians.

The field of the practice of civic medicine is largely preempted by lay organizations, and the reason is obvious. Civic medicine is concerned principally with social conditions, and the lay organizations are founded and managed by sociologists who have made special studies of economics, criminology, education, housing, and other conditions that have a deep effect on life and health. Physicians have said that the remedy of social conditions is extremely difficult because the people are ignorant and refuse their cooperation. The sociologists and lay organizations have taken the doctors at their word, and say "If the doctors fail in the practice of civic medicine because of the ignorance of the people, we will educate the people by the use of nurses, exhibits, lectures, and any other means of reaching them."

The obvious field of lay health workers is that of educating the people and getting them to avail themselves of medical advice both privately and collectively.

The obvious duty of physicians when the lay workers refer cases to them is to accept the cases, and give the best advice possible, and thank the workers who sent them.

The happy cooperative state of affairs has not entirely come to pass. Lay workers have sometimes told doctors what to do in a medical way, and doctors have sometimes said that the sociologists were often attempting the impossible. But order is rapidly evolving in the overlapping fields of medicine and sociology. Evolution has always consisted in developments along all possible lines of variation, some practical and some useless or harmful. All kinds of new devices are tried and only the good survive. We may be pessimistic as we view the numerous failures in social evolution, or we may be optimistic as we consider the successful results and the promising outlook for the future.

The most optimistic sign of all is that medical societies—county, state and national—are entering heartily into their own peculiar half of the field of the practice of civic and social medicine.

## PRESERVE YOUR JOURNALS

We appeal to our members to preserve their Journals. Our special reason for making this request is that the Journals contain descriptions of the activities of the State Medical Society and its officers and committees.

As the officers go about the State we are often asked about the policies of the State Medical Society, and about what has been done, and in nearly every instance they have been able to point to the answer in some recent number of the Journal.

We realize that no one can grasp all phases of State Medical Society work by a casual

reading of everything in the Journal, but every doctor has occasion to look up some phase of work which is fully described in the Journal and nowhere else.

It is a very great convenience to both the officers of the State Society and to an inquiring member to be able to turn to the Journal pages describing a certain activity in which the member is interested. Members who preserve their Journals will find them exceedingly interesting and useful after six months or a year have elapsed.



*ton Medical and Surgical Journal*, October 22, 1925, cxciii, 17) endeavors to show that the prevalent belief in the inefficacy of specific treatment of cardiovascular syphilis, when present to the degree that symptoms or demonstrable signs exist, is fallacious. It has been conclusively proved that antiluetic treatment has resulted in the amelioration of symptoms, especially the harassing pain of angina pectoris of luetic origin, and has been shown to be of benefit in all cardiac deficiencies which have a specific basis. A review of the statistics of autopsy services in large hospitals shows that cardiovascular syphilis occupies a prominent position, and a large number of these cases reflect directly the inefficacy of the former nonspecific methods of treatment. In early cases, the administration of arsphenamine (or of one of the allied arsenicals) is the treatment par excellence. It is but rarely, however, that cardiovascular syphilis is susceptible to diagnosis early enough for one to be as secure in approaching the treatment as one is in the case of chancre or of the secondary manifestations. It has been shown that there is a fairly large percentage of cases where, in spite of clear-cut evidence of the presence of aortitis, aortic regurgitation, or aneurysm, the Wassermann is repeatedly negative. In the clinic of the Boston University School of Medicine, therefore, less attention is laid to the Wassermann and more to the other factors in diagnosis. The author's plan is to begin with a short course of six mercury or bismuth injections given intramuscularly. Weekly injections of arsphenamine are then begun, the initial dose being 0.15 Gm. If this is well tolerated the dose may be increased to 0.4 Gm. About four to six injections should constitute a course. Concomitantly the patient is given potassium iodide in increasing doses reaching 100 grams or more daily. Whenever it is possible arsphenamine or one of the allied arsenicals, should be given, as this treatment is far more effective than any other form of therapy.

**Oxygen in the Treatment of High Blood Pressure** — According to Simon (*Klinische Wochenschrift*, October 1, 1925, iv, 40), this subject is not entirely new, but it is only recently that inhalations have been applied systematically for the purpose stated. It is hardly the long looked for hypotonic remedy, but should certainly prove a valuable accessory to other measures. Loewy was the first to show that the normal pressure is but little influenced while pathologically high pressures of all types can be brought down—the higher the original systolic pressure the greater the reduction, the diastolic being little influenced. The author has followed up the work of Loewy, and was able to corroborate his claims. He then tested the inhalations on a series of se-

vere cases of chronic disease with high pressures. The patients were made to inhale six liters of O during 1 to 1½ minutes, either once or twice daily, for an interval of five days, ten days, etc., according to the case. In an elderly patient with arteriosclerosis and cardiac decompensation the blood pressure had varied from 165 to 200. After eight days of inhalations the pressure had fallen to 135, but when the inhalations were intermitted it returned to its former height. After a second course it was brought even lower—110 to 120. The author relates other similar cases with the same results. The patients took no other medication and no other treatment of any kind is mentioned.

**Collapse of the Lung** — Edward D. Churchill (*Archives of Surgery*, October, 1925, ii, 4) believes that the so-called massive collapse of the lung, which has been receiving increasing attention as a postoperative pulmonary complication, is but a special type of pulmonary atelectasis, and that, at least in the majority of instances, it occurs as a result of the same etiological factors. The most important diagnostic sign of postoperative massive atelectasis is displacement of the heart and mediastinum toward the affected side. The auscultatory signs, which vary with the extent and nature of the pathological process, are correlated with the Roentgen ray picture. Experimental and clinical observations indicate that atelectasis results from the combined action of weakened respiratory force and bronchial obstruction. These two factors may be caused by different agencies, and play rôles of varying importance in different cases. Pulmonary embolus does not cause atelectasis except as an accompaniment of the subsequent fibrosis, though it is possible that an area of pulmonary collapse may alter the pathological course of an embolus which chances to lodge within its borders. A review of the literature gives no direct evidence for the belief that atelectasis in itself favors the development of pneumonitis.

**"Petty Signs" of Tuberculosis** — Nigoul-Foussal gives an account of certain forerunners of acute outbreaks of tuberculosis of the lungs and meninges which are apparently partly supplied by the anatomo-physiological predisposition to disease and otherwise are the result of minimal infection with tubercle bacilli. He justifies his use of the expression, "petty signs" (by which is implied prodromic rather than insignificant), because this is also in use in French writings on Bright's disease, arteriosclerosis and hepatic insufficiency. The author's petty morbidity of tuberculosis differs from that often given, doubtless because he refers essentially to certain clinical and pathological types, and not to tuberculosis as a whole.

rapidly, the wound was covered with hot saline pads and a subcutaneous injection of 1/100 grain strophanthin was given. After ten minutes the heart steadied down to 120, and the blood pressure, which had fallen to 60 mm, returned to 90 mm. The auricular appendage was drawn forward, a soft curved clamp was applied to its base, and it was incised in an anteroposterior direction with scissors. Into this opening the left forefinger was inserted, the clamp was withdrawn, and the appendage was drawn over the finger by means of the sutures. The whole of the interior of the left auricle could now be explored with ease. The finger was passed into the ventricle through the orifice of the mitral valve without encountering resistance, and the cusps of the valve could be easily felt and their condition estimated. As the stenosis was of moderate degree and was accompanied by little thickening of the valves, it was decided to limit intervention to such dilatation as could be effected by the finger. After breaking down adhesions the finger was withdrawn, but at the critical moment of withdrawal the lower retaining suture cut through, and the appendage slipped back into the pericardium, there was a sudden gush of blood which was, however, instantly checked by pressing the appendage against the heart. The opening was now held securely closed with the thumb and finger, while an assistant passed a silk ligature around the appendage and tied it off. The chest was closed, after removing the blood that had escaped into the pleural cavity, and on the conclusion of the operation the general condition of the patient was indistinguishable from that at the beginning. At the end of three months the patient declared that she felt perfectly well, although she still became somewhat breathless on exertion. The author expresses himself as impressed by the mechanical nature of these lesions and the practicability of their surgical relief.

**Ischaemia Cordis Intermittens**—L. Bischoff (*Lancet*, October 10, 1925, cxi, 5328), using the above terminology, describes a group of anginoid phenomena, affecting patients between the ages of 30 and 70 years, mostly males, after more or less brisk walking or climbing, or any hard exercise. There is a disagreeable pain behind the sternum, which passes into a feeling of spasmodic contraction with oppressive sensations of anxiety, culminating in such a sense of approaching dissolution that the patients are obliged to stop. It may lead to complete loss of consciousness. Dyspnea is absent. Often, after a rest of a few minutes, the patient is able to continue his walk in perfect comfort, but soon after the resumption of exercise pain returns. The history of all patients reveals the same phenomena. The author draws a distinction be-

tween this affection and true angina pectoris, noting that the former is excited by exercise, while the latter usually occurs at night or during rest. The complex of symptoms under consideration is connected with an insufficient blood supply to the heart muscle. In these cases, as in ordinary angina, the prognosis will depend on the etiology of the ischemia, i.e., on the occurrence of alterations in the vessels, on the extent of such alterations, and on the state of the aorta, of the heart muscle, and of its reserve power. The author has never heard a double first sound (during quiet breathing in the entire phase) in cases of ischaemia cordis intermittens, while it has been repeatedly observed to be present in true angina pectoris. One patient was observed fluoroscopically during an attack. No alteration worth mentioning (dilatation for example) was noticed, but the apparent pulsations and the visible range of contractions were small.

**The Use of Urea as a Diuretic in Advanced Heart Failure**—J. Hamilton Crawford and J. F. McIntosh (*Archives of Internal Medicine*, October, 1925, xxxvi, 4) administered urea in doses of 30 to 60 Gm. a day to eight patients with advanced heart failure, and then estimated the urea in the blood and urine by the method of Van Slyke and Cullen, the chloride in the urine by a Volhard titration, and the chloride in the plasma by the method of Van Slyke. The result of the administration of the urea was a marked increase in urine volume. The drug was particularly useful in cases in which an adequate water excretion was not maintained after the edema fluid had been removed by other measures. In some cases it relieved the edema when other remedies had failed. The increase in urine output followed closely the curve of urea excretion. With continuous administration the daily urine volume was maintained at an almost constant level. The response after administration was rapid, but the effect passed off in a short time unless the dose was repeated. The changes in the urine volume and in urea excretion were found to be dependent upon the concentration of the urea in the blood. In several cases in which there was a subnormal index of urea excretion which seemed ascribable to advanced heart failure, the index tended to improve with urea administration, along with a general improvement in the clinical condition. No toxic symptoms of any significance were observed. The authors suggest that urea is a useful diuretic in cases of cardiac failure with edema in which treatment of the heart condition has failed to remove the edema or maintain an adequate water excretion.

**The Value of Specific Treatment in Cardiovascular Syphilis**—Bernard I. Goldberg (*Bos-*



# LEGAL



By GEORGE W. WHITESIDE, Esq.  
Counsel, Medical Society of the State of New York

## THE GOVERNMENT OF A PROFESSION

The regents was created in 1784, the Constitution of the State, Article 9, Section 2, continues their existence subject to their powers being modified or changed by the legislature. In Section 51 of the Education Law we find

*"Conformable to law, the regents may supervise the entrance regulations to, and the licensing under, and the practicing of, the profession of medicine"*

We have long been familiar with the action of the regents in supervising "the entrance regulations to, and the licensing under" of the profession of medicine, but little seems to be known of the exercise of their power, under existing laws, of the supervision of the *practice* of the profession of medicine.

The board of regents consists of three more than the existing judicial districts of the State, which means that their membership consists of twelve. They hold office in the order of their election, so that the term of one regent expires each year and his successor is elected by the legislature on the joint ballot of the two houses, which appears to give a regent a twelve-year term.

Under the present law the regents may revoke the license of a practitioner of medicine, or annul his registration, or do both, for certain statutory violations of professional conduct. The charges are heard in the first instance by three members of the board of medical examiners. This committee makes a written report of its findings and recommendations to the board of regents. Upon the examiners' report the regents may, in their discretion, revoke a license or annul a registration, so that the trial tribunal consists of three medical examiners, whose only power is to hear evidence and make a report. The ultimate decision of the action to be taken rests in the discretion of the regents.

The board of medical examiners consists of nine members appointed by the regents, who hold office for three years. They must be physicians of at least five years' practice. They receive an annual compensation of not less than four thousand dollars, payable from the fees received under the article respecting the practice of medicine. The chief duty of the board of medical examiners consists in submitting to the regents a list of suitable questions for examination of candidates for license—the regents prepare the question papers. The medical examiners examine the papers and mark the answers and transmit their

report to the regents. This is the practice provided for by statute in the present medical practice act enacted eighteen years ago.

In the legal profession there is a similar examining committee, whose entire functions are devoted to the preparation of questions and the marking of papers of applicants for admission to the bar. The bar examiners exercise no quasi-judicial functions in the regulation of the profession or in acting as a trial committee or court for members of the profession who may be placed under charges.

The preparation of questions to be submitted to the young men applying for admission to practice medicine requires one type of ability, the exercise of judicial functions for the control of the profession at large—whose members have already been admitted to practice, many of them for many years—calls for a different and more varied kind of experience and understanding. Keep in mind, please, that as has already been quoted from the law, the regents supervise the *practice of the profession of medicine*. Under that power, at the present time, *every member of the medical profession* is subject to the *supervision* of an essentially lay body. The statute under which the regents were first granted the power to revoke licenses for causes other than conviction of felony or irregularity or fraud in procuring a license was the medical practice act of 1907, and in 1910 Section 51 of the Education Law gave the regents power of supervision over the practice of medicine.

The regents, under the present act may, after trial by them, revoke a physician's license who is guilty of "(a) fraud or deceit in his practice," (b) guilty of a crime or misdemeanor, (c) guilty of being an habitual drunkard or drug addict, (d) guilty of undertaking to perform an abortion, and (e) guilty of offering or undertaking to give contraception information or advice. Thus, disciplinary power over the medical profession resides now without the ranks of the profession and in a lay body—a body whose chief function is the control of education from the common school through the university, a body whose educational duties give it little time or background for the study and understanding of the complex problems surrounding professional misconduct in the medical profession. In the choice of these regents who are lay judges of the medical profession, the profession has no voice. In the selection of the medi-

He attempts to rationalize these evidences. Thus, one group of symptoms may be referred wholly to habitual low blood pressure—chilliness, subnormal temperature, lassitude. In another group the alimentary canal furnishes the symptoms and the author attributes them to a basic mucomembranous enteritis which is responsible for constipation, nausea, vomiting, capricious appetite, etc. A third characteristic is overreaction to protein injections of all kinds which may be further associated with oversensitiveness to the action of certain drugs, as quinine and aspirin. A symptom not usually mentioned under forerunners of bacillary tuberculosis is early obesity. This may be due to some endocrine anomaly, but the author suggests that it may be of toxigenic nature, and cites cases in which slight toxemia has led to obesity. Individuals with this symptomatology may remain for years in apparent health, only to succumb suddenly to one of the acute forms of tuberculosis. *Le Bulletin Médical*, Sept 2/5, 1925, xxxiv, 36.

**Splenic Opothrapy in Tuberculosis**—Bayle of Cannes has used this treatment for his tuberculous patients since 1903 (*La Presse Médicale*, September 23, 1925, xxxiii, 76). Justification for its use was furnished by the results obtained in induced laboratory tuberculosis of animals, the rationale being in part a remarkable and rapid action on the blood, comprising increase of both red and white cells (lymphocytes) and hemoglobin. The waste of phosphates was also checked while the blood calcium content was increased. The bacilli were found to be diminished in numbers, and the formation of fibrous tissue and cicatrization was promoted. Many laboratory men are quoted in support of these claims, which apparently may be verified by anyone. The author notes precisely the same consequences in his human subjects and mentions that a single hypodermic injection of the extract will cause an increase of the red cells from 4 to 5 millions. Weight and general condition gain, the lesions are shown by objective tests to heal, and the bacilli disappear from the sputa.

The remedy may be given by the mouth in the incipient or threatened case, and as an adjunct to the hypodermic method, the latter is, however, required in all active cases. One or two ampoules of 5 cc each are injected at such intervals that a dozen injections shall have been received at the expiration of 22 days. The author appears to employ no other medication, although he goes intensively into a consideration of the diet. In addition to his own observation, his colleagues in Cannes and nearby, both in private and sanatorium practice, have reported favorable results. The patients in the second and third stages taken jointly show a recoverability of 75 per cent.

Similar results were obtained by Tremolieres and Colombier by irradiation of the spleen (*Archives d'Electricité med.*, xxxi, 79). They used a weak dose (about 1H) once a week for fifteen weeks. The results noted were marked improvement in the general health, increase in weight, cessation of the night sweats and cough, and reduction in the daily fluctuations of temperature.

**Prevention of Senescence by the Brown-Sequard Testicular Extract.**—Zoth contributes to the *Wiener klinische Wochenschrift* of September 24, 1925, xxxviii, 39, an account of his personal experience with this substance. He began to test the extract with Pregl in 1896 when he was thirty years old. A preliminary report was made at the time and the author has continued his use of the extract for the intervening thirty years in the aim of slowing up the involutory tendencies of man. Although he has used the remedy on others, most of the paper deals with his own case and with the technique of administration which he has continually sought to perfect. He prepares the extract from the glands of sexually mature bullocks, and still follows the old Brown-Sequard-d'Arsonval technique of preparation. He learned that one short course of treatment every summer is sufficient and that attempts to push it are dangerous in that they cause symptoms of serious cardiac mischief. He is sure that the results obtainable with the proper technique surpass any of the new contemporary procedures, including the direct gland implantation and Steinach ligation. The course of treatment should last from two to four weeks. The total amount of glycerin extract, which is injected beneath the skin of the abdomen, should be 20 to 30 cc, and the single dose, 1 to 1.5 cc diluted with twice the quantity of distilled water. In regard to results the author is satisfied with his life-long personal experiment, although he realizes the difficulty of convincing the public with the experience of one individual. As an out-door athlete and gymnasium devotee he finds his capacity for physical exertion is maintained, and he believes he has a superior resistance to disease. Despite the harrowing experience of the war and after-war years he shows no signs of senescence in his 61st year.

In this connection it is interesting to recall the observation of K. M. Walker in the *Lancet* of January 5, 1924, who holds that the internal secretion of the testis is formed by the tubular cells, the interstitial cells being merely trophic in their function. They simply store up nutritive material for use by the tubular cells in case of emergency, and the mere fact that the interstitial cells increase in number after ligation of the vas deferens is no proof that the output of internal secretion has been increased.



## GRADUATE EDUCATION



The work of the Committee on Public Health and Medical Education is growing beyond expectation. While it had been expected that considerable stimulation would be required in order to create a demand for courses of study, experience has shown that the doctors throughout the State are ready and eager to attend the courses. The field is ready, and the demand for instruction is already existing. The Committee has, therefore, been relieved of the preliminary work of arousing an interest in its activities.

The Committee found that several forms of graduate medical instruction were already being conducted throughout the State. There was first the post-graduate instruction given by the medical schools and a few hospitals in the larger centers. These courses were mostly intensive and required attendance at the teaching center and much collateral study and investigation. These courses are for the training of leaders and specialists, and they need little stimulation or aid from the Committee.

A second form of instruction was that given to health officers, under the auspices of the State Department of Health. At least twenty-five of these courses have been given. They are designed not merely to teach health officers how to perform their newer round of required duties, but they gave the health officers a broad view of the whole field of public health and preventive medicine, and showed the student how he could practice these newer branches of medicine in his everyday, unofficial work. Over 500 doctors had taken extensive department of health courses, and their commendation of the courses was practically unanimous.

A third form of graduate medical instruction was that of courses in special subjects made available to physicians in their own home towns, while the students continued to follow their daily medical rounds. These courses were developed under such varying conditions as Kings County—the largest Borough of Greater New York—and Suffolk, Jefferson, St. Lawrence, and Orange counties, all of which are very largely rural.

The Committee deemed it wise to combine the plans of the State Department of Health with that of local teaching centers, and to offer courses for which the State Department of Health was already prepared, especially those in pediatrics and obstetrics.

The intimate co-operation of the Department of Health with the Medical Society of the State of New York has been most fortunate, and calls for the combined courses are coming to the Committee faster than the facilities for giving them

can be organized. But the Committee wishes it understood that the co-operative courses are by no means the only ones that are being planned, it expects to be able to offer equally good courses in diseases of the heart, kidneys, nervous system and other parts of the body.

The Committee has its headquarters in the Building of the Medical Society of the County of Kings, Brooklyn, at 1313 Bedford Avenue, near Atlantic Avenue. There files are being accumulated containing information regarding every county in the State. This information has been derived from every possible source—correspondence, the Medical Surveys published in the *JOURNAL*, personal interviews, questionnaires, the State Department of Health, and any other available source, and the information is constantly growing in extent and value.

A word as to the questionnaire, a copy of which was printed on page 941 of the October first issue of the *JOURNAL*. This questionnaire contains the subjects on which definite information is desired by the Committee, and which must be available in order that the Committee may allocate its resources intelligently.

We urge the officers of the county societies to send their answers promptly and fully.

New courses have recently been started in several counties, as follows:

The Suffolk County Medical Society is starting a pediatric course in Southampton.

Washington and Warren counties are establishing a pediatric course, to be given in Glens Falls.

The Societies of Genesee, Livingston and Wyoming are uniting in a pediatric course in Batavia.

Chemung County will repeat the lectures in obstetrics which were given in Jefferson and St. Lawrence counties (see this *JOURNAL*, August, 1925, page 876).

The counties of Nassau, Columbia and Sullivan are completing the details for courses.

Doubtless other counties—Montgomery, for example—will institute courses independently of the State Society. The State Committee hopes that when county societies act on their own initiative, and put on courses which they arrange for themselves, they will send the Committee details of the courses planned and keep it informed of their activities.

The Committee is working out a plan by which the medical schools will co-operate in giving instruction. The Administrative Board and Faculty of the Buffalo University Medical School have voted unanimously to co-operate with the Committee in assigning teachers to nearby county

cal examiners who now are the trial committee of the regents, the profession has no voice

The ethical standards of the medical profession have been erected by the profession and not imposed upon it from without by any lay body. The profession has not been empowered to enforce these standards upon those unwilling to accept

them. Public confidence in the profession, so essential to the profession's economic stability and so vital to its successful public health activities, must spring from a will by the profession to regulate and elevate its standards by its own initiative rather than from a coercive exercise of police power by a body from without.

### NEGLIGENT TREATMENT OF RASH ON FACE

On a December evening a physician, in answering his door bell, was requested by a boy to call upon the boy's father. This physician, in response to the request, visited the home of the patient, who stated that he was down and out and sick, and had no money with which to pay the physician for any service that he might render. The physician told the patient that money was not a necessary requirement for the rendition of treatment.

Upon examination he found that the man was suffering from a slight bronchitis and prescribed an expectorant. On the following day the physician again called upon the patient, found that the condition was improving and that the patient was up and about and able to go out.

About a week after this visit the patient called at the doctor's office, at which time his face was swollen and reddish and there was a slight rash upon the face. The patient had a fear that the rash was erysipelas, which the physician, however, advised him was not the case. The patient gave a history of a syphilitic infection some years before. The doctor told him that the rash upon the face would undoubtedly clear within a few days, and he would thereafter have a blood test made. The patient fearing that the condition was erysipelas the doctor advised the patient to consult a specialist, but upon being told by the patient that he could not afford the services of a specialist, he then advised him to visit one of the city hospitals, where he would receive free treatment.

After the visit to the hospital the patient again returned to the doctor and stated that he had been advised at the hospital that the rash was not erysipelas. Several days later the patient again returned to the doctor, at which time the rash had almost completely disappeared from his face and the swelling had subsided.

The doctor heard nothing further from this patient until more than two years thereafter, when he received a letter from an attorney claiming that he had negligently and carelessly treated the patient and demanding a settlement of the claim. Refusing to meet the demand for a settlement, an action was instituted against the physician in the Supreme Court. Before a complaint was served in this action a second action was instituted in the Municipal Court. In the action in the Municipal Court a motion was made to dismiss the same on the ground that the cause of action was barred by the Statute of Limitations, which motion was granted. An appeal was taken by the plaintiff to the appellate court, but the judgment in favor of the defendant was affirmed by that court. The plaintiff having failed to serve his complaint in the Supreme Court action, a motion was made to dismiss the same on the ground of failure of prosecution, which motion was granted.

This physician, as compensation for his gratuitous service to the patient, was compelled to defend two actions of alleged malpractice which, fortunately, were terminated in his favor.

# MEDICAL PRACTICE ACT

AS FINALLY ADOPTED BY SPECIAL COMMITTEE OCTOBER 22, 1925

## AN ACT

To amend the public health law, in relation to the practice of medicine.

*The People of the State of New York, represented in Senate and Assembly, do enact as follows*

Section 1 Section one hundred and sixty-one of chapter forty-nine of the laws of nineteen hundred and nine, entitled, "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," is hereby amended to read as follows

§ 161 QUALIFICATIONS No person shall practice medicine, unless registered and legally authorized prior to September first, eighteen hundred and ninety-one or unless licensed by the regents and registered under article eight of chapter six hundred and sixty-one of the laws of eighteen hundred and ninety-three and acts amendatory thereto, or unless licensed by the regents and registered as required by this article, nor shall any person practice under this article who has ever been convicted of a felony *involving moral turpitude* by any court, or whose authority to practice is suspended or revoked, [by the regents on recommendation of the state board] The conviction of [a] *such* felony shall include the conviction of any offense which it committed within the State of New York would constitute a felony under the laws thereof If a person convicted of a felony is subsequently pardoned by the governor of the state where such conviction was had, or by the president of the United States, the regents may, in their discretion, on application of such person, and on the submission to them of satisfactory evidence, restore to such person the right to practice medicine in this state, unless such conviction has been for misconduct in his professional capacity

Section 2 Section one hundred and sixty-four of such chapter is hereby amended to read as follows

§ 164 EXPENSES The fees derived from the operation of this article, *except as otherwise provided in section one hundred and seventy-five, subdivision five*, shall be paid into the state treasury and the legislature shall annually appropriate therefrom for the education department an amount sufficient to pay all proper expenses incurred pursuant to this article

Section 3 Section one hundred and sixty-nine of such chapter is hereby amended to read as follows

§ 169 LICENSES On receiving from the state board an official report that an applicant has successfully passed the examinations and is recommended for license, the regents shall issue to him a license to practice according to the qualifications of the applicant Every license shall be issued by the university under seal and shall be signed by the president and secretary of

the board and by the officer of the university who approved the credential which admitted the candidate to examination, and shall state that the licensee has given satisfactory evidence of fitness as to age, character, preliminary and medical education and all other matters required by law, and that after full examination he has been found properly qualified to practice Applicants examined and licensed in accordance with the provisions of this act who, when admitted to the licensing examination, were citizens of a foreign country, and who had declared intention of becoming citizens of the United States, shall, upon passing the examination, be issued a license valid for six years from the date of such declaration of intention and upon failure of such licensee to furnish evidence of his having actually become a citizen his license shall become invalid and automatically become revoked and his registration shall be annulled Applicants examined and licensed by other state examining boards registered by the regents as maintaining standards not lower than those provided by this article and applicants who matriculated in a New York state medical school before June fifth, eighteen hundred and ninety, and who received the degree of doctor of medicine from a registered medical school before August first, eighteen hundred and ninety-five, may without further examination, on payment of twenty-five dollars to the regents and on submitting such evidence as they may require, receive from them an endorsement of their licenses or diploma conferring all rights and privileges of a regents' license issued after examination The commissioner of education may in his discretion on the approval of the board of regents indorse a license or diploma of a physician from another state, provided the applicant has met all the preliminary and professional qualifications required for earning a license on examination in this state, has been in reputable practice for a period of ten years, and has reached a position of conceded eminence and authority in his profession Any physician, who has actually engaged in the practice of medicine in this state prior to September first, eighteen hundred and ninety-one, and who failed to register, although eligible to do so at the time, or any physician whose registration is not legal because of some error, misunderstanding or unintentional omission, may on the unanimous recommendation of the state board of medical examiners that he has submitted satisfactory proof of having complied with all the requirements prescribed by law at the time of his failure to register, or his incomplete registration, receive from the regents under seal a certificate of the facts which may be registered [by any county clerk and shall make valid his registration] *in accordance with this act* Before any license is issued it shall be numbered

societies, and the New York Post-Graduate Medical School has offered the services of over forty of the teachers

There is a field for courses in other subjects besides those for which the physicians have asked in the questionnaire. Tuberculosis, for example, is by no means a "Popular" subject, and yet it is one yet it is one of the most practical of all the courses which have been suggested. One county society is conducting a course of instruction to classes of physicians who came to the county sanatorium (see this JOURNAL, August, 1925, page 879). This course is an original piece of work, and is a demonstration of what other counties could do.

The subject of psychiatry is also exceedingly important. Dr. Van Etten emphasized it in his presidential addresses before all the District Branches. He showed ever increasing need for more hospitals for the insane, and the failure of the extensive building program of the State to keep pace with the demands for more and more beds. The State has hitherto met the demand by taking care of the mentally sick *after* their disease has become fully developed and chronic. The physicians of the State hospitals have begun to seek a solution of the problem by conducting clinics for the treatment of both incipient and apparently recovered cases, so that the cases will not have to be treated in the hospitals for long months and years.

A still further step is required, that of enlisting the aid of family physicians in advising for the care of "peculiar" children and "nervous" adults before their disease reaches the unsocial stage when hospital treatment is necessary.

Dr. Mortimer Raynor, Superintendent of the Kings Park State Hospital, has outlined a brief course of lectures on psychiatry for general practitioners, and the Suffolk County Medical Society has voted to sponsor a course to be given in the hospital. This course will be observed by the Committee with interest, for it is an attempt to adapt an exceedingly broad subject to the practical limitations of the general practice of medicine.

The Committee believes one of its functions is to promote a knowledge of periodic health examinations. It will, therefore, send a copy of the Manual on Periodic Health Examinations of the American Medical Association to every member of the Medical Society of the State of New York.

It will be issued with a special cover bearing the imprint of the State Medical Society. The copies are supplied by the A. M. A. at cost. The mailing will be done from the office of the State Society by the same means by which the State Journals are addressed, and so every member should receive a copy.

The distribution of the Manual is of great importance to every member of the Society. The Manual is of permanent value, and the Committee is distributing it with the expectation that every member will preserve it for reference.

We have recently heard of a striking example of the value of fundamental teaching, such as that given in the pediatric and obstetrical courses. The Staff of a small hospital in a rural district was discussing a death which was caused by the pernicious vomiting of pregnancy. The old-time treatment of induced abortion was given, and little else was done. The question arose regarding the modern treatment of the toxemias of pregnancy. One physician who had read a typewritten report of the Jefferson County lectures, asked "What is the modern treatment of vomiting of pregnancy?" He went further and investigated the histories of the cases of vomiting of pregnancy in the hospital, and found that practically all had been treated by the method of induced labor.

The discussion was renewed at the next meeting of the Staff, and the physician who had treated the last case presented an outline of the pathology and treatment of vomiting in pregnant women as he had culled it from modern literature. The members of the Staff to whom appendicitis and tubal pregnancies and pancreatic abscesses were familiar, were uncertain about the vomiting of pregnancy, and they voted unanimously to appoint a committee which should outline a method of managing the cases of toxemias of pregnancy which should be considered standard by the hospital. Further, one of the lecturers in the Jefferson County course has been invited to lecture to the physicians on the subject.

This is an example of the inspiring results which may be expected to follow a practical course in obstetrics such as that which the Committee is promoting.

CHARLES A. GORDON,  
*Chairman, Committee on Public Health  
and Medical Education*



mously find that said charges, or any of them are sustained, and shall unanimously recommend that the license of the accused be revoked or his registration be annulled, the regents may thereupon in their discretion, revoke said license or annul said registration, or do both. If the regents shall annul such registration, they shall forthwith transmit to the clerk of the county or counties in which said accused is registered as a physician, a certificate under their seal certifying that such registration has been annulled, and said clerk shall, upon receipt of such certificate, file the same and forthwith mark said registration "annulled." Any person who shall practice medicine after his registration has been marked "annulled," shall be deemed to have practiced medicine without registration. Where the license of any person has been revoked, or his registration has been annulled as herein provided, the regents may, after the expiration of one year, entertain an application for a new license, in like manner as original applications for licenses are entertained, and upon such new application they may in their discretion, exempt the applicant from the necessity of undergoing any examination.]

1 Every physician now lawfully practicing or authorized to practice medicine in this state shall, on or before January first, nineteen hundred and twenty-seven, apply to the treasurer of the commission on discipline for a certificate of registration with the regents upon a form which shall be furnished by said treasurer and every physician who shall hereafter be licensed to practice medicine shall, before engaging in practice, make such application for registration and pay the fee hereinafter specified.

2 A physician registering hereunder shall write or cause to be written on said blank so furnished by said treasurer his full name, office and residence addresses, the date and number of his license and such other facts for the identification of the applicant as a licensed physician as the commission on discipline may deem necessary and shall sign and verify the same before an officer empowered to take acknowledgements of deeds and deliver the same by mail or in person to said treasurer for filing with the regents.

3 The regents, upon receipt of such application, shall issue and send to every duly licensed physician in this state who has made such application, and upon payment of the fee of five dollars to the treasurer of the said commission on discipline, a certificate of registration issued under the seal of the university.

Upon March first, nineteen hundred and twenty-seven, or within ten days thereafter in the year nineteen hundred and twenty-seven, the regents shall publish and cause to be mailed to each such physician so registered and to the county clerk of each county and to the secretary of each duly incorporated state medical society,

a verified list of the duly registered physicians in this state. The names of physicians which after January first, nineteen hundred and twenty-seven shall be added to, as well as those that are withdrawn from said list, shall be reported by the regents quarterly to the secretary of each duly incorporated state medical society of which county medical societies are components and to the county clerk of each county. The list or lists of physicians prepared by the regents shall be so arranged that the name of each physician shall be grouped according to the county of his residence and in each group said names shall be arranged alphabetically.

4 Any licensed physician who having failed or neglected to register by January first, nineteen hundred and twenty-seven, as required by the provisions of this section, shall be required to pay upon registration, in addition to the fee of five dollars, a further fee of one dollar for each thirty days or part thereof, that he is in default, and any licensed physician who engages in practice and wilfully refuses or omits to register hereunder, shall be subject to a civil penalty of one dollar for each day that such wilful refusal or omission shall continue, provided that if the same continues for more than thirty days, the penalty thereafter shall be five dollars per day so long as the said wilful refusal or omission shall continue, provided, however, that such penalties shall not apply to any physician, duly licensed by the State of New York who, by reason of absence and practice in another state, or after a period of retirement from the practice of medicine, resumes practice in this state, if such physician, before re-entering upon such practice shall comply with the provisions herein by applying for a certificate of registration. Said penalty shall be recoverable in an action maintained in the name of the People of the State of New York by the attorney-general.

5 The penalties provided in this section for failure, neglect or omission of a duly licensed physician to register under this article shall be the only penalties that may be imposed therefor, and the legality of his license shall not be affected thereby, and such penalties may, for good cause shown, in the discretion of the attorney-general, upon recommendation of the commission on discipline, be remitted or compromised.

6 Each licensed physician shall conspicuously display his proper registration certificate in his office at all times.

Section 5 Section one hundred and seventy-one of such chapter as amended by chapter fifty-three of the laws of nineteen hundred and fifteen is hereby repealed.

Section 6 Section one hundred and seventy-two of such chapter is hereby renumbered Section one hundred and seventy-one.

Section 7 Section one hundred and seventy-three of such chapter as amended by chapter two hundred and eighty-two of the laws of nineteen hundred and twenty-four is hereby renum-

and recorded in a book kept in the regents' office, and its number shall be noted in the license, and a photograph of the licensee filed with the records. The record shall be open to public inspection, and in all legal proceedings shall have the same weight as evidence that is given to a record of conveyance of land.

Section 4 Section one hundred and seventy of such chapter is hereby amended to read as follows:

§ 170 REGISTRATION [Registry, revocation of license, annulment of registry. Every license to practice medicine shall, before the licensee begins practice thereunder, be registered in a book kept in the clerk's office of the county where such practice is to be carried on, with name, residence, place and date of birth, and source, number and date of his license to practice. Before registering, such licensee shall file, to be kept in a bound volume in the county clerk's office, an affidavit of the above facts, and also that he is the person named in such license, and had, before receiving the same, complied with all the requirements as to attendance, terms and amount of study and examinations required by law and the rules of the university as preliminary to the conferment thereof, that no money was paid for such license, except the regular fees paid by all applicants therefor, that no fraud, misrepresentation or mistake in any material regard was employed by anyone or occurred in order that such license should be conferred. Every license, or if lost, a copy thereof legally certified so as to be admissible as evidence, or a duly attested transcript of the record of its conferment, shall, before registering, be exhibited to the county clerk, who, only in case it was issued or endorsed as a license under seal by the regents, shall endorse or stamp on it the date and his name preceded by the words, "registered as authority to practice medicine in the clerk's office of \_\_\_\_\_ county." The clerk

shall thereupon give to every physician so registered a transcript of the entries in the register with a certificate, under seal that he has filed the prescribed affidavit. The licensee shall pay to the county clerk a total fee of one dollar for registration, affidavit and certificate. The regents shall have power at any and all times to inquire into the identity of any person claiming to be a licensed or registered physician and after due service of notice in writing, require him to make reasonable proof, satisfactory to them, that he is the person licensed to practice medicine under the license by virtue of which he claims the privilege of this article. When the regents find that a person claiming to be a physician, licensed under this article, is not in fact the person to whom the license was issued, they shall reduce their findings to writing and file them in the office of the clerk of the county in which said person resides or practices medicine. Said certificate shall be prima facie evidence that the person mentioned therein is falsely impersonating a

practitioner or a former practitioner of a like or different name. The regents may revoke the license of a practitioner of medicine, or annul his registration, or do both, in any of the following cases:

(a) A practitioner of medicine who is guilty of any fraud or deceit in his practice, or who is guilty of a crime or misdemeanor, or who is guilty of any fraud or deceit by which he was admitted to practice, or

(b) Is an habitual drunkard or habitually addicted to the use of morphine, opium, cocaine, or other drugs having a similar effect, or

(c) Who undertakes or engages in any manner or by any ways or means whatsoever, to procure or perform any criminal abortion as the same is defined by section eighty of the penal law, or

(d) Who offers or undertakes by any manner or means to violate any of the provisions of section eleven hundred and forty-two of the penal law.

Proceedings for revocation of a license or the annulment of registration shall be begun by filing a written charge or charges against the accused. These charges may be preferred by any person or corporation, or the regents may on their own motion direct the executive officers of the board of regents to prefer said charges. Said charges shall be filed with the executive officer of the board of regents, and a copy thereof filed with the secretary of the board of medical examiners. The board of medical examiners, when charges are preferred, shall designate three of their number as a committee to hear and determine said charges. A time and place for the hearing of said charges shall be fixed by said committee as soon as convenient, and a copy of the charges, together with a notice of the time and place when they will be heard and determined, shall be served upon the accused or his counsel, at least ten days before the date actually fixed for said hearing. When personal service or service upon counsel cannot be effected, and such fact is certified on oath by any person duly authorized to make legal service, the regents shall cause to be published for at least seven times, for at least twenty days prior to the hearing, in two daily papers in the county in which the physician was last known to practice, a notice to the effect that at a definite time and place a hearing will be had for the purpose of hearing charges against the physician upon an application to revoke his license. At said hearing the accused shall have the right to cross-examine the witnesses against him and to produce witnesses in his defense, and to appear personally or by counsel. The said committee shall make a written report of its findings and recommendations, to be signed by all its members, and the same shall be forthwith transmitted to the executive officer of the board of regents. If the said committee shall unanim-

hygiene, chemistry, obstetrics, diagnosis and the theory and practice of osteopathy, with actual attendance of not less than twenty months, which facts shall be shown by his or her diploma and affidavit, shall upon application and payment of ten dollars be granted, without examination, a license to practice osteopathy, provided application for such license be made within six months after the thirteenth day of May, nineteen hundred and seven. A license to practice osteopathy shall not permit the holder thereof to administer drugs or perform surgery with the use of instruments. Licenses to practice osteopathy shall be registered in accordance with the provisions of this article, and the word osteopath shall be included in such registration, and such license shall entitle the holder thereof to the use of the degree D O, or doctor of osteopathy.

*Section 8 Section one hundred and seventy-four of such chapter is hereby renumbered section one hundred and seventy-three and amended to read as follows*

**§ 174 PENALTIES AND THEIR COLLECTION** Any person who, not being then lawfully authorized to practice medicine within this state and so registered according to law, shall practice medicine within this state without lawful registration or in violation of any provision of this article, and any person who shall buy, sell or fraudulently obtain any medical diploma, license, record or registration, or who shall aid or abet such buying, selling or fraudulently obtaining, or who shall practice medicine under cover of any medical diploma, license, record or registration illegally obtained, or signed, or issued unlawfully or under fraudulent representations or mistake of fact in a material regard, or, who, after conviction of a felony, shall attempt to practice medicine, or shall so practice, and any person who shall in connection with his name use any designation tending to imply or designate him as a practitioner of medicine within the meaning of this article without having registered in accordance therewith, or any person who shall practice medicine or advertise to practice medicine under a name other than his own, or any person not a registered physician who shall advertise to practice medicine, shall be guilty of a misdemeanor. Any person who shall practice medicine under a false or assumed name, or who shall falsely personate another practitioner or former practitioner of a like or different name, shall be guilty of a felony. When any prosecution under this article, or under sections eleven hundred and forty-two, eighty, eighty-one, eighty-two, seventeen hundred and forty-seven of the penal law, and any amendments thereto, is made on the complaint of any incorporated medical society of the state, or any county medical society entitled to representation in a state society, any fine collected shall be paid to the society making the complaint, and any excess of

the amount of fines so paid over the expense incurred by the said society in enforcing the medical laws of this state, shall be paid at the end of the year to the county treasurer.]

### § 173 PENALTIES

1 Any person who shall,

(a) Sell or fraudulently obtain or furnish any medical or osteopathic diploma, license, record or registration, or aid or abet in the same, or

(b) Practice medicine under cover of any diploma, license, record or registration illegally or fraudulently obtained or signed or issued unlawfully or under fraudulent representation or mistake of fact in a material regard, or

(c) Advertise to practice medicine under a name other than his own or under a false or assumed name, and

2 Any person who not being then lawfully licensed and authorized to practice medicine within this state shall

(a) Practice or advertise to practice medicine, or

(b) Use in connection with his name any designation tending to imply or designate him as a practitioner of medicine, or

(c) Use the title "doctor" or any abbreviation thereof in connection with his name or with any trade name in the conduct of any occupation or profession involving or pertaining to the public health, or treatment or cure of any human disease, pain, deformity, or physical condition, unless duly authorized by law to use the same, and

3 Any person who during the time his license to practice medicine shall be suspended or revoked, shall practice medicine, shall be guilty of a misdemeanor

Such misdemeanor shall be punishable by imprisonment for not more than one year or by a fine of not more than five hundred dollars or by both such fine and imprisonment for each separate violation, and for a second offense shall be punishable by such fine and imprisonment

4 All courts of special sessions within their respective territorial jurisdictions are hereby empowered to hear, try and determine such crimes without indictment and to impose in full the punishments of fines and imprisonments herein prescribed

Such misdemeanors shall be prosecuted by the attorney-general in the name of the people of the state, provided, however, that nothing in this section shall be interpreted to prevent or impede the prosecution of such proceedings by the district attorney or any county having a population of five hundred thousand or more, when such proceedings shall have been initiated by him

5 The display of a sign or an advertisement bearing a person's name as a practitioner of medicine in any manner or by implication or containing any other matter forbidden by law

*bered section one hundred and seventy-two and amended to read as follows*

§ 173 CONSTRUCTION OF THIS ARTICLE This article shall not be construed to affect commissioned medical officers serving in the United States army, navy or marine hospital service, while so commissioned, or any one while actually serving without salary or professional fees on the resident medical staff of any legally incorporated hospital, or anyone while actually serving as an interne in a state hospital or other state institution in which medical service is provided, or any legally registered dentist exclusively engaged in practicing dentistry, or any person or manufacturer who mechanically fits or sells lenses, artificial eyes, limbs or other apparatus or appliances, or is engaged in the mechanical examination of eyes, for the purpose of constructing or adjusting spectacles, eye glasses and lenses, or any lawfully qualified physician in other states or countries meeting legally registered physicians in this state in consultation, or any physician residing on a border of a neighboring state and duly licensed under the laws thereof to practice medicine therein, whose practice extends into this state, and who does not open an office or appoint a place to meet patients or receive calls within this state, or any physician duly registered in one county called to attend isolated cases in another county, but not residing or habitually practicing therein, or the furnishing of medical assistance in case of emergency, or the domestic administration of family remedies, or the practice of chiropody, or the practice of the religious tenets of any church. This article shall be construed to repeal all acts or parts of acts authorizing conferment of any degree in medicine *causa honoris* or *ad eundem* or otherwise than on students duly graduated after satisfactory completion of a preliminary medical course not less than that required by this article as a condition of license. It is further provided that any person who shall be actively engaged in the practice of osteopathy in the state of New York on the thirteenth day of May, nineteen hundred and seven, and who shall present to the board of regents satisfactory evidence that he is a graduate in good standing of a regularly conducted school or college of osteopathy within the United States which at the time of his or her graduation required a course of study of two years or longer, including the subjects of anatomy, physiology, pathology, hygiene, chemistry, obstetrics, diagnosis and the theory and practice of osteopathy, with actual attendance of not less than twenty months, which facts shall be shown by his or her diploma and affidavit, shall upon application and payment of ten dollars be granted, without examination, a license to practice osteopathy, provided application for such license be made within six months after the thirteenth day of May, nineteen hundred and seven. A license to practice osteopathy shall not permit the holder thereof to administer

drugs or perform surgery with the use of instruments. Licenses to practice osteopathy shall be registered in accordance with the provisions of this article, and the word osteopath be included in such registration, and such license shall entitle the holder thereof to the use of the degree D O, or doctor of osteopathy.]

#### § 172 CONSTRUCTION OF THIS ARTICLE

1 This article shall not be construed so as to prevent the following (1) The practice of medicine in this state in obedience with the requirements of the laws of the United States, of any commissioned medical officer serving in the United States army, navy or public health service while engaged in the performance of the actual duties prescribed for him under the United States statutes, or (2) the practice of medicine in a duly incorporated hospital operating pursuant to the state charities law, or in a state hospital or other state institution in which medical service is provided, of a duly appointed member of the resident medical staff or of an interne, or (3) the practice of medicine by any physician duly licensed to practice medicine in a bordering state, who resides on a border of such neighboring state, whose practice extends into this state and who does not open an office or appoint a place to meet patients or receive calls within this state, or (4) any lawfully qualified physician in other states or countries meeting legally registered physicians in this state in consultation, or (5) the furnishing of medical assistance in case of emergency, or (6) the domestic administration of family remedies, or (7) the practice of chiropody, dentistry or veterinary medicine, providing those practicing are legally authorized and licensed under the laws of this state so to do, or (8) the practice of the religious tenets of any church, or (9) the fitting or selling of lenses, artificial eyes, limbs or other apparatus or appliances by any person or manufacturer of the same or the engaging in the mechanical examination of eyes for the purpose of constructing or adjusting spectacles, eyeglasses and lenses

11 This article shall be construed to repeal all acts or parts of acts authorizing conferment of any degree in medicine *causa honoris* or *ad eundem* or otherwise than on students duly graduated after satisfactory completion of a preliminary medical course not less than that required by this article as a condition of license. It is further provided that any person who shall be actively engaged in the practice of osteopathy in the State of New York on the thirteenth day of May, nineteen hundred and seven, and who shall present to the board of regents satisfactory evidence that he is a graduate in good standing of a regularly conducted school or college of osteopathy within the United States which at the time of his or her graduation required a course of study of two years or longer, including the subjects of anatomy, physiology, pathology,

1 The term of office of each of said members of said commission shall be five years, except that upon the taking effect of this act two members shall be appointed whose terms shall expire December thirty-first, nineteen hundred and twenty-seven, two members whose terms shall expire December thirty-first nineteen hundred and twenty-eight; two members whose terms shall expire December thirty-first, nineteen hundred and twenty-nine, two members whose terms shall expire December thirty-first, nineteen hundred and thirty, and two members whose terms shall expire December thirty-first, nineteen hundred and thirty-one, and as such terms expire they shall be filled by the addition to said commission of two members whose terms shall be five years. In the case of vacancy at any time by resignation, death or otherwise in the membership of the commission, the said vacancy shall be filled for the unexpired term in the same manner as provided for the original selection of such member.

2 Any duly incorporated state medical or osteopathic society having five hundred or more members may nominate candidates for members of such commission, not to exceed three nominations for each member of such commission to which such society shall be entitled hereunder. When the candidates are so nominated the chief judge of the court of appeals shall appoint for the terms specified herein as he shall determine, said members of the said commission, so that said commission shall consist of five members who have been duly nominated by the medical society of the state of New York, one member by the New York State homeopathic society, one member by the New York State osteopathic society, and upon his own nomination shall appoint three members of conspicuous professional standing. Each member of the said commission shall be a duly licensed physician of this state.

3 Said commission shall serve without compensation and shall annually, within ten days after the first day of January of each year, organize by the election of a chairman, secretary and treasurer.

4 Said commission shall have jurisdiction to hear and determine all charges against duly licensed physicians of this state for violation of the provisions of section one hundred and seventy-four hereof, and shall, upon the finding of such practitioner guilty, have jurisdiction to revoke and annul his license, annul his registration, suspend him from practice, or reprimand or otherwise discipline him. Proceedings against any practitioner under this section shall be begun by filing a written charge or charges against the accused. These charges may be preferred by any person, corporation or public officer, and they shall be filed with the secretary of the commission on discipline. The chairman of the said commission, when charges are preferred, unless he dismisses them as unsubstantial, may

designate one or more of the members of said commission to hear and report upon said charges to the said commission, or upon his motion may order the hearing of said charges to be held before an official referee who shall have power to hear and report thereon to said commission. The time and place of the hearing of such charges shall be fixed by the secretary of the commission as soon as convenient and a copy of the charges, together with a notice of the time and place when they will be heard shall be served upon the accused or his counsel at least ten days before the date actually fixed for said hearing. Where personal service or service upon counsel after due diligence cannot be effected and such fact is certified on oath by any person duly authorized to make legal service, the secretary of the said commission on discipline shall cause to be published for four times at least thirty days prior to the hearing, a notice of the hearing in a newspaper published in the county in which the physician was last known to practice, and a copy of such notice shall also be mailed to the accused at his last known address. All such notices of hearing of charges shall contain a plain and concise statement of the material facts without unnecessary repetition, but not the evidence by which the charges are to be proved, with a notification that a stenographic record of such proceedings will be kept if he demand it, and that the accused will have opportunity to appear either personally or by counsel at the hearing, with the right to produce witnesses and evidence upon his own behalf, to cross-examine such witnesses, to examine such evidence as may be produced against him and to have subpoenas issued by the said commission. Said committee or official to whom said charges were preferred shall make a written report of its findings and recommendations and same shall be forthwith transmitted to the secretary of the commission on discipline with a fair resume of the evidence. Said commission may thereupon act upon said recommendations as it shall deem fit, or may take further testimony if the same seem desirable in the interest of justice. Thereupon the said commission shall order, by a majority vote (the vote of each member of said commission to be recorded as part of the order) such degree of discipline as in their judgment the facts justify, or the dismissal of the charges, and/or the exoneration of the accused.

5 Any licensed practitioner found guilty under the provisions of this section, or whose license is otherwise revoked or suspended or registration annulled, or who has been refused registration, or who is otherwise reprimanded or disciplined by the commission on discipline under this article, may have an order of certiorari for the purpose of reviewing such determination returnable before the appellate division of the judicial department where the accused resides, but

shall be presumptive evidence in any prosecution or hearing that the person whose name is so borne is responsible for the display of such sign or advertisement and of a holding out and of the practice of medicine by such person for each separate day such sign or advertisement is anywhere displayed by anyone, but such presumptions are rebuttable by the defense. It shall be necessary to prove in any prosecution or hearing under this article only a single act prohibited by law or a single holding out or an attempt, without proving a general course of conduct, in order to constitute a violation.

6 In any action for damages for personal injuries or death against a person not licensed hereunder for any act or acts constituting the practice of medicine as herem defined, when such act or acts were a competent producing proximate or contributing cause of such injuries or death, the fact that such person practiced medicine as herem defined without being duly licensed shall be deemed *prima facie* evidence of negligence.

7 All violations of this act, when reported to the attorney-general and duly substantiated by affidavits or other satisfactory evidence, shall be investigated and if the report is found to be true and the complaint substantiated, the attorney-general shall prosecute such violation. The attorney-general shall appoint such inspectors as are necessary, to be paid from the funds received hereunder, to investigate promptly and thoroughly such violations and to procure where possible legal evidence of the same for prosecution of the offenders.

In the prosecution of any criminal action for violation of this article by the attorney-general or his deputy, said attorney-general or his deputy shall exercise all the powers and perform all the duties with respect to such actions or proceedings which the district attorney would otherwise be authorized or required to exercise or perform, and in such actions or proceedings the district attorney shall only exercise such powers and perform such duties as are required of him by the attorney-general or the deputy attorney-general so attending.

Section 9 Article eight of such chapter is hereby amended by adding thereto a new section to be known as section one hundred and seventy-four to read as follows:

#### §174 REVOCATION OF CERTIFICATES, ANNULMENT OF REGISTRATIONS AND DISCIPLINE

1 Whenever any practitioner of medicine shall be convicted of a felony, involving moral turpitude there shall be presented to the regents a certified or exemplified copy of the judgment of the court and/or the order of the commission on discipline wherein such conviction of felony was adjudged, and thereupon the registration of the person so convicted shall be annulled and his license revoked. And it shall be the duty of the

clerk of the court wherein such conviction takes place to transmit a certificate of such conviction to the regents. Upon reversal of such judgment by a court having jurisdiction, the regents, upon receipt of a certified copy of such judgment or order of reversal, shall vacate their order of revocation or annulment.

2 The license of a practitioner of medicine may be revoked, suspended or annulled or such practitioner reprimanded or disciplined in accordance with the provisions and procedure of this act in any of the following cases:

Upon finding after due hearing:

(a) That the physician is guilty of fraud or deceit in the practice of medicine or in his admission to the practice of medicine,

(b) That a physician has been convicted in a court of competent jurisdiction, either within or without this state, of a crime involving moral turpitude, or

(c) That a physician is an habitual drunkard, or addicted to the use of morphine, cocaine or other drugs having a similar effect, or has become insane, or

(d) That a physician is guilty of untrue, fraudulent, misleading or deceptive advertising, or advertising that he can cure diseases which are recognized by the medical profession as incurable, or advertising that he can cure or treat disease by a secret method, procedure, treatment or medicine, or that he can treat, operate and prescribe for any human condition by a method, means or procedure which he refuses to divulge upon demand to the commission on discipline, or

(e) That a physician did undertake or engage in any manner or by any ways or means whatsoever to procure or to perform any criminal abortion and/or to violate section eleven hundred and forty-two of the penal law.

(f) That a physician is guilty of the commission of any act which unfavorably affects the character, dignity, or interests of the medical profession and/or degrades its standard of honor or materially violates those principles of professional conduct that are ordinarily recognized by physicians and surgeons of the state as consistent with honorable practice among the average members of the medical profession in good standing.

Section 10 Article eight of such chapter is hereby amended by adding thereto a new section to be known as section one hundred and seventy-five:

§175 PROCEDURE IN DISCIPLINARY PROCEEDINGS Within sixty days after this act shall take effect there shall be appointed in accordance with the provisions hereof a commission which shall be known as the commission on discipline, which shall consist of ten members who shall be appointed by the chief judge of the court of appeals of this state in accordance with the provisions hereof.



# NEWS



## MEETING OF THE COUNCIL

A special meeting of the Council of the Medical Society of the State of New York was held at the rooms of the State Society, 17 West 43rd Street, New York City, on Thursday evening, October 29th, 1925

Dr Nathan B Van Etten, President, in the Chair

A quorum being present the meeting was called to order at 8 50 P M, and on roll call the following answered to their names

Drs Nathan B Van Etten, William H Ross, Frederick H Flaherty, E Eliot Harris, George M Fisher, Daniel S Dougherty, Charles Gordon Heyd, Owen E Jones, Edward R Cunneiffe, Henry L K Shaw, Charles A. Gordon, Andrew MacFarlane, William Warren Britt, John A Card, Joseph S Thomas, Horace M Hicks, Harry R Trick

Dr J E Jennings, Chairman Special Committee to Draft a Medical Practice Act, Mr George W Whiteside, Counsel, and Dr Joseph S Lawrence, Executive Officer, were also present

The following recommendations were on motion duly made and seconded, adopted

That a bill be prepared by Mr Whiteside and introduced into the Legislature to license nurses' registries, and promulgate rules and regulations by which a nurse when sent out on a case will carry with her a card containing information as to her qualifications, status, salary, etc

That the Council authorize the President to appoint a committee of three to discuss and study industrial problems of the State and confer with the State Industrial Commission

The President appointed Dr W Warren Britt of Tonawanda, Chairman, Dr Horace M Hicks of Amsterdam, and Dr Ransom S Hooker of New York City

That the request of the Chairman of the Committee on Scientific Work, for a special appropriation for a demonstration on Syphilis, to be held on Thursday of the Annual Meeting, be referred to the Executive Committee

That Drs John E Jennings, William P Healy, Edward W Weber, L Howard Moss, Samuel J Kopetzky, Isidore H Goldberger, Edward C Podvin and Henry Roth be elected members of the Committee on Arrangements

### PRACTICE OF MEDICINE ACT

Dr Jennings, Chairman of the Special Committee appointed to Draft a Medical Practice Act, presented the following report

Your committee appointed by the President, to

prepare a Medical Practice Act, reports as follows

The Committee consisting of Drs Jennings (chairman), Chalmers, Stanwix, Leitner, Fisher, Sadler and Winslow was appointed, and a meeting was held at the Academy of Medicine on June 25th, 1925, at which the President, Dr Van Etten Drs Jennings, Fisher, Chalmers, Stanwix and Sadler were present Plans were discussed, a general program adopted and the meeting adjourned

Seven subsequent meetings were held at the Columbia University Club on the following dates July 9th, July 23d, August 6th, August 27th, September 1st, September 22nd and October 22nd At all of these meetings, with the exception of the first preliminary meeting, legal counsel was present, Mr Oliver of Mr Whiteside's office for the second, third, fourth and seventh meetings, Mr Whiteside for the fifth, sixth and eighth meetings

Dr Winslow failing to report, Dr Flaherty was appointed in his stead and took his seat at the meeting on August 27th

Your Committee began its work by a consideration of the present Medical Practice Act and its bearing upon the conditions it is evidently intended to control

It may be said that public menace from those "holding themselves out as being able to diagnose, treat operate or prescribe for any human disease, pain, injury, deformity or physical condition" in the words of the law, arises from two sources

The first—those who operate without a license, who have not qualified according to law, the illegal practitioners

The second—those who having complied with the requirements of the law for admission to practice, abuse the confidence of the public, the profession and of the State

It is believed that the second group is responsible for as much or more actual evil as the first

The illegal practitioner of medicine should be detected and brought to justice like any other offender, by the department of justice

It seems no part of the proper duty of the Department of Education or of medical societies to enforce the law Hence the proposed act to amend the Medical Practice Act relieves the Department of Education of this burden by providing for one enrollment of all licensed physicians to



no such determination of the commission on discipline shall be stayed or enjoined except upon application to such appellate division, after notice to the secretary of the commission on discipline. The commission on discipline and/or any member thereof may issue subpoenas and administer oaths pursuant to section sixty-one of the public officers' law in connection with any hearing or investigation under this article and it shall be the duty of such commission to issue subpoenas at the request of and upon behalf of the defense. Said commission on discipline shall not be bound by the laws of evidence in the conduct of its proceedings, but the determination shall be founded upon sufficient legal evidence to sustain the same. The attorney-general shall designate a deputy attorney-general to attend on and advise said commission whenever such service is asked by said commission. For each day that such deputy attorney-general shall be so engaged in behalf of said commission, he shall be paid by said commission a per diem fee of not less than ten dollars. All fees, fines and penalties and forfeitures of bail and other monies that accrue in the prosecution of unlicensed practitioners hereunder and/or paid for registration fees hereunder, shall be paid to the treasurer of the said commission on discipline and from the proceeds thereof the said commission shall defray, as far as the same is sufficient, the expenses of the said commission, the expenses of the regents in printing and distributing the lists of physicians as required by this article, and the expenses of the attorney-general in the prosecution of unlicensed practitioners, and the legislature shall appropriate any unexpended balances returned to the state treasurer by the department of education which were paid to the department of education under this article, to the treasurer of said commission for the expenses of said commission. Said commission, through its said treasurer, shall report any unexpended balance of such monies so paid to the commission remaining in his hands on June thirtieth of each year to the state treasurer, and on and after December thirty-first, nineteen hundred and twenty-eight, and said day each year thereafter, shall return such unexpended balance existing at such time to the state treasurer.

6 Any controversy between two or more physicians; or between a physician or physicians and another person, which said parties to such controversy agree to submit to arbitration, may be submitted in writing to said commission on discipline, who may in their discretion act as arbitrators in said controversy, and the decision of said commission upon such arbitration shall be final, and where the same orders the payment of a sum of money same may be docketed as a judgment of a court of record and enforced as such judgment, provided the terms of the arbitration include such provision.

7 The treasurer of said commission shall furnish a bond approved by the chairman of the

commission in such reasonable sum as the chairman shall fix for the faithful performance of his duties.

8 The commission shall have power to employ such clerical and stenographic help as may be necessary to transact its business and to fix the salaries of such employees and shall have power also to fix a salary for its treasurer.

9 The chief judge of the court of appeals may remove any member of said commission from office who shall have been found guilty, after due hearing, of malfeasance in office or neglect of duty.

10 No member of the commission shall participate in any way in the determination of any charges in which he may be either a witness as to facts or an accused, nor in any case where the parties, complainant or accused, are related to him by consanguinity or affinity within the sixth degree. The degree shall be ascertained by ascending from the commissioner to the common ancestor and descending to the party, counting a degree for each person in both lines, including the member of the commission and the party and excluding the common ancestor.

11 Should, for any reason, three or more members of the commission be disqualified from participating in the decision of any case, or be for other reason unable to participate therein, their places may be temporarily filled for the purpose of determining the case to be heard by the remaining members of the commission nominating twice the number of candidates for such vacancy from whom there shall be selected, after notice to the respective parties, the necessary number of members to constitute a quorum. A quorum of said commission shall consist of six members.

12 Said commission shall have power to make such rules and regulations for the conduct of its business as it shall deem necessary, provided such rules and regulations do not conflict with any of the provisions of this article.

13 The proceedings of said commission shall, before the filing of its final judgment or decision, be secret.

14 The said commission shall have power, where a proceeding has been dismissed, either on the merits or otherwise, to relieve the accused from any possible odium that may attach by reason of the making of charges against him, by such public exoneration as it shall see fit to make if requested by the accused so to do.

Section 11 That if any clause, sentence, paragraph or part of this act shall for any reason be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder of said act, but shall be confined in its operation to the clause, sentence, paragraph or part thereof directly involved in the controversy in which such judgment shall have been rendered.

Section 12 This act shall take effect imme-



## SUFFOLK COUNTY MEDICAL SOCIETY

The one hundred and nineteenth annual meeting of the Suffolk County Medical Society was held on Thursday, October 29th, in Riverhead. The President, Dr. George H. Schenck, presided, and 33 members and 6 visitors were present.

Dr. Schenck read the annual presidential address in which he reviewed the activities of the Society during the past year. He mentioned the original work of the special committee on hospital management, as being of great practical value to the four general hospitals of the county. He described the courses in pediatrics which have been conducted as a part of the State Medical Society. He also made a plea for the adoption of the practice of Periodic Health Examinations and stated that he himself knew of five hundred dollars worth of corrective work that had come to himself and another doctor as the result of examinations made by the Life Extension Institute.

Dr. W. H. Ross, Chairman of the Legislative Committee of the County Society and First Vice-President of the State Medical Society, described the general features of the new Practice of Medicine bill. On motion the meeting voted unanimously to approve the bill.

Dr. Guy H. Turrell reported about the Monthly News Letter of the Society, and said that its cost is approximately \$300 annually, which is nearly three dollars per member. He outlined plans for reporting the meetings of the staffs of the four general hospitals of the County and of the four regional medical societies which center about the four hospitals. The News Letter has become so useful to the members that no one questioned the wisdom of continuing its publication.

Dr. Turrell also made a report as Chairman of the Committee on Public Health, and said that the Committee had consulted Dr. Mortimer Raynor, Superintendent of the Kings Park State Hospital, about instituting a course of psychiatric lectures for general practitioners. He said that the care of the insane was the principal item of expense of the State Government, and that the staffs of some of the State hospitals were conducting mental hygiene clinics for the care of incipient cases and those on parole, with the view of preventing the development or recurrence of the disease. He said that a further step that was needed was that physicians in general practice should be taught the fundamentals of psychiatry, for nearly all insane cases consult their doctors for insomnia, nervousness, and other mild manifestations of mental abnormalities.

Dr. Raynor presented an outline of a course of nine lectures and offered to give the courses in the Kings Park Hospital to physicians in the vicinity. On motion the plan of the proposed course was approved, and the Committee on

Public Health was authorized to make arrangements for giving the courses. Dr. Turrell later reported that six doctors present at the meeting said they would attend the course.

Dr. Turrell further reported that a few articles of a public health nature had been prepared and sent to the local newspapers through the cooperation of the County Tuberculosis Committee. Accounts of the meetings of the County Society had been published in this way.

Dr. E. P. Kolb, Superintendent of the Suffolk County Tuberculosis Sanatorium, described the course in tuberculosis which he was conducting at the Sanatorium, and said that one class of six had completed the course and another class had started.

The death of Dr. M. B. Heyman, Superintendent of the Wards Island State Hospital and president of this Society in 1909, was announced, and the Secretary was instructed to write Mrs. Heyman an informal letter of remembrance.

A Committee consisting of Drs. Terrell, Hulse and Loper was appointed to make arrangements for a dinner to commemorate the fiftieth anniversary of the graduation in medicine of Dr. E. S. Moore, of Bay Shore, and Dr. C. C. Miles of Greenport.

The following officers were elected for the year 1926:

President, J. S. Ames, Babylon  
Vice-President, Frank Overton, Patchogue  
Secretary, E. P. Kolb, Holtsville  
Assistant Secretary, W. A. Hulse, Bay Shore.  
Treasurer, David Hallock, Southampton  
Censors, John H. Nugent, A. G. Terrell, David Edwards

Delegates to the State Medical Society, Frank Overton and W. H. Ross

Alternates, David Edwards and George H. Schenck.

The members dined together in the Griffin House, and then reconvened for the scientific session. The guest and principal speaker was Dr. William St. Lawrence, 950 Park Avenue, New York, who spoke on the Administration of Diphtheria Toxin-antitoxin, and of the new serum for the prevention and cure of scarlet fever. Dr. St. Lawrence is a clear and forceful speaker, and is available for pediatric talks and clinics elsewhere.

Dr. Frank Overton gave a brief demonstration of "Wiggly" ankles among school children, and the exercises to stiffen the joints and prevent flat feet. The object of the demonstration was to show how easily the condition could be detected and how the physical trainers in the public schools could give effective exercises to correct the condition.

- complete the rolls and for a mechanism for keeping them thereafter complete

It is provided that a certificate of endorsement of license shall then be issued to each registrant and that the possession of such certificate shall be recognized as prima facie evidence of licensure, and a failure to produce it on proper demand penalized

The Attorney General of the State is instructed to assume the enforcement of the Act but it is provided that he shall not interfere in processes already initiated by District Attorneys in counties of over 500,000 population

The practice without a license is declared prima facie evidence of negligence in civil suits arising from damage sustained as a result of such practice

Misconduct of these admitted to practice—the Profession of Medicine has from time immemorial exacted adherence to a high code of ethics which it is able to maintain among honorable members of the profession. It lacks the mechanism to reach and discipline the men who are beyond the code of honor

The Board of Regents is now given power to revoke or suspend license to practice, but other measures seem desirable, indeed necessary

A body analogous to the Grievance Committee

of the Bar Association is needed if this important work is to be done

This Act provided for such a commission of discipline of the physicians to be nominated by the medical societies of the State, to be appointed by the Chief Justice of the Court of Appeals and to function under a method described without pa

"This commission shall have jurisdiction to hear and determine all charges against duly licensed physicians of this state for violation of the provisions of section one hundred and seventy-four hereof, and shall, upon the finding of such practitioner guilty, have jurisdiction to revoke and annul his license, annul his registration, suspend him from practice or reprimand or otherwise discipline him"

The details of the provisions for the establishment of this body are contained in the Proposed Amendment to the Medical Practice Act which is herewith submitted

On motion duly seconded and carried, the Council approved the work of the Committee and extended the Committee its sincere thanks for the work that it had done

There being no further business, the meeting adjourned at 11 P M

DANIEL S DOUGHERTY,  
Secretary

## BRONX COUNTY MEDICAL SOCIETY

A regular meeting of the Bronx County Medical Society was held at Hollywood Gardens, 896 Prospect Avenue, on October 21, 1925. The President, Dr Jacobs, called the meeting to order at 9 P M

Election of candidates being in order, it was moved and carried that the Secretary be instructed to cast one ballot for the following applicants for membership

Nathaniel Jay Gould, Saul Schlossman

Reports of Committees being called for, Dr Eichler, for the Committee on Revision of the By-Laws, reported that the Committee had completed its work and suggested that a special meeting be called to consider and adopt the By-Laws

Dr Friedman, for the Committee on Public Health, reported with special reference to the proposed Periodic Health Examinations

Dr Podvin, for the Bulletin Committee, urged more general cooperation on the part of the members, and requested suggestions or articles for publication in *The Bulletin*

Dr Lukin, Chairman of the Committee on Medical Economics, introduced the following Resolutions

"In view of the fact that the report of the Cornell Clinic for the years 1921-1924 contains unfair references to the medical profession, contains exaggerated self-laudation, and through its review by the lay newspapers serves only

as an advertising medium for that Clinic, and

"Whereas the individual medical man is deprived of the use of advertising through State and National codes of ethics,

"BE IT THEREFORE RESOLVED, That the Bronx County Medical Society declare said report unfair and unethical and that the analysis of the report in question as it appeared in our October *Bulletin*, together with a copy of these Resolutions, be transmitted to the proper authorities for action"

These Resolutions were referred to the Committee on Minors.

Under New Business, the President appealed to the membership for suggestions in regard to the meeting room and the proposed new building; and also suggested that *The Bulletin* be used as a medium for expressing the opinions of the members

Scientific Program—Diagnosis and Treatment of Diseases of the Gall Bladder, David Riesman

Discussion by Philip Eichler, Alexander Goldman, Henry Roth, William Weinberger, Milton R Bookman, Seymour Basch, L M Kahn and J Lewis Amster. Dr Riesman closed the discussion

It was moved that a vote of thanks be extended to Dr Riesman. This motion was unanimously carried, and the President expressed the appreciation of the Society to Dr Riesman

## MEDICAL SOCIETY OF THE COUNTY OF SARATOGA

The annual meeting of the Medical Society of the County of Saratoga was held October 30, 1925, at the Haynes House, Ballston, Spa

Following a luncheon the following scientific program was presented

Dr T Frederick Doescher of Albany, on "Gastric and Duodenal Ulcer, The Medical Treatment" Frederick T Drescher, M D, Albany

"The Surgical Treatment of Gastric and Duodenal Ulcer" E. MacD Stanton, M D, Schenectady

The application of Dr James F Roohan, having been approved by the Board of Censors, motion made that the Secretary be instructed to cast one ballot This was done and Dr Roohan was declared elected

A memoriam to Dr Amos Walter Thompson was next read by Dr Carl Comstock

Motion made and seconded that a copy be sent to Mrs Thompson and a copy be spread on the minutes of the meeting Carried

The Report of the Committee on Post-Graduate Instruction was next presented

Motion made and seconded that it be accepted. Carried

Motion made and seconded that the matter of medical advertisement be left on the table until the next meeting The Secretary was instructed

to write the American Medical Association concerning E F Trieffinger

Motion made and seconded that the President appoint a Nominating Committee Carried

The President appointed Drs Frank J Sherman, Carl R Comstock and William Van Doren

The Nominating Committee presented the following nominations for officers for the ensuing year

President, Dr Earl H King, Saratoga Springs

Vice-President, Dr Arthur W Johnson, Mechanicville

Secretary, Dr Ralph Baker Post, Ballston Spa

Treasurer, Dr John B Ledlie, Saratoga Springs

Censors Drs Merrit E Van Aernem, Saratoga Springs, Walter C Crombie, Mechanicville, George H Fish, Saratoga Springs

Motion made and seconded that the Secretary be instructed to cast one ballot.

This was done and the officers were declared elected

Motion made and seconded that the present By-Law in regard to annual dues be changed to read five dollars per year instead of two dollars Carried

---

## ANNUAL INDUSTRIAL SAFETY CONGRESS

The Ninth Annual Industrial Safety Congress and Exhibit of the New York State Department of Labor will be held in Syracuse, with the headquarters at the Hotel Onondaga on November 30, December 1st, 2nd and 3rd

The safety in industry problem in the State of New York is an important one as judged by the fact that the number of reported industrial accidents for the year ended June 30th, 1925, broke all records, being more than three hundred and seventy-four thousand, not to mention the suffering and general economic loss which this entailed The loss to the people in the State in dollars alone amounted to about seventy millions

To meet this problem, men prominent in all of the branches of industry and also in the professions connected with industry will be present Addresses and carefully prepared scientific papers dealing with industrial safety in its various phases

will comprise the greater part of the program, but no less important will be the participation of the medical profession in the meeting this year

In the first place, the New York State Society of Industrial Medicine will hold its annual meeting in conjunction with the congress, and will assist in every way to make the congress successful This meeting will take place on December 2nd, at 9 30 A M, in the Hiawatha Room of the Onondaga Hotel In the evening of December 2, at the same place at 8 P M, a special session will be held dealing with the surgery of industry

On December 3rd, at 9 30 A M, the morning will be devoted to rehabilitation, and on the afternoon of December 3rd, at 2 P M, the medical session will be devoted to the reading of papers on industrial hygiene The Medical Society of the State of New York is prominently represented on the program

## MEDICAL SOCIETY OF THE COUNTY OF WASHINGTON

The annual meeting of the Medical Society of the County of Washington was held at Hudson Falls, October 6, 1925

The President, Dr Byrnes, called the meeting to order at 11 A M

Members present Byrnes, Prescott, Banker, Paris, Park, Pashley, Cuthbert, Hulsebosch, Oatman, Huntington, Blackfan, Leonard, Munson, Rogers, Stillman, Fortune, Casey, Heath, Tillotson, Holmes

Visitors Henry L K Shaw, M D, of Albany, E DuB Elliott, M D, of Glens Falls

The minutes of the last meeting were read and approved

The President appointed Drs Pashley, Park and Munson as a nominating committee, and the following officers were nominated and elected

President, M A Rogers, M D, Vice-President, Charles A Prescott, M D, Secretary, Silas J Banker, M D, Treasurer, Russel C Paris, M D Censors Byron C Tillotson, Chairman, Edward W Joslin, Stanley T Fortune Committee on Legislation Walter A Leonard, George M Stillman, Harry S Blackfan Delegate to State Society J Leonard Byrnes

A letter was read from Dr Shaw, Chairman of the Committee on Legislation of the State Society, suggesting that the aid of laymen, through the National Association, called the Association for Medical Progress, be employed in our work before the Legislature

A resolution was passed that the President appoint a committee of members representing the different towns of the county to solicit members for this laymen association

The President appointed B C Tillotson, J T Park, A E Falkenbury, M A Rogers, R E LaGrange, H S Blackfan, W S Bennett, Z V D Orton

The Board of Censors reported one registration—Dr H Warren Johnson, of Cambridge, and George Goodell, practicing in Hartford, not registered

Dr Munson presented a paper on "Anterior Poliomyelitis," giving the present views and treatment

Dr Munson presented the following idea relative to the phase of rural practice

I The doctor who is the only physician in the town feels that he is responsible for those who may be sick, and since he has no one with whom to leave his practice he will not leave for any post-graduate work

II He feels that from lack of opportunity to see new work and to study other methods, he is going backwards and rusting out

III The living facilities as such are fairly good The amount of money that the rural practitioner makes, in most instances, is satisfactory but there is no opportunity for recreation or sport Briefly, these are the outstanding drawbacks to rural practice

If it were possible for the Rockefeller Foundation or the Commonwealth Fund, or some similar organization to create a board of relief, one or two or more doctors who have had rural practice, who are physically able and understand the psychology of country practice, who might relieve the general practitioner in the country and let him go to some medical center and do six weeks' post-graduate, at the same time giving him an opportunity for theatres, ball games, etc.

The discussion which followed showed a decided unanimity of opinion that the idea was a good one and that it merited more detailed study

### AFTERNOON SESSION

Dr Shaw explained the object and reason for having laymen help in the legislative work, and the members were all in favor of giving it a trial

Dr Leonard reported for the Tuberculosis Committee and offered a resolution that the committee be discharged and a Committee on Public Health be appointed to take over their work and also prenatal work Passed

The President presented a resolution that the Society go on record as favoring the addition of prenatal work to the tuberculosis work, and an increased appropriation be asked from the Board of Supervisors to carry this out

The President presented an address on Mitral Stenosis, which was very interesting and instructive

It was voted that the Semi-Annual Meeting be held at Fort Edward

The Society then adjourned to the rooms of the Washington County Tuberculosis Clinic, where Dr Shaw gave a very interesting talk on Infant Feeding, illustrated with five undernourished infants and also a number of children from five to eight years old

The matter of post-graduate lectures was left to the Comitia Minora, with a suggestion that they confer with the Warren County Society asking them to join us in this matter

10

[illegible][illegible][illegible]

۱۰۰  
 ۱۰۱  
 ۱۰۲  
 ۱۰۳  
 ۱۰۴  
 ۱۰۵  
 ۱۰۶  
 ۱۰۷  
 ۱۰۸  
 ۱۰۹  
 ۱۱۰  
 ۱۱۱  
 ۱۱۲  
 ۱۱۳  
 ۱۱۴  
 ۱۱۵  
 ۱۱۶  
 ۱۱۷  
 ۱۱۸  
 ۱۱۹  
 ۱۲۰  
 ۱۲۱  
 ۱۲۲  
 ۱۲۳  
 ۱۲۴  
 ۱۲۵  
 ۱۲۶  
 ۱۲۷  
 ۱۲۸  
 ۱۲۹  
 ۱۳۰  
 ۱۳۱  
 ۱۳۲  
 ۱۳۳  
 ۱۳۴  
 ۱۳۵  
 ۱۳۶  
 ۱۳۷  
 ۱۳۸  
 ۱۳۹  
 ۱۴۰  
 ۱۴۱  
 ۱۴۲  
 ۱۴۳  
 ۱۴۴  
 ۱۴۵  
 ۱۴۶  
 ۱۴۷  
 ۱۴۸  
 ۱۴۹  
 ۱۵۰  
 ۱۵۱  
 ۱۵۲  
 ۱۵۳  
 ۱۵۴  
 ۱۵۵  
 ۱۵۶  
 ۱۵۷  
 ۱۵۸  
 ۱۵۹  
 ۱۶۰  
 ۱۶۱  
 ۱۶۲  
 ۱۶۳  
 ۱۶۴  
 ۱۶۵  
 ۱۶۶  
 ۱۶۷  
 ۱۶۸  
 ۱۶۹  
 ۱۷۰  
 ۱۷۱  
 ۱۷۲  
 ۱۷۳  
 ۱۷۴  
 ۱۷۵  
 ۱۷۶  
 ۱۷۷  
 ۱۷۸  
 ۱۷۹  
 ۱۸۰  
 ۱۸۱  
 ۱۸۲  
 ۱۸۳  
 ۱۸۴  
 ۱۸۵  
 ۱۸۶  
 ۱۸۷  
 ۱۸۸  
 ۱۸۹  
 ۱۹۰  
 ۱۹۱  
 ۱۹۲  
 ۱۹۳  
 ۱۹۴  
 ۱۹۵  
 ۱۹۶  
 ۱۹۷  
 ۱۹۸  
 ۱۹۹  
 ۲۰۰  
 ۲۰۱  
 ۲۰۲  
 ۲۰۳  
 ۲۰۴  
 ۲۰۵  
 ۲۰۶  
 ۲۰۷  
 ۲۰۸  
 ۲۰۹  
 ۲۱۰  
 ۲۱۱  
 ۲۱۲  
 ۲۱۳  
 ۲۱۴  
 ۲۱۵  
 ۲۱۶  
 ۲۱۷  
 ۲۱۸  
 ۲۱۹  
 ۲۲۰  
 ۲۲۱  
 ۲۲۲  
 ۲۲۳  
 ۲۲۴  
 ۲۲۵  
 ۲۲۶  
 ۲۲۷  
 ۲۲۸  
 ۲۲۹  
 ۲۳۰  
 ۲۳۱  
 ۲۳۲  
 ۲۳۳  
 ۲۳۴  
 ۲۳۵  
 ۲۳۶  
 ۲۳۷  
 ۲۳۸  
 ۲۳۹  
 ۲۴۰  
 ۲۴۱  
 ۲۴۲  
 ۲۴۳  
 ۲۴۴  
 ۲۴۵  
 ۲۴۶  
 ۲۴۷  
 ۲۴۸  
 ۲۴۹  
 ۲۵۰  
 ۲۵۱  
 ۲۵۲  
 ۲۵۳  
 ۲۵۴  
 ۲۵۵  
 ۲۵۶  
 ۲۵۷  
 ۲۵۸  
 ۲۵۹  
 ۲۶۰  
 ۲۶۱  
 ۲۶۲  
 ۲۶۳  
 ۲۶۴  
 ۲۶۵  
 ۲۶۶  
 ۲۶۷  
 ۲۶۸  
 ۲۶۹  
 ۲۷۰  
 ۲۷۱  
 ۲۷۲  
 ۲۷۳  
 ۲۷۴  
 ۲۷۵  
 ۲۷۶  
 ۲۷۷  
 ۲۷۸  
 ۲۷۹  
 ۲۸۰  
 ۲۸۱  
 ۲۸۲  
 ۲۸۳  
 ۲۸۴  
 ۲۸۵  
 ۲۸۶  
 ۲۸۷  
 ۲۸۸  
 ۲۸۹  
 ۲۹۰  
 ۲۹۱  
 ۲۹۲  
 ۲۹۳  
 ۲۹۴  
 ۲۹۵  
 ۲۹۶  
 ۲۹۷  
 ۲۹۸  
 ۲۹۹  
 ۳۰۰  
 ۳۰۱  
 ۳۰۲  
 ۳۰۳  
 ۳۰۴  
 ۳۰۵  
 ۳۰۶  
 ۳۰۷  
 ۳۰۸  
 ۳۰۹  
 ۳۱۰  
 ۳۱۱  
 ۳۱۲  
 ۳۱۳  
 ۳۱۴  
 ۳۱۵  
 ۳۱۶  
 ۳۱۷  
 ۳۱۸  
 ۳۱۹  
 ۳۲۰  
 ۳۲۱  
 ۳۲۲  
 ۳۲۳  
 ۳۲۴  
 ۳۲۵  
 ۳۲۶  
 ۳۲۷  
 ۳۲۸  
 ۳۲۹  
 ۳۳۰  
 ۳۳۱  
 ۳۳۲  
 ۳۳۳  
 ۳۳۴  
 ۳۳۵  
 ۳۳۶  
 ۳۳۷  
 ۳۳۸  
 ۳۳۹  
 ۳۴۰  
 ۳۴۱  
 ۳۴۲  
 ۳۴۳  
 ۳۴۴  
 ۳۴۵  
 ۳۴۶  
 ۳۴۷  
 ۳۴۸  
 ۳۴۹  
 ۳۵۰  
 ۳۵۱  
 ۳۵۲  
 ۳۵۳  
 ۳۵۴  
 ۳۵۵  
 ۳۵۶  
 ۳۵۷  
 ۳۵۸  
 ۳۵۹  
 ۳۶۰  
 ۳۶۱  
 ۳۶۲  
 ۳۶۳  
 ۳۶۴  
 ۳۶۵  
 ۳۶۶  
 ۳۶۷  
 ۳۶۸  
 ۳۶۹  
 ۳۷۰  
 ۳۷۱  
 ۳۷۲  
 ۳۷۳  
 ۳۷۴  
 ۳۷۵  
 ۳۷۶  
 ۳۷۷  
 ۳۷۸  
 ۳۷۹  
 ۳۸۰  
 ۳۸۱  
 ۳۸۲  
 ۳۸۳  
 ۳۸۴  
 ۳۸۵  
 ۳۸۶  
 ۳۸۷  
 ۳۸۸  
 ۳۸۹  
 ۳۹۰  
 ۳۹۱  
 ۳۹۲  
 ۳۹۳  
 ۳۹۴  
 ۳۹۵  
 ۳۹۶  
 ۳۹۷  
 ۳۹۸  
 ۳۹۹  
 ۴۰۰  
 ۴۰۱  
 ۴۰۲  
 ۴۰۳  
 ۴۰۴  
 ۴۰۵  
 ۴۰۶  
 ۴۰۷  
 ۴۰۸  
 ۴۰۹  
 ۴۱۰  
 ۴۱۱  
 ۴۱۲  
 ۴۱۳  
 ۴۱۴  
 ۴۱۵  
 ۴۱۶  
 ۴۱۷  
 ۴۱۸  
 ۴۱۹  
 ۴۲۰  
 ۴۲۱  
 ۴۲۲  
 ۴۲۳  
 ۴۲۴  
 ۴۲۵  
 ۴۲۶  
 ۴۲۷  
 ۴۲۸  
 ۴۲۹  
 ۴۳۰  
 ۴۳۱  
 ۴۳۲  
 ۴۳۳  
 ۴۳۴  
 ۴۳۵  
 ۴۳۶  
 ۴۳۷  
 ۴۳۸  
 ۴۳۹  
 ۴۴۰  
 ۴۴۱  
 ۴۴۲  
 ۴۴۳  
 ۴۴۴  
 ۴۴۵  
 ۴۴۶  
 ۴۴۷  
 ۴۴۸  
 ۴۴۹  
 ۴۵۰  
 ۴۵۱  
 ۴۵۲  
 ۴۵۳  
 ۴۵۴  
 ۴۵۵  
 ۴۵۶  
 ۴۵۷  
 ۴۵۸  
 ۴۵۹  
 ۴۶۰  
 ۴۶۱  
 ۴۶۲  
 ۴۶۳  
 ۴۶۴  
 ۴۶۵  
 ۴۶۶  
 ۴۶۷  
 ۴۶۸  
 ۴۶۹  
 ۴۷۰  
 ۴۷۱

Student Center to North Ave. & Village St.  
No. 1, Apt. 123 (New York N.Y.) 10001  
every 1st and 3rd of the M. R. Sullivan Co. Inc.  
Bldg. & Lumber Co. - Chgo. Ill. 60601  
Corp. 312-00-1234, 51200

Musical Signs and Gestures and Ornaments. By Louis CHURCHMAN DUCLOS, M.D., LL.D., F.A.C.S. 5th Edition, revised and reset. Octavo of 152 pages with 120 illustrations. Philadelphia and London, W. B. Saunders Company, 1923. Cloth, \$3.00.

Collected Papers of the Mayo Clinic and the Mayo Foundation. Edited by Mrs. M. H. Mellich. Volume 16, 1924. Octavo of 1331 pages with 34 illustrations. Philadelphia and London: W. B. Saunders Company, 1925. Cloth, \$15.00.

ABR'S PEDIATRICS. By 150 Specialists. Edited by I. W. A. ABR, M.D. Volume 7 containing 870 pages with 70 illustrations. (Set to be complete in eight octavo volumes.) Philadelphia and London: W. B. Saunders Company, 1925. Cloth \$10.00 per volume. Sold by subscription.

A. MIXED or PHYSICAL DIAGNOSTICS By ALVIN  
FLURY MD LL.D. Ninth Edition revised by HENRY  
C. THURMAN M.S., MD 12mo of 320 pages illus-  
trated Philadelphia and New York, Lea and Feb-  
riger 1925 Cloth \$5.00.

A PRACTICE OF GYNECOLOGY By HENRY HARTT, M.D.  
F.R.C.P. Fifth Edition Octavo of 744 pages with  
417 illustrations and 15 colored plates Philadelphia,  
 Lea and Febiger 1925 Cloth \$2.50

MEDICAL CLINICS OF NORTH AMERICA. Volume 8 Number 6, May 1925 (Boston Number.) Published every other month by the W. B. Saunders Company, Philadelphia and London. Per Clinic Year (6 issues) Cloth, \$1 ~ paper \$12.00.



# THE DAILY PRESS



When one reads a newspaper with a medical eye, he is likely to find many articles which come within the range of a physician's professional thought. The New York Herald Tribune of October 28 contains several articles dealing with conditions in which a physician is directly interested:

The very first article on the front page is a long account of a thrilling rescue of the crew of a sinking ship in mid-ocean. What has that got to do with the practice of medicine? The calm coordination of effort by both the endangered crew and the rescuers through long hours of watchful effort is duplicated daily in the practice of every doctor. Panic and cowardice, and wild hysteria are exhibited in the sick room as frequently as on a sinking ship, and more frequently than exhibitions of disabling fear, the doctor finds quiet demonstrations of faith and devotion, of fatiguing service, of self control and of constancy and of gratitude.

Bravery and cowardice, calmness and hysterics are found among the crews of endangered ships, about as often as in the families of the sick, for these qualities are traits of character, and are brought out by any grave emergency when life is threatened, be it in a storm at sea or during the course of a critical fever at a bedside.

In these days of hired attendants, the older doctors like to recall the mother or grandmother, who in her small community was indispensable in every emergency. No one could be born or meet the shadow of death except she was there to calm the distracted household and see that the right thing was always done. She was the exemplification of good sense and devotion,—and wherever she was, there was a radiance of both faith and good works. She embodied the spirit of the Master who calmed the raging seas of perplexing fear, and directed the efforts of the distracted household into efficient channels. She was the Captain of the lifeboat in every time of storm in her community.

The second item in the Herald Tribune of special interest to doctors described the action of the coal dealers of New York City in offering 250,000 tons of soft coal to retail buyers in order to relieve the shortage of fuel, due to the strike among the miners of hard coal. The City Department of Health had already voted the temporary suspension of the rules against burning soft coal. The action of the coal dealers followed what the newspapers called a "threat" that the city would buy the coal and distribute it at about eight dollars a ton, if the coal dealers did not provide the stocks and sell them at a low margin of profit.

The Queens County Grand Jury received dozens of complaints from residents who could not get coal, and it handed up a presentment citing the serious menace to public health, resulting from the coal strike. This and public sentiment generally led the City authorities in all departments, from the lawyers in the Mayor's office to the doctors in the health and hospital departments, to unite in concerted action to meet a grave emergency.

Public officials can always find reasons for either delay or action as they choose. They can wind themselves helpless with red tape, or they can cut its folds, and can quote the lawbooks as the justification of their action.

Why are officials eager to ascribe an emergency health condition to the coal strike, and are often slow to act in still more important health matters? The answer is two-fold, first, the lack of fuel produces immediate discomfort, and second, the cold affects every person. Sick babies are rather rare, smallpox is seldom seen, and when unclean milk produces an epidemic in a community, it is soon forgotten. But cold and poor cooking make everybody aware of a severe coal shortage, and at once there goes up an insistent demand for relief.

But after all, the people and the public officials are even more helpless to prevent the coal shortage than they are to prevent smallpox, and to secure pure supplies of milk and water. It is probable that health matters are handled with greater efficiency than almost any other branch of public work.

In a third item which was of interest to the doctors described the 300 odd replies received in response to an advertisement for a "real servant," who was not afraid of hard work. Only five replied sneeringly and objected to what they called the harsh requirements of being expected to work and give such service as the household might require.

The servant problem is much like the situation regarding the nurse. Some doctors would probably be surprised to find how many trained nurses still retain the old-fashioned ideas of whole-souled service, who are not clock-gazers, who will sit at table with a "practical" nurse, and who will even share a room with a probationer. The number of these devoted nurses extends into the thousands, but the demand for their services far exceeds the supply.

When householders are able to secure devoted help, then physicians also will be able to secure devoted nurses whose chief aim is to take good care of the patients in distinction from their disease.

# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL. 25, No 25

NEW YORK, N Y

DECEMBER 15, 1925

## THE PRESENT STATUS OF SURGERY FOR BENIGN ULCER OF THE STOMACH AND DUODENUM\*

By CHARLES H PECK, M.D

NEW YORK CITY

THE surgery of benign ulcer has been the topic of so many recent papers and discussions that it would seem as though the subject must be thoroughly exhausted. Nevertheless wide differences of opinion still exist between surgeon and physician and especially between surgeons, as to the indications for operation and the choice of procedure.

There is perhaps less controversy between internist and surgeon as to the cases in need of operative treatment than there is between surgeons as to what shall be done when the abdomen is opened and the ulcer demonstrated.

As the pathology, prognosis and operative indications in chronic duodenal ulcer differ widely from those of chronic gastric ulcer, the two groups should be considered separately. Acute perforation in either group calls for special consideration and will not be included in this communication.

*Chronic Duodenal Ulcer*—For convenience of study it is well to divide chronic duodenal ulcer into groups based upon the pathologic changes present. While this grouping may be varied greatly by different operators, the following will answer our purpose.

1 Small, single, anterior wall ulcers, without narrowing of the lumen or fixation of the duodenum, nor encroachment on the pylorus.

2 Chronic indurated ulcers, without obstruction or hemorrhage, single or multiple.

3 Chronic penetrating ulcer, with sealed perforation, fixation of the duodenum and often an inflammatory mass.

4 Duodenal stricture, or so called pyloric stenosis, with retention of food and dilated stomach.

5 Bleeding ulcer.

*Group One*—May often be treated satisfactorily by local excision without gastro-enteros-

tomy, as practised by Judd and Rankin, or by the Horsley operation, or by Finney's pyloroplasty in the course of which the ulcer is excised.

We have had a moderate number of cases treated by local excision and by the Horsley method, with satisfactory result and are impressed with the simplicity of the procedure in suitable cases. Our experience is too limited and recent, however, to enable us to speak confidently of late results. Horsley himself admits recurrence of symptoms and secondary operation in some of his own cases, and I know of at least one Finney operation which had to be followed a year or so later by gastro-enterostomy. Of all duodenal ulcers, the percentage which fall in this group is relatively small.

*Groups Two and Three*—Chronic ulcer without stenosis or hemorrhage constitute the great majority of all duodenal ulcers.

We believe that gastro-enterostomy is the best primary operation for these cases, whether chronic perforation or inflammatory mass is present or not.

The argument that gastro-enterostomy is ineffective if there is no obstruction we believe to be fallacious.

Whatever the real cause of duodenal ulcer may be, mechanical and chemical influences play a distinct rôle. The ulcers nearly all develop within  $1\frac{1}{2}$  inches of the pylorus, the part of the duodenal wall which receives the impact of acrid stomach content, pumped intermittently through the pylorus in spurts, as though by the piston of a syringe. This content is often a strong chemical irritant, not altogether dependent on the amount of hydrochloric acid present for its corrosive action and quite capable of causing injury to the delicate duodenal mucous membrane.

The great frequency of this lesion in young men, the group perhaps most likely to be careless or reckless about the combinations of food and

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse, May 13, 1925.



# BOOK REVIEWS



**LANG'S GERMAN-ENGLISH DICTIONARY OF TERMS USED IN MEDICINE AND THE ALLIED SCIENCES** Edited and Revised by MILTON K. MEYERS, M.D. Third Edition, enlarged Octavo of 613 pages Phila., P. Blakiston's Son & Co, 1924 Cloth, \$7.00

This is the third and enlarged edition of a German-English medical dictionary, which is found to be, not only complete and very well arranged, but because of its thoroughness, will prove of inestimable value to him who writes as well as to him who may from time to time simply refer to the German literature in the course of reading.

Perhaps a few illustrations may not be amiss, in order that the reviewer's contention may be more readily emphasized. For example, in connection with the term "Lippen—lip, labium, edge, crest, border," one finds following this sixty-one terms with lip as part of so many compound words.

Under the term "Bandwurm—Tape-worm," the text gives the various types of the parasite both in the original as well as the English equivalent, after that follow various compound words with "Band-wurm" as the basis, e. g., "Bandwurm-Ei (Ovum of tapeworm)", "Bandwurm-Ghied (proglottis of tapeworm)", etc.

In connection with the term "Leber" (liver), the book uses enough compound words to occupy three and a half full length columns (half page).

One other outstanding feature of this book is the fact that it avoids the usual mistake so frequently found in books of its kind, namely that of translating for example—"Arthrodie—ball and socket joint" (instead of simply—arthrodia), "Colopexie—suspension of the colon by sutures" (instead of simply—colopexia), etc.

Owing to the great variety and number of words herein translated and defined, the translator of German publications as well as the casual reader of the German literature will find this Glossary of great help, time saving, as well as instructive.

HARRY APPEL

**THE PHYSIOLOGY OF MIND** An Interpretation Based on Biological, Morphological, Physical and Chemical Considerations By FRANCIS X. DERCUM, A.M. M.D., Ph.D. Second edition, reset. Octavo of 287 pages Phila. and London, W. B. Saunders Co, 1925 Cloth, \$3.50

This book is largely a discussion of certain fundamental considerations underlying the study of the mind. The style is quite readable and the subject matter is interesting. As is customary in his writings, the author seizes upon every opportunity to "let slip the dogs of war" upon Freudism.

FREDERIC DAMRAU

**THE INHERITANCE OF MENTAL DISEASES** By ABRAHAM MEYERSON Octavo of 336 pages Baltimore, Williams and Wilkins Co, 1925 Cloth, \$5.00

After an exhaustive study of the literature the author has attempted to evaluate the importance of the various factors entering into the hereditary transmission of mental disease. The reader who is in search of information on this subject will here find a considerable mass of data clearly expressed and conservatively interpreted. An excellent bibliography is appended.

FREDERIC DAMRAU

**PRINCIPALS OF SURGERY FOR NURSES** By M. S. WOOLF, M.A., B.Sc., M.R.C.S. (Eng.), L.R.C.P. (Lond.) Octavo of 350 pages, illustrated Phila. and London, W. B. Saunders Co, 1925 Cloth, \$3.00

This is indeed the most complete and yet simple treatise on Surgery for Nurses that we have encountered. It cannot but achieve its object as outlined in the preface, "nurses have desired something less than a medical students' text-book and something more than a work on technic,—whereas they have often surgical procedure well in hand, the principles on which it is founded have remained obscure to them."

The more prominent surgical conditions are treated in simple, plain language, and at the end of each chapter a very complete summary taken from Hey Groves' Synopsis allows one to more thoroughly cover the subject.

With the present tendency to a shorter term of service in training schools, this very compact little volume should become a popular text-book with student nurses, and will be greatly appreciated by all those who, like the author, undertake to teach Surgery to nurses.

W. V. P.

**PRACTICAL HISTOLOGY** By HENRY ERDMANN RADASCH, M.Sc., M.D. Second Edition. Revised and Enlarged, 12mo of 621 pages, with 333 illustrations Phila., P. Blakiston's Son and Co, 1924 Cloth, \$5.00

A second edition of this volume is an amplified and improved model of the first. The subject matter is handled in a capable and concise manner. The illustrations are ample and clear.

Although this book cannot replace the older standard works in this subject, it will serve as a useful guide and addendum to the student.

MAX LEDERER.

**TOXICOLOGY OR THE EFFECTS OF POISONS** By FRANK P. UNDERHILL, Ph.D. 12mo of 292 pages Phila., P. Blakiston's Son and Co, 1924 Cloth, \$2.25

This is a book based upon a course of lectures given before the medical students of Yale Medical School. The title does not indicate the full scope of the book. It includes a description of a pretty full list of drugs and chemicals having a poisonous effect, with fatal dose, symptoms, post mortem appearances and treatment. The poisons are grouped into the usual Inorganic, Metallic, Poisonous Gases, Alkaloidal Poisons, and a large group of unclassified Organic Poisons. This last group occupying about 100 of the 263 pages deals mostly with well known drug which in excessive doses exert an untoward or poisonous action. While most of this information can be found in any of the larger text-books of pharmacology and therapeutics, it is here brought together under the heading of poisons.

It seems to the reviewer that the directions for treatment are not as definite and specific as they ought to be. No emergency strikes greater terror in the mind of a physician than acute poisoning. Such directions as "empty the stomach," "give stimulants and demulcent drinks" seem too general to satisfy the demand for immediate help in a desperate emergency like a case of acute poisoning.

The information is reliable and up to date, and well adapted to the use of students in following a course of lectures.

E. H. B.



other cases operated upon in which the original operation was done elsewhere are well and free from symptoms

Lewisohn recently reported a series of 92 cases of gastro-enterostomy from the Mt Sinai Clinic in which 16 per cent developed jejunal ulcer proved by secondary operation and an additional 17 per cent had symptoms indicating jejunal ulcer, not proven by operation. We do not believe that such a high incidence is of common occurrence, as our own experience and that of most clinics puts the percentage at less than 3 per cent.

The question of post-operative morbidity after simple gastro-enterostomy is the subject of much discussion, and there is much pessimism expressed which we do not share. We have taken pains to follow these patients and in our series of the cases traced 98 in number, including the 4 jejunal ulcers, 89 or 90.8 per cent or 91.7 per cent are permanently relieved and free from gastric symptoms.

**Summary**—1 Surgical treatment of duodenal ulcer, should be advised only after medical treatment has failed to give relief, when symptoms relapse after temporary improvement, or when X-ray examination shows definite stenosis or penetrating ulcer.

2 The operation of choice should be simple gastro-enterostomy. Radical resection should be reserved for cases with severe hemorrhage, those with recurrent symptoms after simple operations, or cases of jejunal ulcer.

3 A lasting clinical cure may be expected in 85-90 per cent of cases treated by simple gastro-enterostomy.

**Chronic Gastric Ulcer**—Presents problems which differ radically from those of duodenal ulcer. It is a generally accepted principle that gastric ulcers must be excised or removed in some way, whenever it is possible. These ulcers do not heal after simple gastro-enterostomy as frequently as duodenal ulcers, symptoms are apt to persist, and in addition there is always the fear that malignancy may be present at the time of operation or may develop in the ulcer area later.

The frequency with which cancer is implanted on benign ulcer has long been a matter of dispute, the estimates varying from the 68 per cent of the earlier Mayo Clinic reports, down to 2 or 3 per cent, or even zero as a few radical disponents claim.

It is at least a well known fact that it is impossible to exclude the presence of cancer implantation, by gross examination at the time of operation, and a pretty general belief that it may develop later in an appreciable number of cases whatever the exact percentage may be.

The three chief operative procedures are

1 Local excision of the ulcer with or without gastro-enterostomy

2 Cautery puncture, with or without gastro-enterostomy

3 Partial gastrectomy or pylorotomy

Local excision may be supplemented by the use of the cautery and gastro-enterostomy should always be added, as the resulting cicatrix necessarily distorts the stomach to some extent, and interferes with its normal peristaltic action.

For ulcers of moderate size, especially those near the middle of the lesser curvature this is our method of choice and it gives excellent results.

In ulcers high up, near the cardia, where excision is difficult or impossible, cautery puncture, with gastro-enterostomy offers a satisfactory method.

Pylorotomy or partial gastrectomy should be done for ulcers close to the pylorus, and for the larger ulcers in the pyloric third of the stomach. It is preferred by many surgeons for the majority of all gastric ulcers, instead of local excision.

The particular method varies according to the fancy of the surgeon. We prefer the Billroth II when the ulcer is not too high up or too large. When more than half of the stomach must be resected the Mayo-Polya method is probably the best, the ante-colic type being apparently more in favor now than the anastomosis through the transverse meso-colon. It is the method of choice with many surgeons, even in the lower resections.

Modifications of the Billroth I, i. e., excision followed by gastro-duodenal anastomosis have had a recent wave of popularity, due in part perhaps to the brilliant work of Von Haberer at Innsbruck.

Finney has recently advocated an end to side gastro-duodenal anastomosis, which may be used when the duodenum can be sufficiently mobilized.

Free mobilization of the duodenum is essential in any gastro-duodenal anastomosis, and is not always easily obtained.

Chronic perforation with adhesion to the pancreas or posterior structures may make mobilization of the stomach and resection extremely difficult, and sometimes impossible.

**Hour Glass Stomach**, the result of ulcer calls for special procedures among which are

1 Gastro-gastrostomy between the two pouches

2 Gastro-plasty of the type of Finney pyloroplasty

3 Gastro-enterostomy

4 Partial gastrectomy

5 Trans-gastric resection

We have had satisfactory results with all of these methods except gastro-enterostomy.

We have had 79 cases of gastric ulcer in our series, with eight deaths, a mortality of 10 per cent.

drink introduced into their stomachs is a suggestive fact

When the ulcer is once formed, it is constantly irritated by the impact of chyme and by the action of the pyloric sphincter, and has little encouragement to heal.

Gastro-enterostomy lessens the irritant character of the stomach content, partly by diminishing the acidity, and partly by lessening the time in which it is churned about in the stomach

It also lessens greatly the amount which passes through the pylorus, and especially the force of the impact of that which does pass

We believe that these influences may be interpreted as in part, at least, explaining why the ulcers heal so often and so promptly after simple gastro-enterostomy and why the clinical results are so good in a high percentage of cases so treated

That in a small percentage of cases, healing fails, and symptoms persist or recur, we freely admit, but we believe that this happens in less than 15 per cent, even when the cases are unselected and the severe pathologic types are included in the study. We do not believe that radical pylorotomy or partial gastrectomy should be the choice for the primary operation in the types of ulcer above considered, in spite of the widespread teaching to the contrary and the popular attempt to discredit gastro-enterostomy now prevalent

*Group Four*—That cases with duodenal stricture or so-called pyloric stenosis are best treated by gastro-enterostomy is generally conceded

The patients are often starved, dehydrated and emaciated to the last degree, and we have been obliged repeatedly to resort to transfusion, hypodermoclysis, and operation under local anaesthesia, to avoid immediate fatality. The change in expression, gain in vitality and general comfort, smoothing out of wrinkles and gain in weight which comes after food and fluid reaches the intestine where it can be assimilated in sufficient quantity, picture some of the most brilliant and satisfactory results met with in abdominal surgery

*Group Five*—Bleeding ulcer occurs most frequently in those situated on the posterior wall or against the head of the pancreas, and in deep, penetrating ulcers. Hemorrhage occurs in about 14 per cent of all cases and is always a serious complication. We have seen patients die of duodenal hemorrhage before any operation could be performed, and others so exsanguinated that preliminary blood transfusion alone made operation possible

Gastro-enterostomy is not a guarantee against recurrence of hemorrhage which may prove fatal and excision of the ulcer is desirable if the condition of the patient will permit

We have performed pylorotomy several times

for bleeding ulcer, but on the other hand have been obliged to be content with simple gastro-enterostomy many times when the risk of the radical operation seemed too great for the exsanguinated and debilitated patient. Transfusion in moderate amount is a great aid in these cases. I was once forced reluctantly to operate upon a woman of 74 years of age for repeated duodenal hemorrhage after refusing to do so for fifteen months

Simple gastro-enterostomy was followed by a complete cessation of both the hemorrhages and the ulcer symptoms and she is alive and well, able to eat what she chooses at the age of 84

Hemorrhage is apt to occur in cases in which extensive induration and fixation of the duodenum would make radical operation extremely hazardous or impossible. A two-stage operation, gastro-enterostomy first, followed by resection 10 to 14 days later may be indicated, especially if hemorrhage recurs after the gastro-enterostomy. The inflammatory induration often melts away and makes secondary resection easier and safer than it would have been at the primary operation

In many cases of hemorrhage it is wiser to defer operative treatment, depending on rest, sedatives, fluid diet and small, repeated transfusions to control the bleeding

This plan is often successful, permitting the election of a later time for operation when the patient has recovered from the immediate effects of hemorrhage and is a better operative risk

We have had 228 cases of chronic duodenal ulcer, 144 since 1915 and 74 previously reported with 19 deaths, a total mortality of 0.88 per cent

Comparatively few of these deaths have been directly attributable to the operation per se, as many of them have been in elderly people with complicating conditions. Of three deaths occurring in 22 cases since January 1st, 1924, one was in a feeble woman of 60 in whom cholecystectomy was done in addition to the gastro-enterostomy, an error in operative judgment

Nine deaths in the series were due to post-operative pneumonia, three to uraemia in old nephritics, one to diabetic coma, one to cerebral thrombosis and one to pulmonary embolism

Three deaths were attributable to the operation per se, one from vicious circle, one from acute stomach dilatation, and in one there was peritonitis following breaking open of the wound

There was no post-operative hemorrhage in the series, and only three cases of vicious circle, two of which recovered after secondary operations and are now well, after nine years and five years respectively

There have been only five cases of jejunal ulcer in the series as far as we have been able to trace, all proven by secondary operation. Four recovered and one died, two of the recovered cases still have symptoms and two are well. Two

tegrity of the organs of sense, of the centripetal nerves, of the conduction paths and terminal stations within the nerve centres, and of the associative mechanisms that combine the activities of the central stations with one another. Sense-stimulation, conduction of centripetal influences, perception, memory revival, association of ideas—all are parts of the process of knowing. Disorders of sensation, of conduction, of attention, of perception, of memory or of association limit or distort the data upon which identification, orientation, imagination, reasoning and judgment depend.

Eyes, ears, nose, taste-buds, touch spots, pain spots, and temperature spots in the skin, as well as the sensory nerve-beginnings in the muscles, bones, joints and viscera, must be intact if sensory stimuli are to start the centripetal impulses that are necessary or desirable for orientation, for the gaining of knowledge of the world outside, or for warnings of abnormal processes going on inside the body. A school-boy may appear to be stupid because of a severe hyperopic astigmatism, a tendency to isolation may be traceable to the embarrassment of bilateral labyrinthine deafness, a sensation of pain may be the first warning of the onset of a pleurisy, an appendicitis, or an attack of gout.

Or, again, if conduction be interfered with in peripheral nerves, in the spinal cord, or in the brain, *anaesthesias*, or *paraesthesias*, of corresponding distribution will be demonstrable. Thus, vision may become defective because of an optic neuritis, a bladder may become distended because a patient with tabetic degeneration in the spinal cord may not have the normal sensation that accompanies overfilling; numbness in the fingers and toes may be the first intimation of the cord changes accompanying or preceding the development of a pernicious anaemia, or complete loss of sensation of one-half of the body may point to a destructive lesion of the posterior part of the occipital lobe of the internal capsule.

Irritations of sensory conduction paths may excite remarkable psychic reactions in the form of sensations of *pain*, for example, the neuralgias of peripheral nerve origin (like sciatica, lumbago and tic douloureux) or the lightning pains of tabes due to irritations of the posterior roots of the spinal nerves and their intramedullary continuations. Many of the *common complaints* for which patients consult physicians consist of subjective sensations due to irritations of sense organs or of sensory conduction paths, in addition to the neuralgias just referred to. I need mention only headache, dizziness, sore throat, otalgia, palpitation, angina pectoris, stitch in the side, epigastralgia, nausea, hunger pain, colic, tenderness, dysmenorrhoea, arthralgia, osteoscopic pain, and myalgia—all of which are psychical reactions to mechanical or chemical stimulations of nerves. In this domain especially, every general and every

special practitioner of medicine has learned to evaluate psychic factors for diagnosis.

Disturbances of sense perception and identification are also common in general medical experience. Since normal perception depends upon the fusion of sensations with revived memories of similar sensations previously experienced, disturbances here may have their cause in abnormal sensation, in faulty memory, or in imperfect assimilation of sensation to revived experience. Here belong, on the one hand, the *sense-deceptions* that we know as hallucinations and illusions, and, on the other, the *sensory aphasias and agnosias*. You will all recall alcoholics (in post-Volstead as well as in pre-Volstead days) who saw many small, black, moving objects where you could see none, each of you has doubtless heard schizophrenics give reports of the visions they saw and the voices they heard, though healthy persons present failed to corroborate the occurrence of such sights or sounds, or you may have noticed with alarm the illusion of the paranoiac who interpreted some harmless sound as a threat. Failure to recognize or to identify perceptions even though sensation be unimpaired is a peculiar psychic disturbance, sometimes spoken of as mental anaesthesia. If the failure of recognition has to deal with symbolic things, like words, figures, musical notes or gestures it is called sensory aphasia, of which inability to read (*alexia*) and inability to recognize the meaning of words heard (*word deafness*) are well-known examples, but if the failure of identification be of non-symbolic things it is called sensory asymblia or agnosia (*visual, acoustic or tactile*). These psychic disturbances are nearly always due to severe organic lesions—vascular, neoplastic, or inflammatory.

The sensory aphasias and the agnosias just referred to are, in part, *memory defects*, due to injury or destruction of local areas in which certain memory traces (*engrams*) are stored. We distinguish these *partial amnesias* from the more general amnesias (or losses of memory) and *paramnesias* (or perversions of memory).

In *general amnesia*, all memories both old and recent may be impaired. Thus in advanced atherosclerosis of the cerebral arteries or in destructive processes of the cerebral cortex such as occur in dementia paralytica there may be inability to recall either the experiences of earlier or of later life. When school memories can be easily revived but recent events cannot be remembered, the memory difficulty may be due to loss of the ability to increase or supplement the store of memories (so-called "*recording faculty*") and this incapacity may in turn depend upon a disorder of attention, either an inability to direct the thought to a definite task (*hypovigility*), or to maintain this direction in the presence of intercurrent stimuli (*hypotenacity*).

Among the *paramnesias*, or perversions of

# PSYCHIC FACTORS IN GENERAL MEDICAL DIAGNOSIS\*

By LEWELLYS F BARKER, M D

BALTIMORE, MD

## WHAT MEDICAL DIAGNOSIS IS

**B**Y DIAGNOSIS we mean a thorough knowledge of the human being that we study. Diagnosis is, therefore, an ideal which we attempt to approach, the acquisition of complete knowledge regarding any living organism being beyond our powers. More particularly, in medical diagnosis we strive to ascertain in how far a given human being is healthy or ill and the reasons therefor, by which in turn we mean in how far he is (as a whole and in each of his parts) capable or incapable of making adequate responses to the physical and psychological influences of the environment in which he lives, and why. Adequacy of responsivity indicates health, whereas inadequacy of responsivity indicates disease or anomaly. Health and disease are conditioned, it is the task of diagnosis to attempt to determine the conditioning factors in given instances.

## WHAT WE MEAN BY PSYCHIC FACTORS

Human beings are extremely complex living organisms that result from the interplay of surroundings with fertilized egg-cells. Their potentialities of structure and function lie in the germ-cells in which they start, which of the potentialities come to actual development depends, as biologists now agree, upon the influences that act upon the germ cells and their derivatives during intrauterine and post natal life.

The functional activities of human beings are usually subdivided into somatic and psychic, though it is by no means easy sharply to separate the one set of functions from the other. Without entering into any discussion of this topic, I shall here class as "psychic" not only everything that occurs in consciousness, but also all those functions that, occurring unconsciously, may in other circumstances become conscious. My paper has to deal then with the significance of the conscious (or potentially conscious) phenomena discoverable in studies directed toward the determination of the degree of adequacy, or inadequacy, of responsivity of human constitutions to environmental influences. In how far are these psychic factors (conscious or unconscious) of importance for medical diagnosis, that is to say, for the determination of the existence of healthy states on the one hand or of anomalous or diseased states on the other?

It would seem that in man, as in the higher animals generally, the psychic functions have evolved from the simpler instinctive tendencies. In each instinctive tendency, three constituents

are discernible — (1) a knowing or cognitive constituent, (2) a feeling or affective constituent and (3) a striving or conative constituent. The sum total of the human psychisms pertaining to knowing we speak of as *cognition* and *intellect*, of those pertaining to feeling and emotion as *affectivity*, and of those pertaining to striving as *will* or *conation*. A human personality is then a complex of cognition, affectivity and conation, the two latter are often considered together as composing *character* (as contrasted with cognition and intellect). The *intellect* seems to be an instrument that has been evolved in the interest of character, in other words, in order better to satisfy our desires by our activities, it has become necessary increasingly to know. Adequate responsivity of a human being to physical and social pressures in a changing environment depends then upon suitable cognitive, affective and conative functioning. Obviously, therefore, for good medical diagnosis, that is to say for satisfactory recognition of adequacy or inadequacy of responsivity in the persons physicians study, ability to investigate the psychic functions upon which responsivity and irresponsivity largely depend would seem to be indispensable. And similarly, therapy, the task of which is to endeavor to make irresponsible organisms more adequately responsive, can scarcely hope to be successful if, concentrating upon physical defects alone, it fail to give attention to the psychic factors of adjustment. Both soma and psyche require accurate and painstaking investigation in medical diagnosis and adequate attention in medical therapy, he who would be a skillful diagnostician or an expert therapist dare not neglect either the somatic or the psychic deviations from normal functioning.

## THE COGNITIVE AND INTELLECTUAL FUNCTIONS AND MEDICAL DIAGNOSIS

### (The Functions of Knowing)

Comprehensively to deal with the cognitive, affective and conative factors that are important for general medical diagnosis would require the writing of a large treatise, in a brief paper one must be content merely to sketch the topic in broad outlines.

Cognition depends upon the ability to receive impressions from the external world through sense-organs, to conduct these impressions through peripheral nerves to central nervous organs, to combine these impressions with one another and with revived impressions of previous experiences, and to form perceptions and judgments that are consonant with objective reality. In other words, intellectual functioning in an adequately responsive person presupposes the in-

\* Read at the annual meeting of the Medical Society of the State of New York at Syracuse, May 13 1925

of 'suniness' or of 'blueness'. And the more episodic emotional states of delight or of disgust or joy or of grief, of love or of hatred, of anxiety or of peace, of satisfaction or of dissatisfaction, of anger or of humility, of fear or of courage, and so on through the whole gamut or the emotions, are also familiar to each of us.

No two persons exhibit precisely the same affective reactions, and the affectivity of a single person may fluctuate greatly at different times and seasons. What we call *character*, *temperament* and *disposition* are largely determined by affectivity. The strength and depth of the ethical affects account for the differences between a good and a bad character. A person of sanguine temperament exhibits labile affects whereas one of phlegmatic temperament manifests steadier and sometimes deeper feeling and emotion. Similarly, irritability or placidity of disposition are terms indicative of affective tendencies, due either to constitution or to situation. Nothing else in another person influences us as much as the affective states that he exhibits, we feel them and instinctively react to them, that is why they are largely regulative of our social relationships.

Moreover, thought and behavior are markedly dependent upon desires and moods, for 'intellect' and 'will' work at the behest of the 'affects', it is natural for every one to try to satisfy his desires, to gain pleasures and to avoid discomforts. Thus the attitude assumed by the person as a whole is an expression of the affective states he experiences. And the latter appear to depend in large part upon neuro-endocrine make-up and the ways in which the neuro-endocrine apparatus reacts to the internal and the external environment.

In our patients we meet with the most remarkable disturbances in the domain of the affects—pathological intensification, pathological protraction, pathological irradiation and displacement. The outspoken disturbances are familiar to every layman as well as to every practitioner. In the melancholic patient we observe every gradation of depression from marked "downheartedness" to the deepest sadness and gloom, he suffers continual "mental torture," so severe that he often prefers to die rather than to live, he has lost all interest in persons and in things except in his sufferings, he harbors ideas of self depreciation of self blame, of poverty and of sin, he thinks and moves slowly, his attitude is stooped, the angles of his mouth hang down, and his skin is wrinkled and dessicated so that he looks older than his years. In the manic patient we observe the affective opposite, namely every gradation of *euphoria* from simple preternatural cheerfulness and enjoyment of the world and of life to highly pathological excitement and elation; he is ecstatically happy, interested in everything, but very distractible, turning from

one object of interest to another with great rapidity because of the superficiality and acceleration of his associations. Nothing is an effort for him, he feels no fatigue and he accordingly manifests outspoken pressure of activity. His ideas are expansive and grandiose, he feels superior, indeed greatly overestimates his own value and position and makes claims that sometimes bring him into violent conflict with those about him, he is prone to be erotic and venturesome, his thoughts, his speech and his movements are accentuated. He stands erect with smiling face, glistening eyes and aggressive attitude and his skin is smooth and turgid so that he looks younger than his years. These two contrasting syndromes of pathological affectivity—the *melancholic* and the *manic*—are met with in their purest forms in the manic-depressive psychosis where one may alternate with the other. Milder cyclothymic states are, however, very frequent and their true nature often goes unrecognized. In my opinion, many of the patients who suffer from recurrent nervous breakdowns (spoken of as recurrent neurasthenia or recurrent psycho-neurotic state) really belong in this group, for if the family history be investigated a family tendency to elation-depression syndromes, or to suicides, will often be discovered. Many of these patients with milder symptoms in their depressed periods seek relief from their discomforts by consulting internists, surgeons and medical and surgical specialists rather than neurologists or psychiatrists and submit themselves to all sorts of therapeutic regimes in the hope of relieving what they call their "toxic condition." Particularly in hypo-chondriacal depressions has this been true. With the best intentions appendices, tonsils and teeth are removed, gall bladders are excised, supposed ureteral strictures are dilated, sphincters are stretched, nasal operations are performed, antra are washed out, high colonic irrigations are given, hysterectomies are performed, autogenous vaccines are prepared and administered, foreign proteins are injected, orthopedic appliances are adjusted, special diets are ordered, uniglandular and multiglandular endocrine products are fed, hydrotherapy, mechanotherapy, climatotherapy, radiotherapy and psychotherapy are tried—all without avail. In time, the depression runs its course, the inhibition symptoms disappear to be succeeded by normal affectivity or by mild elation, the patient becomes what he calls "well" whether at the time of change he be in the hands of a regular practitioner or of a quack. Whoever happens to be in attendance upon him when the change occurs may be accredited with the "cure," though sometimes the patient will attribute the "cure" to some special measure that he himself has thought of and applied just precedent to the change!

The affective states of elation and of depression are by no means confined to the groups of

memory, may be mentioned those peculiar states in which patients describe wholly imaginary events as though they were memories of actual experiences, here belong the confabulations of hysterical patients and the pseudo-remiscences of persons suffering from the polyneuritic psychosis of Korsakoff. Not far removed from these disturbances are the pathological lying exhibited by certain degenerates and the pseudologia fantastica of certain egoistic psychopaths who give free rein to their fancies in the concoction and relation of dramatic tales of their alleged experiences.

Disturbances of *association* and of *thought* are much more abstruse phenomena than those hitherto considered, for the normal associative processes and normal intelligence are the most complex functions that occur anywhere in nature. I shall not attempt to discuss them at length, but will mention merely a few of the more striking pathological conditions of interest for general medical diagnosis. Associations are combinations and arrangements of psychisms (sensations, perceptions, revived memories) into larger units, they are essential parts of the processes of thinking, of imagining, and of judgment-formation, they are the foundation of the *intelligence*. Associations may be pathologically accelerated or retarded. A good example of such *acceleration* is to be observed in the flight of ideas and exaggerated distractibility of manic and hypomanic states, I have a hyperthyroid patient under observation just now whose thoughts come so rapidly that, in trying to give expression to them, they (to use her own words) "stumble over one another." The opposite state, pathological retardation of associations, is characteristic of many morbid depressions, you have all observed the slow, labored talk and the apparent poverty of ideas of melancholics.

Another disturbance of association is the appearance of *bizarre links* in a chain of thought difficult for a normal person to understand. Thus in dementia praecox the successive components of the expressed thoughts may be so peculiar as to puzzle completely the examining physician as to their origin, they resemble the unintelligible associations that may occur in one's dreams. Every gradation may be met with from mild distortion to the most peculiar condensations, displacements and symbolisms, the severest disturbances give rise to "incoherence."

It is probable that abnormalities of association are responsible, at least in part, for the origin of a variety of *pathological ideas*, such as (1) the imperative ideas or obsessions, (2) the exaggerated ideas of hypochondriasis and of premonitional states, and (3) the true delusions.

Patients suffering from compulsion-neuroses (psychasthenia) may be bothered much by *obsessions*, thus they may think that their hands

are contaminated, that they will carry infections to others, or that they will injure someone with a sharp instrument. Though it is realized fully that these thoughts are absurd, nevertheless, they constantly recur and annoy the patients. Combined with various phobias, with pathological impulses, with indecision, and with feelings of unreality, the patients on whom they intrude may be severely tortured by these imperative ideas.

The *exaggerated ideas* that occur in hypochondriacs and in those who experience "premonitions" are not recognized by those who harbor them as intruders in consciousness or as being absurd, on the contrary, they are looked upon as true expressions of the inner personality. Such exaggerated ideas stand very close to the pathological ideas that we designate as true delusions.

A *delusion* differs from an error in that the latter may be corrected by a new and enlightening experience, whereas the former is created by an inner (affective) need, not by an accidental fault of logic, and is likely to persist as long as the abnormal affective state that gives rise to it persists, despite all efforts to correct it by instruction or by enlargement of experience. Thus, no one can convince the patient that his delusion is a false idea, for he completely lacks what is called "disease-insight." In melancholic states, delusions of unworthiness, of sin, and of poverty are dominant, in manic states, delusions of power and of grandeur are characteristic, and in paranoid states, ideas of reference and delusions of persecution are unmistakable symptoms. In all these delusions the disturbances are affective as well as cognitive, they are probably determined as much by feeling-tone and emotion as by abnormalities of the associative processes.

## THE AFFECTIVE FUNCTIONS AND MEDICAL DIAGNOSIS

### (The Functions of Feeling)

When we turn to the affective functions we enter a domain of the very greatest importance for general medical diagnosis, since on the one hand nearly all diseased states of the body cause some disturbance of the feeling of well-being and, on the other, the disturbances of affectivity in certain disorders that are primarily nervous or mental may mislead practitioners who are not sufficiently familiar with them to suspect the existence of diseases of the heart, of the gastrointestinal tract, or of other special domains of the soma.

By the affective functions (or *affectivity*) we understand the psychic phenomena known as feeling-tones, moods and emotions. Every cognitive psychism, be it a sensation, or an idea, is accompanied by a positive or a negative *feeling-tone*—that is to say, it is tinged by pleasure or displeasure. Every one knows, too, what is meant by *moods*—more or less prolonged states

more than the practitioner of medicine needs to be tolerant of the vagaries of human behavior, or to possess the insight that will enable him to understand and to explain the weak or the perverse "will"?

If your patience were not already exhausted, I should be tempted to discuss certain *disturbances of the personality as a whole* (e.g., alternating personality, splittings of the personality disintegration of the personality and depersonalization) as well as certain *disturbances of the consciousness as a whole* (e.g., sleep disorders, hypnosis, comas, tuper, twilight states and deliria) and their relations to medical diagnosis. But I forbear

I hope that the matters already presented may suffice to convince practitioners of the importance of investigating psychical as well as physical factors in their patients when they wish to make comprehensive diagnostic studies. May the time soon come when medical schools will pay more attention to psychology and psychiatry, as was urged by Dr. Matzinger at your meeting last year<sup>1</sup>. And may I express the hope, also, that more physicians will combine with interested laymen in forwarding campaigns of Mental Hygiene in the communities in which they live. Such campaigns are fully as important as many other preventive measures for the promotion of the health and the welfare of our people.

## INFECTIONS OF THE URINARY TRACT IN CHILDREN \*

By HENRY G. BUGBEE, M.D.

NEW YORK CITY

IN the Second Edition of Holt's "Textbook on Pediatrics" (Published in 1902), he states that infections of the urinary tract in children consist of cystitis, pyelitis or pyelocystitis, the latter often associated with a nephritis, that they are found largely in female children, the colon bacillus being the offending organism, gaining entrance to the urethra from napkins soiled with feces coming in contact with the vulva with an ascending infection of the urethra, bladder, and, possibly, along the ureter to the kidney. Primary kidney infections are mentioned as an accompaniment of certain infectious diseases or caused by the irritation of renal calculi or associated with tuberculosis or tumors. He states that occasional infections in boys may bring up the question of the possibility of a blood infection or direct extension from intestines to the bladder. Holt further says that these infections often accompany diarrheal diseases.

Since that time, infections of the urinary tract in children have been regarded on this basis by the majority of pediatricians.

During the past five years, however, attention has been focused on these conditions and more accurate observations made through study by urologists and by the combined observations of urologists and pediatricians. Scientific investigations have been carried out by both specialists and the consensus of opinion, at the present time, is that the urinary tract in infants and children is subject to the same type of infections as in adults and that the mode of infection is probably the same.

There are apparently two general types of infections in children, namely, those without urinary stasis and those in which a definite lesion is

present which interferes with complete drainage.

In the first type of infection, the organism most often found is the colon bacillus which has been produced in large numbers in the intestinal tract due to some intestinal disturbance, and which is supplied to the kidneys through the blood stream.

It is not my purpose to enter into an elaborate discussion of the theories advanced for the particular route of infection, but clinical and experimental data point overwhelmingly to this mode of infection in children which is unquestionably true in adults. My own observations, as well as those of most other urologists, would suggest that these lesions in children are quite similar to those in adults.

Holt noted the absence of acute vaginitis in female children who were supposed to be infected from the outside, and I have noted in the majority of children very little distress referable to the urethra. Furthermore with the subsidence of the kidney infection, treatment is seldom necessary to clear up the lower urinary tract.

Coccus infections are most often secondary to focal infections somewhere in the body—the tonsils often being primarily the focus.

The lesions found in both colon bacillus and coccus infections of the kidney point to the theory that the infections are a pyelonephritis rather than a true pyelitis.

Helmholz has shown in his experiments that the kidney seldom, if ever, filters through bacteria without some change taking place in the kidney parenchyma.

The milder types of kidney infection, due to the colon bacillus, may cause comparatively little systemic reaction, few of the symptoms being associated with the kidney until after pus and bacteria have been discovered in the urine.

\* Read before the Connecticut State Medical Society at Yale University, September 23, 1925.



patients just mentioned, they are sometimes met with as episodes in other disorders, notably in schizophrenia and in organic psychoses like dementia paralytica, great care should therefore be taken to make a thorough study of each case before deciding upon its nosological position and relationships.

Time will not permit of further discussion of disorders of affectivity. I shall therefore only refer without comment to the *pathological irritability* met with in manics, in epileptics, in paralytics and in imbeciles, to the *apathy*, the *negativism* and the *affective ambivalence* so often observed in schizophrenics, and to the *affective defects and perversions* encountered in psychoneurotics, in psychopathic personalities, in juvenile offenders, in delinquents and in criminals.

### THE CONATIVE FUNCTIONS AND MEDICAL DIAGNOSIS

#### (The Functions of Striving)

Thus far I have dealt chiefly with two main psychic functions, "thinking" and "feeling"—that is to say with the cognitive and affective activities, it is now time to refer, if but briefly, to the third main psychic function, "striving"—that is to say, to the *conative* functions. Here we have to deal with the relations of human volition (or "will") and human action ("behavior") to medical diagnosis, in other words, in how far can a study of a man's *decisions* and of a man's *conduct* be useful in evaluating adequacy and inadequacy of responsivity, which we have agreed to regard as criteria of healthy and of diseased or anomalous states?

Normal human organisms strive to attain certain goals. Among their aims are self-preservation, race continuation, the acquisition and dissemination of knowledge, social intercourse with their fellows, the creation and the appreciation of beauty, and "right" conduct. They have the "will to live," "the will to power," the "will to co-habit," the "will to work," the "will to play," the "will to associate," and still other "wills." Nutritive impulses, activity impulses, sexual impulses, social impulses, aesthetic impulses and ethical impulses are present in all healthy persons. In a theoretically normal life, a life of adequate responsivity, all of these strivings would be represented in a balanced way. In actual life this ideal is rarely, if ever, closely approximated. And among our patients we meet with the most diverse deviations from normally balanced strivings, we encounter manifold defects, exaggerations, and perversions of those strivings. Even in healthy persons the existence of multiple impulses necessitates what we call "choice", when one impulse is favored, others must, temporarily, be suppressed.

"Choice" or "decision" involves the whole personality, though it depends chiefly upon the existing state of affectivity, an action appears when

one or another impulse has attained to domination. As Bleuler says, "We do what we wish because we wish what we do." And our doing and our wishing appear to be the functional resultants of the interaction of our inherited equipment with a long series of influences (substances and forces) in our environment. If this view be correct, two corollaries are obvious: (1) fully to understand the behavior of a human being one would require a complete knowledge of his heredity and of his environment and of the interactions between the two, and (2) a knowledge of the behavior of a human being should throw light upon the structure and functions of his body and mind and should give clues to the recognition of the inheritance factors and of the environmental influences upon which structure and function depend. Obviously, then, the study of the conative functions (the wishes, the decisions, and the acts) of patients and of their conditionings must be of great importance for the higher forms of medical diagnosis. That is why internists and neuropsychiatrists, especially, lay such great stress upon the *anamnesis* and inquire fully into *hereditary predispositions* and prenatal and postnatal *environmental situations*. Dietary experiences, sexual experiences, education, economic struggles, work and recreation, aesthetic experiences, ethical attitudes, mental conflicts—all may be of importance. And the history of the behavior of the person through all these experiences together with his behavior when under the physician's observation will, taken with the facts in the family history, yield the data upon which medical judgment regarding the "springs" of behavior must be based.

The science of human behavior is as yet but in its beginnings, but modern neurology and psychiatry are making valiant contributions to it. The study of the decisions and of the acts of psychoneurotics, of psychotics, of delinquents and of criminals has not only been of great help in the medical diagnosis of abnormal mental states but has already thrown much light upon the psychological processes of healthy people. No physician familiar with the motor aphasia and apraxias of organic brain diseases, the indecision of psychasthenics, the conative conflicts of psychoneurotics, the facilitated conduct of manics, the inhibited behavior of melancholics, the stereotyped movements and attitudes, the command-automatisms, the grimaces and the mannerisms of schizophrenics, the sex-perversions and other behavior-anomalies of psychopathic personalities, the restricted aims and achievements of oligophrenics, and the anti-social acts of criminals and delinquents will be likely to deny the significance of studies of the conative functions for the understanding of the patients with whose welfare he is entrusted. Such studies are most valuable, too, because of their influence on the physician's own "total view of life", for who



more than the practitioner of medicine needs to be tolerant of the vagaries of human behavior, or to possess the insight that will enable him to understand and to explain the weak or the perverse "will"?

If your patience were not already exhausted, I should be tempted to discuss certain *disturbances of the personality as a whole* (e.g., alternating personality, splittings of the personality disintegration of the personality and depersonalization) as well as certain *disturbances of the consciousness as a whole* (e.g., sleep disorders, hypnosis, comas, tupor, twilight states and deliria) and their relations to medical diagnosis. But I forbear

I hope that the matters already presented may suffice to convince practitioners of the importance of investigating psychical as well as physical factors in their patients when they wish to make comprehensive diagnostic studies. May the time soon come when medical schools will pay more attention to psychology and psychiatry, as was urged by Dr. Matzinger at your meeting last year! And may I express the hope, also, that more physicians will combine with interested laymen in forwarding campaigns of Mental Hygiene in the communities in which they live. Such campaigns are fully as important as many other preventive measures for the promotion of the health and the welfare of our people.

## INFECTIONS OF THE URINARY TRACT IN CHILDREN \*

By HENRY G. BUGBEE, M.D.

NEW YORK CITY

IN the Second Edition of Holt's "Textbook on Pediatrics" (Published in 1902), he states that infections of the urinary tract in children consist of cystitis, pyelitis or pyelocystitis, the latter often associated with a nephritis, that they are found largely in female children, the colon bacillus being the offending organism, gaining entrance to the urethra from napkins soiled with feces coming in contact with the vulva with an ascending infection of the urethra, bladder, and, possibly, along the ureter to the kidney. Primary kidney infections are mentioned as an accompaniment of certain infectious diseases or caused by the irritation of renal calculi or associated with tuberculosis or tumors. He states that occasional infections in boys may bring up the question of the possibility of a blood infection or direct extension from intestines to the bladder. Holt further says that these infections often accompany diarrheal diseases.

Since that time, infections of the urinary tract in children have been regarded on this basis by the majority of pediatricians.

During the past five years, however, attention has been focused on these conditions and more accurate observations made through study by urologists and by the combined observations of urologists and pediatricians. Scientific investigations have been carried out by both specialists and the consensus of opinion, at the present time, is that the urinary tract in infants and children is subject to the same type of infections as in adults and that the mode of infection is probably the same.

There are apparently two general types of infections in children, namely, those without urinary stasis and those in which a definite lesion is

present which interferes with complete drainage. In the first type of infection, the organism most often found is the colon bacillus which has been produced in large numbers in the intestinal tract due to some intestinal disturbance, and which is supplied to the kidneys through the blood stream.

It is not my purpose to enter into an elaborate discussion of the theories advanced for the particular route of infection, but clinical and experimental data point overwhelmingly to this mode of infection in children which is unquestionably true in adults. My own observations, as well as those of most other urologists, would suggest that these lesions in children are quite similar to those in adults.

Holt noted the absence of acute vaginitis in female children who were supposed to be infected from the outside, and I have noted in the majority of children very little distress referable to the urethra. Furthermore with the subsidence of the kidney infection, treatment is seldom necessary to clear up the lower urinary tract.

Coccus infections are most often secondary to focal infections somewhere in the body—the tonsils often being primarily the focus.

The lesions found in both colon bacillus and coccus infections of the kidney point to the theory that the infections are a pyelonephritis rather than a true pyelitis.

Helmholz has shown in his experiments that the kidney seldom, if ever, filters through bacteria without some change taking place in the kidney parenchyma.

The milder types of kidney infection, due to the colon bacillus, may cause comparatively little systemic reaction, few of the symptoms being associated with the kidney until after pus and bacteria have been discovered in the urine.

\* Read before the Connecticut State Medical Society at Yale University, September 23, 1925.

These infections, as a rule, clear up readily, are treated by the family physician or pediatrician, and are seldom seen by the urologist.

The acute infections of the kidney, that I have seen in consultation with pediatricians have been of the severe type, the children often being critically ill with a temperature up to 105, rapid pulse, often vomiting, abdominal distension, etc. A large percentage of children with this type of infection that I have seen have been suffering from an intestinal disorder. Often when these children were first seen the urine was clear. Attention may have been fixed upon the kidney by localized tenderness. These cases often clear up readily after a thorough clearing out of the intestinal tract with colonic irrigations and a flushing of the kidneys.

In this regard, water is the most important drug and should be given in as large quantities as the child can take. Early in the infection, alkalis seem to be beneficial by stimulating the kidney activity and by changing the reaction of the urine, thereby possibly inhibiting the growth of the colon bacilli.

If the temperature and local signs do not disappear readily, there is no contra-indication to cystoscopic investigation of the urinary tract. At the present time with the instruments that are made especially for children, it is quite as possible after dilating the urethra, to pass a cystoscope into the bladder of a child as of an adult. Pediatricians are often loathe to have these small patients cystoscoped until they have seen that it is possible to carry out this manipulation without damage to the urethra or without severe reaction, but it has been my experience of late that I have been the one to hold out on the manipulation until other methods of treatment have been tried.

After the cystoscope has been introduced into bladder, it is no more difficult to investigate the bladder and catheterize the ureters in a child than in an adult.

In severe acute infections, even in the absence of an obstruction in the ureter, the passing of a ureteral catheter and irrigation of one or both kidney pelves may establish drainage from the kidney tubules and the symptoms subside almost immediately. I have, on a number of occasions, left a ureteral catheter in a child from three to eight days and irrigated the kidney several times a day.

In one child of ten, entering the hospital with a temperature of 106, and with a question of diagnosis of acute pyelonephritis or acute appendicitis, this treatment resulted in an immediate disappearance of all of her symptoms. At the end of eight days, her urine was entirely clear.

When the kidneys are acting freely, it may be well to change the reaction of the urine to acid by stopping the administration of alkalis, sub-

stituting benzoic acid if necessary, and then giving Urotropin. Methylene blue is often useful as it does not cause congestion of the renal tubules, and has a slight inhibitory effect upon the colon bacilli. Hexylresorcinol is still in the experimental stage.

In coccus infections of the kidney, the parenchyma is always involved and often minute abscesses are found throughout the kidney tissue.

In a case observed during the past six months a child of two and a half years entered the hospital with a temperature of 105.2. There was pus in the urine and both kidneys could be palpated, the right being distinctly enlarged and tender. Over a period of ten days I made a cystoscopic examination on three occasions and found small plugs of pus in the urine from the right kidney and the culture showed streptococci. There were a few pus cells in the urine from the left kidney. With each irrigation of the right kidney pelvis, the temperature dropped to a lower level. The physicians in attendance felt that the child was losing ground, and should be operated. At operation the kidney was found enlarged and engorged. The capsule was removed and numerous minute abscesses were found in the kidney parenchyma. These small abscesses were curetted, the kidney was drained and the child recovered.

I have always felt that this child would have done quite as well without the operation. The demonstration of the lesion was interesting, but at the most only an increase of circulation was obtained.

I have not been able to demonstrate cases of colon bacillus infection of the lower urinary tract in children without an infection of one or both kidneys. There are reports of several instances in children in which cultures from the kidneys were negative, while those from the bladder were positive. This has been found in adults.

Often times the kidney specimen is obtained too dilute and in too small a quantity to give a positive culture, while the larger quantity of bladder urine, which is more concentrated, would give a positive culture. If these tests are repeated, however, it is often possible to obtain positive cultures from the kidneys or the kidney infection may have cleared up and the secondary infection of the lower tract persisted.

While the vast majority of acute infections of the urinary tract in children will clear up under medication and general systemic treatment, especially when the gastro-intestinal tract is taken into consideration at the same time, very severe infections that do not clear up at once should have special investigation by means of cystoscopic methods, also, chronic infections that do not clear up through systemic means should be investigated in the same manner. Many of the

latter type of cases that I have seen in consultation have presented a real lesion of the urinary tract which would have made it impossible for the patient to recover under the ordinary methods of treatment

I have done a nephrectomy in several cases of unilateral kidney infection which would not clear up even though drainage from the kidney was entirely satisfactory. These kidneys have invariably shown multiple minute abscesses throughout the parenchyma.

The two most important factors entering into the etiology of infections of the urinary tract are: First, a supply of bacteria to the kidney, and, second, an interference with proper drainage.

In persistent infections of the urinary tract in infants, I have found a lesion which has interfered with drainage so often present, that I cannot speak too emphatically of the wisdom of proper investigation in these cases. The instance of these lesions stimulated me to investigate post-mortem specimens and in conjunction with Dr. Woolstein, Pathologist of the Babies Hospital in New York, we reviewed 4,903 necropsies and found 117 anomalies of the urinary tract, 101 of these infants dying under one year of age. In almost every instance these anomalies had interfered with proper urinary drainage and bacteria which might otherwise have been eliminated without causing symptoms had caused an infection when aided by urinary stasis. These lesions consisted of phimosis, stricture of the urethra, valve formations of the mucous membrane of the urethra and of the mucous membrane of the bladder, producing a flap which

dropped over the vesical orifice or over a ureteral orifice, congenital hypertrophy of the verumontanum, spina-bifida occulta, causing interference with the proper expulsion of urine from the bladder, diverticula of the bladder, strictures and anomalies of the ureter, calculi in the pelvis of the kidney or in the ureter, cystic degeneration of the kidney, redundancy of kidney substance, horseshoe kidneys, rudimentary kidneys, and congenital absence of a kidney, fusion of the kidneys, displacement of one or both kidneys.

A lesion was found in 2½% of all autopsies which gives some idea of the frequency with which anomalies are present. Obviously an infection superimposed upon such a condition would not clear up by ordinary methods of treatment. Only the most careful study of the child and probably only by surgery would it be possible to relieve the condition.

My particular message, therefore, is to impress upon you the fact that the urinary tract in children is subject to the same lesions and pathological processes as in adults, and that in treating obscure abdominal conditions, the possibility of an infection of the urinary tract must be born in mind, that a complete examination of the urinary tract is quite as possible in children as in adults, and that a sterile specimen of urine should always be obtained (which means catheterization in the female child), that the persistence of pyuria, hematuria or abdominal pain should be an indication for such an examination, and only by such means may it be possible to clear up the condition.

## THE INFLUENCE OF SEX UPON THE CONSTITUTIONAL FACTOR IN DISEASE\*

By GEORGE DRAPER, M.D.

NEW YORK CITY

From the Department of the Practice of Medicine, Presbyterian Hospital and Columbia University, New York City

**T**HROUGHOUT the course of investigations at the Constitution Clinic of the Presbyterian Hospital our attention has been drawn increasingly to the influence of sex as a factor in determining individual constitution or total personality. Reference was made to this problem in a previous report,<sup>1</sup> and the purpose of this essay is to develop the subject still further. Ordinarily, one's conception of sex is in terms either of the phenomenon of reproduction or of the psychological confusions which arise from the interplay of the emotions of men and women. The particular aspects of the matter which here concern us are

related more directly to the general biology of sex, and their discussion expresses an effort to draw from clinical medicine some light to help in the exploration of this still obscure portion of the natural history of life.

It has long been known that though sex is almost universally found it does not seem to be a necessary attribute of living things. This is true of many of the lower animal forms, as well as of plants. When sex does appear in the ascending scale of living organisms, it presents the most amazing and varied forms of expression. Parthenogenesis alternating with fertilization in the same species, asexual and sexual cycles, females with actual inclusions of the male elements in her tissues or parasitic upon them, organisms starting

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse, May 12, 1925.

out as one sex which then in the course of growth change to the opposite sex and back again, these are some of the curious mechanisms of reproduction which biologists have shown to exist. But, besides the matter of reproductive mechanism, there remain to be explained the remarkable conditions of hermaphroditism (an organism possessing the gonads of both sexes), pseudo-hermaphroditism (an organism possessing parts of the sex apparatus of both sexes), gynandro-morphism (an organism exhibiting body characters of both sexes, either half and half or in elaborate mosaïque), and the whole question of the secondary sex characters. These last are not limited to the physical habitus, but find equally definite expression in the three other panels of personality (physiology, psychology and possibly also, immunity).

Beyond these phenomena of sex one finds still more complex fields of transmission of characters through what is called the sex linked or sex limited mechanism. Morgan,<sup>2</sup> Davenport,<sup>3</sup> Pearl<sup>4</sup> and many others have written extensively on this subject and described many characters, including disease susceptibilities, which are inherited through the devious paths of sex linkage. Furthermore, the whole question of the determination of sex is an important part of the problem and has been extensively discussed by Doncaster,<sup>5</sup> Wilson,<sup>6</sup> Conklin,<sup>7</sup> Winnwater<sup>8</sup> and others. Then after sex has been determined, the degree to which it differentiates introduces still another factor of importance to clinical medicine. In addition to hereditary forces which influence differentiation, it has been shown that environmental conditions which change the metabolic rate in the embryo,<sup>9</sup> or hormone effects may limit differentiation. Indeed, Lillie<sup>10</sup> believes that the determination of sex is not an "irreversible predestination, but "a quantitative overbalance in the direction of one sex or another" which may be subsequently changed. Notwithstanding the effect of environment, however, the evidence seems to be strong that sex is an inherited character.

Ordinarily, in the higher forms at least, we associate sex entirely with the gonads. From this standpoint testicle and ovary epitomize the sex difference and their hormones determine the form and extent of the secondary sex characters. But there seems to be some evidence that sex may be something more than the presence of a gonad. Steche,<sup>11</sup> for example, has shown in moths by precipitin tests that the bloods of males and females of the same species differ as much as do the bloods of individuals of the same sex of different species. Furthermore, the complete association of gonads and secondary sex characters is not fully established in all forms. It is true that in the vertebrates, Steinach<sup>12</sup> and others have shown by castration and transplantation experiments that the gonads definitely influence second-

ary sex characters. But on the other hand Meisenheimer and Roper<sup>13</sup> have demonstrated that in insects the secondary sex characters are entirely independent of the presence of the sex glands.

In connection with castration experiments, it is interesting to observe that in all species among vertebrates removal of the gonads produces far more extensive effects upon the male than upon the female. Furthermore, the castrated male takes on characters which in many respects are similar to the female. The obvious inference from these facts is that the female is less widely differentiated from the neuter or species type than is the male. This inference is given support by the single case of a true neuter (lacking any gonad tissue) described by Pollard<sup>14</sup>. The individual possessed feminized habitus, sedentary tastes and the rather feeble personality commonly found in male castrates. Laurent,<sup>15</sup> in his book "Les Bisexuels," advances the thought that femaleness is the expression of an arrested species type.

The observations of Jordan<sup>16</sup> on hermaphroditism are interesting in this connection. He believes that the human embryo is originally potentially hermaphroditic and that the definite sex of an individual results from inhibition and, later, suppression of the opposite sex primordium. Just as types of metabolism underlying various characters and activities of the organism become represented in germ cells by parts of chromosomes, so grades of metabolism determining male or female sex are likewise represented. When the metabolism is of the male determining grade, the primordial germ cells differentiate into sperm, when the rate is of female determining grade, ova differentiate from the primordium. This conception receives considerable support from the now well-known fact that the basal metabolic rate at all ages is 2 per cent to 4 per cent higher for males than for females. Furthermore, the probable relationship of different metabolism rates to the sexes is strongly suggested in an ancient observation of biologists which Doncaster<sup>17</sup> reflects in the statement that the egg is large, quiescent and stores up energy. The sperm, on the other hand, is small, actively motile and spends energy. These differences are, in general, characteristic of the sexes in almost all species. Geddes and Thompson<sup>18</sup> have expressed the same thought by saying that femaleness is correlated with preponderant anabolism, maleness with preponderant katabolism.

Obviously, if this increased metabolic rate is a characteristic of maleness, it must be effective very early in the life of the organism. For there seems to be little doubt that sex is established perhaps at the first cell division, if not earlier, in either egg or sperm. Now if sex is thus early established, what happens at puberty? Clinical

experience surely indicates that disease propensities are rearranged at the time of that episode. Is there a change, or merely an intensification of the sex quality throughout, or is there simply a completing of sex by the addition of sperm discharge and ovulation? And at the climacteric, is there a loss of each differential sex quality with a convergence again upon the basic species type?

### CLINICAL SECTION

From these introductory remarks on the biology of sex, we may turn our attention to certain clinical observations which are not without interest in this connection.

In the first place, a study of vital statistics shows clearly that from the start the battle of life goes harder with the male than with the female. Thus the disproportionate chance of survival for males at different periods from fertilization up till the end of the first year<sup>15</sup> is indicated by the following figures<sup>19</sup>

For every 100 female abortions there are 160 male.

For every 100 female still births there are 136 male.

For every 100 female living births there are 106 male.

At the end of the first year for 103 females living there are 100 males.

From then on the sex death rate curves run nearly parallel, with the male rate always slightly greater until the thirty-fifth year when the male rate runs ahead rapidly. For example, the percentage of male or female death rate by ages runs<sup>20</sup>

1 to 14 years	110.5
5 " 9 "	119
10 " 14 "	105.5
15 " 19 "	112.4
20 " 24 "	117.3
25 " 34 "	119.7
35 " 44 "	136.3

In an extensive study of this long-known fact of greater male mortality, Moebius<sup>21</sup> concluded that it depended upon the greater hazards of life to which males were exposed, including alcohol and venery. But a careful consideration of the distribution of disease according to its sex frequency leads one to question the soundness of Moebius' conclusion.

If one reads the paragraph on etiology for each disease in Osler's, or any other good text book of medicine, or, indeed, in the larger systems of medicine, one is struck with the cursory manner in which the bearing of sex on susceptibility is passed over. Furthermore, there are differences in the statements of various authors concerning the sex differences in susceptibility. However, from the text books, systems and census reports the following lists have been made out, showing such differences as are known to exist between the disease potentialities of the sexes.

### MALES

27 Diseases	Preponderance
Pneumonia	5 to 1
C S B Meningitis	Slight
Amoebic dysentery	15 to 1
Polio-myelitis	Slight +
Diabetes	3 to 2
Scurvy	Greatly +
Gastric Ulcer	4 or 5 to 1
Acute pancreatitis	Large majority
Bronchial asthma	More often
Sero fib pleurisy	48 to 1
Pernicious anemia	2 to 1
Lækæmia	More often
Hodgkins	More often
Hæmophilia	100% p
Angina pectoris	6 to 1
Addison's disease (muscle power)	More often
Bantus disease	More often
Alcoholism	6 to 1
Tabes	10 to 1
Paresis	Much more
Progress B Paral.	More often
Erbs dystrophy	More often
Syringomyelia	23 to 1
Cerebral Haem	Greatly +
Sciatica	Greatly +
Paralysis agitans	Greatly +
Pseudohermaph	10 to 1
(2,000 cases)	

### FEMALES

20 Diseases	Preponderance
Diphtheria	Slight +
Influenza	2 to 1
Whooping cough	1.25 to 1
Rheumatic fever	Consid. +
Tonsillitis	Slight +
Pellagra	Slight +
Obesity	Consid. +
Gall stones	3 or 5 to 1
Movable kidney	7 to 1
Chlorosis	100% p
Goitre (exophth)	6 or 8 to 1
Myxoedæmia	6 to 1
Hyperthyroidism	12.5 to 1
Acromegaly	More often
Multiple sclerosis	More often
Continued sclerosis	More often
Korsakoff's syndrome	7 to 1
Chorea	24 to 1
Purpura Haemorrhagica	4 or 5 to 1
Migraine	6 to 1
Raynaud's disease	15 to 1
Arthritis deformans (menopause)	44 to 1
Hysteria	7 to 1

Now it will be observed that diseases of rather different mechanisms appear in the two lists. Thus, males are more susceptible to most infections, especially pneumonia and pleurisy, pancreas and adrenal disease, vascular disease, muscular dystrophies, spinal cord tract disease and blood dyscrasias. With the exception, perhaps, of the infections, these are maladies involving all the mechanism for energy expenditure. Females, on the other hand, besides the interesting and unexplained greater susceptibility to whooping cough, influenza and rheumatic fever, show more susceptibility than the male to the endocrinopathies, diffuse cord lesions and functional nervous disorders, arthritis deformans, gall stones and obesity. In general, this group of diseases involves the protective and energy accumulating mechanisms.

It is also possible to re-group diseases in relation to sex influence in the following manner.

I Diseases in which difference of incidence depends on the greater exposure of the male to all the more hazardous environmental influences. Under this heading may be mentioned injuries, dust exposure diseases (t.b.), pneumonia, typhoid fever, dysentery and nephritis.

II Diseases in which difference of incidence is not so clearly due to greater hazard, for example, whooping cough and cancer, which are considerably more frequent in females, and polio-

out as one sex which then in the course of growth change to the opposite sex and back again, these are some of the curious mechanisms of reproduction which biologists have shown to exist. But, besides the matter of reproductive mechanism, there remain to be explained the remarkable conditions of hermaphroditism (an organism possessing the gonads of both sexes), pseudo-hermaphroditism (an organism possessing parts of the sex apparatus of both sexes), gynandro-morphism (an organism exhibiting body characters of both sexes, either half and half or in elaborate mosaïque), and the whole question of the secondary sex characters. These last are not limited to the physical habitus, but find equally definite expression in the three other panels of personality (physiology, psychology and possibly also, immunity)

Beyond these phenomena of sex one finds the still more complex field of transmission of characters through what is called the sex linked or sex limited mechanism. Morgan,<sup>2</sup> Davenport,<sup>3</sup> Pearl<sup>4</sup> and many others have written extensively on this subject and described many characters, including disease susceptibilities, which are inherited through the devious paths of sex linkage. Furthermore, the whole question of the determination of sex is an important part of the problem and has been extensively discussed by Doncaster,<sup>5</sup> Wilson,<sup>6</sup> Conklin,<sup>7</sup> Winnwater<sup>8</sup> and others. Then after sex has been determined, the degree to which it differentiates introduces still another factor of importance to clinical medicine. In addition to hereditary forces which influence differentiation, it has been shown that environmental conditions which change the metabolic rate in the embryo,<sup>9</sup> or hormone effects may limit differentiation. Indeed, Lillie<sup>10</sup> believes that the determination of sex is not an "irreversible predestination, but "a quantitative overbalance in the direction of one sex or another" which may be subsequently changed. Notwithstanding the effect of environment, however, the evidence seems to be strong that sex is an inherited character.

Ordinarily, in the higher forms at least, we associate sex entirely with the gonads. From this standpoint testicle and ovary epitomize the sex difference and their hormones determine the form and extent of the secondary sex characters. But there seems to be some evidence that sex may be something more than the presence of a gonad. Steche,<sup>11</sup> for example, has shown in moths by precipitin tests that the bloods of males and females of the same species differ as much as do the bloods of individuals of the same sex of different species. Furthermore, the complete association of gonads and secondary sex characters is not fully established in all forms. It is true that in the vertebrates, Steinach<sup>12</sup> and others have shown by castration and transplantation experiments that the gonads definitely influence second-

ary sex characters. But on the other hand Meisenheimer and Roper<sup>13</sup> have demonstrated that in insects the secondary sex characters are entirely independent of the presence of the sex glands.

In connection with castration experiments, it is interesting to observe that in all species among vertebrates removal of the gonads produces far more extensive effects upon the male than upon the female. Furthermore, the castrated male takes on characters which in many respects are similar to the female. The obvious inference from these facts is that the female is less widely differentiated from the neuter or species type than is the male. This inference is given support by the single case of a true neuter (lacking any gonad tissue) described by Pollailon.<sup>14</sup> The individual possessed feminized habitus, sedentary tastes and the rather feeble personality commonly found in male castrates. Laurent,<sup>15</sup> in his book "Les Bisexues," advances the thought that femaleness is the expression of an arrested species type.

The observations of Jordan<sup>16</sup> on hermaphroditism are interesting in this connection. He believes that the human embryo is originally potentially hermaphroditic and that the definite sex of an individual results from inhibition and, later, suppression of the opposite sex primordium. Just as types of metabolism underlying various characters and activities of the organism become represented in germ cells by parts of chromosomes, so grades of metabolism determining male or female sex are likewise represented. When the metabolism is of the male determining grade, the primordial germ cells differentiate into sperm, when the rate is of female determining grade, ova differentiate from the primordium. This conception receives considerable support from the now well-known fact that the basal metabolic rate at all ages is 2 per cent to 4 per cent higher for males than for females. Furthermore, the probable relationship of different metabolism rates to the sexes is strongly suggested in an ancient observation of biologists which Doncaster<sup>17</sup> reflects in the statement that the egg is large, quiescent and stores up energy. The sperm, on the other hand, is small, actively motile and spends energy. These differences are, in general, characteristic of the sexes in almost all species. Geddes and Thompson<sup>18</sup> have expressed the same thought by saying that femaleness is correlated with preponderant anabolism, maleness with preponderant katabolism.

Obviously, if this increased metabolic rate is a characteristic of maleness, it must be effective very early in the life of the organism. For there seems to be little doubt that sex is established perhaps at the first cell division, if not earlier, in either egg or sperm. Now if sex is thus early established, what happens at puberty? Clinical

and type of pseudo-hermaphroditism, or the relationship which such individuals bear to the completed sexes and to the community. However, notwithstanding the extent and the excellence of the observations and descriptions given by these authors, there remains much to be explained about hermaphroditism and pseudo-hermaphroditism in human beings. But entirely outside this group of bi-sexual forms there are still to be found those individuals who, though possessing an adequate reproductive apparatus of one sex, display in certain subtle lines of body contour, facial or manual expression and turns of mind the secondary characters of the other. This type is, of course, best looked upon as analogous to the state of gynandromorphism earlier mentioned as found in birds and insects.

Now, when the distribution of disease between the sexes is considered, and when the morphology and psyche of patients are studied in relation to their diseases, one receives a strong impression that sex is a constitutional factor of fundamental importance in determining disease potentiality. Indeed, in certain diseases this selective susceptibility between the sexes is so definite that one is forced to look upon disease potentially as a secondary sex character, a co-ordinate of physical contour and psychic pattern. It was pointed out that in some of the lower orders, especially the insects, there was no association between the presence or absence of the gonads and the existence of secondary sex characters. But the existence of a very definite, if not causal, relationship of secondary sex characters and gonads in man, has long been known, and within the last decade thoroughly studied by Tandler and Grosz and their host of followers. The former believe that all secondary sex characters are primarily species characters which have been especially modified to hold particular relationship with the genital plan. Consequently, these authors feel that in studying any organ or character the point to be kept in mind is how much of this character expresses species and how much of it is a secondary sex modification.

Their experiments with castrated animals, and their observations on eunuchs and eunuchoids furthermore led them to the conclusion that the bodily and mental changes following castration in each sex do not indicate a change to characters of the opposite sex, but rather that each castrate converges to a common species type with similar characters. Castration, then, according to these authors, results in a prolonged state of unripeness. The epiphyses are held open and, consequently, long bone growth is not checked. Early castration in either sex thus has the dual effect of arresting development and differentiation, but of encouraging growth. The peculiarities exposed as the result of castration are, therefore, considered to be species characters. Now if the effects of low efficiency gonads, as found in

eunuchoids and so-called intermediate sex forms, are to be looked upon as the results of a sort of partial genetic castration, then such individuals of each sex tend toward a common or species type. Consequently, these persons should have the disease potentiality common to their species and not to their weakly indicated sex.

So far as it has been possible to analyze the material which has been collected at the Constitution Clinic it appears that there are three ways in which the sex factor enters in to the relationship between constitution and disease. In the first place, there is the situation wherein both sexes display diminished secondary sex characters and likewise present the eunuchoidal trunk extremity ratio. Thus, for example, both sexes in the pernicious anemia race have shown short trunks and long extremities, the so-called eunuchoidal habits. Their secondary sex characters furthermore have enhanced this picture of gonadal inferiority. But, as Tandler and Grosz have pointed out, this sex differentiation may actually disclose the basic species form common to both sexes. From this the thought arises that without the protection of a fully differentiated sex influence certain idiosyncrasies which carry a predisposition to easy blood destruction and poor hematopoiesis develop pernicious anemia.

The second manner in which the sex factor finds expression is in those diseases which are found much more frequently in one sex than another. Thus, for example, as has been mentioned, gall bladder disease is three or four times more common in women than in men. But in addition to this well-recognized fact, our studies have shown that the males who develop cholelithiasis clearly tend toward the fat avirile type, or may express the feministic trend in the psychic pattern. Furthermore, the male pelvis among gall bladder people is the widest of all males and females, except that of the pernicious anemia females. This pelvic largeness is reflected again in the high bi-iliac-biacromial index of the males of the gall bladder race. From these observations it would seem not unreasonable to suppose that the more completely differentiated individuals are toward maleness or femaleness, the less close should be their predispositions for those diseases in which the sex factor is a determining one. Possibly, when studies of all the panels of personality are completed and correlated it will be found that those individuals of one sex who succumb to a disease chiefly encountered in the opposite sex should exhibit signs of an incomplete differentiation toward their own sex.

The third way in which the sex factor may manifest itself is not as well defined as are the two preceding. Briefly, it appears that when the sex character differences are accounted for, there remain marked differences between the sexes in those morphologic characters which are criteria of species. These latter differences are most

myelitis which shows a definite affinity for the male

III Diseases in which difference of incidence suggests that the sex factor is a true constitutional influence in determining susceptibility

- Endocrine disturbances
- Chronic rheumatic osteo-arthritis, obesity
- Gall bladder disease, ulcer of the stomach, purpura hæmorrhagica
- Korsakoff's syndrome
- Congenital deformities

IV Genetic influences showing through sex linkage The following conditions reported by Laughlin,<sup>22</sup> Davenport<sup>23</sup> and others are dominant in males and recessive in females

- Coloboma
- Color blindness
- Night blindness
- Nystagmus
- Ichthyosis
- Multiple sclerosis
- Gower's muscular atrophy
- Hæmophilia
- Webbed toes

In the light of these observations and those discussed earlier in the paper, it may be of interest to attempt a somewhat more critical analysis of some of the diseases whose incidence differs among the two sexes

**Influenza** Females are affected slightly more often than males, but a significant thing about influenza in females is, on the one hand, its remarkable association with menstruation, and, on the other hand, its devastating effect upon woman during pregnancy

**Diabetes Mellitus** The frequency of diabetes mellitus is somewhat greater in males up to the age of 45, or until maleness begins to wane. From 45 years on females display greater numbers. This would suggest a susceptibility factor in femaleness. But if the two sexes converge after the climacteric toward a common species type, why should waning maleness result in greater resistance to the disease than waning femaleness? An answer to this question may be found in the theory which Emerson<sup>24</sup> has advanced that hard physical work is a protection. The muscular indolence of women, as well as their overfeeding after 45, is a well-known situation and may account for their greater susceptibility

**Gall Bladder** Male 942, female 2,478 per 100,000 of population. This is practically the reverse of the situation found in gastric and duodenal ulcer. While it might be possible to ascribe the far greater incidence among females to their habits of over-eating and insufficient exercise, there are certain reasons for believing that other factors are at work, for the males who develop gall bladder disease, especially cholelithiasis, present definite feminized trends in various

phases of their constitutional plan. Thus, in addition to an actual pelvis width, as well as a pelvic shoulder breadth index which is greater than that found in males of all other disease races, there are also feministic traits of gesture and psyche. Such males may be perfectly adequate sires, but none the less present definite gynandromorphic mosaics

**Congenital Malformations** It is interesting that all forms of congenital malformation are more common in males than in females. Is this because the female, being nearer the species types, is less highly differentiated? The thought obviously suggests itself that the male being more complex, is more subject to faults of development.

**Syphilis** It is exceedingly difficult to get reliable statistics for the relative syphilis rate in male and female, but there is a very general belief among physicians that the disease works less havoc in women than in men. Hutchinson's so-called law, which postulated the possibility of a healthy mother bearing a syphilitic child, bore evidence to the many cases of symptom-free syphilis in women. This tenet of Hutchinson has, of course, been practically exploded since the introduction of the Wassermann test. There is also a strong clinical impression that women develop central nervous system syphilis (paresis, locomotor ataxia, etc.), much less often than men. Statistics from State hospitals show that males develop the CNS nervous disorders about four times as often as women, but there are many more original male cases than female. Nevertheless, statistics from 88 state hospitals show that the death rate for males with general paresis was 74.7 per cent, while that for females was 68.4 per cent. Dr. Pollock's figures indicate that the annual death rate from paresis is 341 per 100 males under treatment, and 279 per 1,000 females under treatment.

**Alcoholism** Alcoholism is about six times more frequent among males than among females. But it is remarkable that over 70 per cent of the cases of Korsakoff's syndrome, occur in females.

**Grave's Disease** This disease is six or eight times more common in females than in males, but it is the experience of most observers, as well as my own, that males who develop the severer forms display marked gynandromorphism with noticeable emphasis of feministic traits.

It is well recognized that among human beings there are many examples of incompletely differentiated individuals of each sex. The laity, as well as physicians, are familiar with persons of one sex whose voice, facial expression, postures and mannerisms suggest the opposite. Laurent,<sup>25</sup> Neugebauer,<sup>26</sup> Carpenter,<sup>27</sup> Buzzacott,<sup>28</sup> Wymore<sup>29</sup> and many others have written extensively on the subject of the sex inter-grade or bi-sexual man. Most of these authors, however, have discussed the question of either form—the purely morphological aspect—the degree



of view is an arch, that is, it is a curved structure made up of an indefinite number of segments, and capable of preserving its integrity though supported only at its extremities. The upper edge of the septum is not only one of these segments, but it performs the important function of the keystone of the arch. Consequently, if this is destroyed, as by an abscess of the septum, or if it is displaced either by accidental traumatism or during the performance of the submucous operation, the arch becomes re-established on a lower plane and a saddle-back deformity results. The fact that the nose is a tent-like structure of skin and soft tissues supported by this arch of bone and cartilage must be kept constantly in mind by the surgeon.

It may be difficult, if not impossible, to reconstruct a nose where some of the segments *have been destroyed*, without the transplantation of bone and cartilage. In recent injuries, however, without the loss of framework, the fractured and displaced fragments may be re-assembled in their normal position and held there until union occurs by means of the bridge-plant, which was devised by me a number of years ago and with which you are all familiar. I have found that

it is of great value in these fresh dislocations and fracture cases, but contrary to my early expectations, its use is limited in the case of old fractures with deformity, for here, owing to the elasticity of the skin and the contraction of the scar-tissue, the original deformity is apt to recur after removal of the bridge-splint. In nearly all of these old fracture cases, the bony framework is there, but it is displaced, causing deformity and interference with function. Here much can be accomplished by the intra-nasal, subcutaneous transposition of tissue, a method devised, perfected and used with such remarkable success by the late Dr. John O. Roe of Rochester, whose work in this field has never yet been equalled. We note with no little amusement that some of the recent aspirants to the field of plastic surgery have consigned to the "lumber-pile" intra-nasal methods of correcting nasal deformities, this is as it should be, for intra-nasal surgery especially in this field, demands a finer technique than is at the command of the novice in rhinology. Furthermore, the correction of nasal deformities requires in the operator a certain modicum of artistic talent, a God-given attribute, distributed, not to all who are called, but only to those who



Old Traumatic Deformity, Corrected by Subcutaneous Methods and by Transplantation of Bone

marked in the group of nephritis and hypertension. Thus, among other things, the females of the nephritis people have relatively longer abdomens, lower pelvis, lower sternum, lower set umbilicus and relatively greater length of long bones than the male. It is as though the external agents clashed with the predispositions of males of one species and females of another to produce nephritis. If one could express it in terms of experimental animals, it would be like saying that the nephritis group was composed of maleairedale terriers and female St Bernards.

### CONCLUSIONS

I. The greater disease and death rate of the male cannot be wholly ascribed, as Moebius insists, to greater exposure of the male to physical work, alcohol and venery. There is most suggestive evidence of a selective resistance and susceptibility directly related to the tissue quality differences of maleness and femaleness.

II. It would seem that in bi-sexual organisms sex may not only serve the second law of nature, but may contribute also the first law by providing special adjustments to environment for the good of each sex.

III. The lack of sex differentiation from the basic or common species type results in a lack of resistance for those diseases to which the species type is peculiarly susceptible.

IV. Males of one subspecies may be susceptible to a disease to which the female of another subspecies is susceptible, but to which the reciprocal female and male are resistant. (Maleairedale terrier—female, St. Bernard).

V. Members of a sex who develop diseases more common to the opposite sex show characters of incomplete differentiation toward their own sex.

VI. Sex appears to be a fundamental quality of the tissue protoplasm and the susceptibility to certain diseases behaves in many cases like a secondary sex character.

### BIBLIOGRAPHY

- 1 Draper, George. Human Constitution, Philadelphia, 1924.
- 2 Morgan, T. H. Heredity and Sex. Col. University Press, N. Y., 1923.

- 3 Davenport, C. B. Inheritance in Poultry. Carnegie Inst., Wash., 1906, Pub 55.
- 4 Pearl, R., and Surface, F. M. *Arch. Entom. Mech.*, 1910, vol. XXX, p. 45.
- 5 Doncaster, L. *Journ. of Genetics*, 1914, vol. IV, p. 1. The Determination of Sex, Cambridge Univ. Press, 1914.
- 6 Wilson, E. B. The Cell in Development and Heredity, 3rd Edition. MacMillan Company, 1925.
- 7 Conklin, E. G. Heredity and Environment in the Development of Man. Princeton Univ. Press, 1923.
- 8 Von Wintharper, H. *Arch. de Biol.*, 1912, vol. XXVII, p. 91.
- 9 Stockard, C. R. and Papanicolaou, F. N. *Journ. Exp. Zool.*, 1918, vol. XXVI.
- 10 Lillie, F. R. *Journ. Exp. Zool.*, 1917, vol. XXIII.
- 11 Steche, O. *Zeitschr. für induct. Abstammung*, 1912, vol. II, p. 131.
- 12 Steinach, E. *Zentralbl. f. Physiol.*, 1913, vol. XXII, p. 3.
- 13 Meisenheimer, T. *Exp. Studien zur Soma n. Guschlechts Differenzierung*, Jena, 1909.
- 14 Polhailon. Quoted by Laurent.
- 15 Laurent, E. *Les Bisexuels*, Paris, 1894.
- 16 Jordan, H. E. *Am. Journal Anatomy*, 1922, vol. XXXI, p. 27.
- 17 Doncaster. *Loc. cit.*
- 18 Geddes, P., and Thompson, J. A. The Evolution of Sex, New York, 1901.
- 19 Pruzig, F. *Handbook Med. Stats.*, 1906.
- 20 Metropolitan Life Insurance Co. *Bulletin*, 1923, vol. IV, No. 5.
- 21 Moebius, P. J. *Bertrage, zur Lehre v. d. Guschlechtsunter-schieden*, Halle, 1907.
- 22 Loughlin. Eugenic Sterilization in U. S., Psychopath. Lab. of Municipal Court, 1912.
- 23 Davenport, C. B. Heredity in Relation to Eugenics, N. Y., 1911.
- 24 Emerson, H., and Larimore, L. D. *Arch. Int. Med.*, 1924, vol. XXXIV, p. 585.
- 25 Laurent, E. *Loc. cit.*
- 26 V. Neugebauer, F. L. *Hermaph. b. Menchen*, Leipzig, 1908.
- 28 and 29 Buzzacott, F. H., and Wymore, M. I. Bi-sexual Man or Evolution of Sexes, Chicago, 1912.
- 30 Draper, George. *Science*, 1925, vol. LXI, p. 525.

## CORRECTION OF NASAL DEFORMITIES\*

By WILLIAM WESLEY CARTER, A.M., M.D., F.A.C.S.

NEW YORK CITY

THE scientific correction of nasal deformities is based upon the developmental history of the organ and its histological structure. By scientific correction I mean the restoration of the nose to its normal status, from both a functional and cosmetic point of view by keeping in mind the laws of biology and using correct surgical methods. Permanent, satisfactory results can be secured in no other way and no reputable plastic surgeon should look upon his duties in any other light.

Aside from my own work on the Dynamics of Nasal Development and my reference to this

subject in some of my writings, I know of no surgeon who has paid any attention to the embryology and development of the nose in connection with the correction of deformities of this organ.

The external nose does not acquire its definite, individual form until after birth, and for sometime afterward marked changes occur, both intra- and extra-nasally. As a rule racial characteristics are delayed until after puberty, but the racial trend is often noted sometime before this epoch. In the white races the nasal bones are large and prominent, while in the yellow and dark races they are small and narrow, and are insignificant as segments of the nasal arch. The nose from both a mechanical and architectural point

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse, May 13, 1925.

these should be superficial, so as not to compress the vacular layer of the flap. When the flap is finally sutured down and the first step of the operation is completed, before putting on the bandage, one should assure himself that there is an adequate supply of blood down to the tip of the flap. If this is pale and no blood flows from its distal end when it is gently massaged, we may be sure that necrosis will occur if it is left to itself. As originally suggested by me, I have, in such an emergency, applied a leech to the extremity of the flap and have seen the erstwhile pale and bloodless tissue assume a healthy, pink hue as soon as this worm began to work, once the flow of blood is started, the flap is safe as far as nourishment is concerned. In these cases heat, applied by means of my hot-water

nasal jacket is of great value when the circulation in the flap is endangered. The prompt application of heat is of great benefit in fresh injuries to the nose, both accidental and operative, not only is the swelling limited, but contused and even macerated tissue may be saved if the normal remarkable resistance of the nasal tissues to traumatism is further favored by the use of this agent.

The application of my methods in the correction of nasal deformities is best demonstrated by the figures thrown upon the screen, so I will conclude by saying that in no department of surgery are satisfactory results more dependent upon the recognition of correct principles and the use of the proper technique than in the surgery of this particular field.

---

## Deaths

BELKNAP, EUGENE W., Syracuse, College of Physicians and Surgeons of New York, 1892, Fellow American Medical Association, Member State Society, Obstetrician University and Free Dispensary. Died November 21, 1925.

CRARY, GEORGE WALDO, New York City, College of Physicians and Surgeons of New York, 1885, Fellow American Medical Association, Member State Society, New York Academy of Medicine, Alumni Association Bellevue and Roosevelt Hospitals, Consulting Dermatologist Roosevelt, Memorial and Nursery and Childs Hospitals. Died November 16, 1925.

DRURY, BENJAMIN FRANKLIN, Gouverneur, University of Vermont, 1859, Member State Society. Died October 22, 1925.

FULLER, EARL D., Utica, Albany Medical College, 1878, Fellow American Medical Association, Member State Society, Physician St. Luke's Hospital. Died October 27, 1925.

GARNSEY, WILLIAM SMITH, Gloversville, New York Homeopathic Medical College, 1880, Member State Society. Died November 15, 1925.

GOULD, RICHARD J., Buffalo, Buffalo Medical College, 1898, Member State Society, Surgeon Deaconess Hospital, Associate Physician Millard Fillmore Hospital. Died November 16, 1925.

HUMPHREY, RAY HOLLY, Endicott, Albany Medical College, 1913, Fellow American Medical Association, Member State Society. Died October 11, 1925.

JAGER, PHILIP, New York City, New York Eclectic Medical College, 1899, Member State Society. Died November 16, 1925.

JEWETT, CHARLES SHERMAN, Buffalo, College of Physicians and Surgeons of New York, 1890, Fellow American Medical Association, Member State Society, Visiting Physician County Hospital, Consulting Physician City Hospital. Died November 5, 1925.

PALMER, ALBERT H., Marlboro, New York University, 1876, Fellow American Medical Association, Member State Society. Died October 26, 1925.

PAUL, WILLIAM KENDALL, Belmont, Cleveland, Ohio, 1884, Member State Society. Died September 5, 1925.

ST. JOHN, FRANCIS W., Weedsport, Albany Medical College, 1887, Fellow American Medical Association, Member State Society. Died October, 1925.

STUDDIFORD, WILLIAM EMORY, New York City, Bellevue Medical College, 1891, Fellow American Medical Association, Fellow American College of Surgeons, American Gynecological Society, Academy of Medicine, Member State Society, Alumni Association Bellevue Hospital, Director Sloane Hospital, Consulting Gynecologist Presbyterian Hospital, Consulting Obstetrician Nursery and Childs Hospital. Died November 17, 1925.

WOOD, LOUIS CURTIS, Poughkeepsie, Bellevue Medical College, 1881, Fellow American Medical Association, Member State Society. Died September 21, 1925.

are chosen. One may doubt the accuracy of this statement when he looks over the long list of men who have recently taken up this work. The majority of nasal deformities resulting from disarrangement or destruction of some of the segments of the arch can be corrected by intra-nasal methods, and this always is the route chosen by those skilled in this field, for no noticeable scar results, and if the correct technique is used infection is far less apt to occur, especially is this true if bone and cartilage are being transplanted, as in saddle-back deformities. My original operation, devised in 1909, was through an incision between the eye-brows, but for the above reasons and others, I abandoned it many years ago in favor of the intra-nasal route. In my bone and cartilage work I always use the autogenous graft from the rib. I prefer this to the shin-bone because a section of the rib is easily removed and shaped to suit the deformity, moreover this bone is richly supplied with nutrient foramina and has not the ivory-like texture of the tibia. I preserve the periosteum on the outer surface and then split the rib, using the outer periosteum-covered half and include more or less of the cancellous tissue, depending upon the thickness desired. If it is necessary for the transplant to extend into the tip of the nose, I remove the graft, as I originally suggested several ago, at the junction of the rib and costal cartilage, the lower  $\frac{1}{3}$  of the transplant consisting of cartilage and the upper  $\frac{2}{3}$  of bone. This preserves the resiliency of the nasal tip. If the tip of the nose has a tendency to droop, I place a supporting bone strut in the lower edge of the septum. In my early work, I used on several occasions bone grafts without periosteum, these showed little vitality and were useful chiefly as a framework for the growth of bone from the adjacent periosteum-covered bone with which it was placed in contact. Periosteum-covered transplants have inherent power of growth and should generally be used in this work. Under no circumstances should paraffin or any other foreign body be introduced into the living tissues.

I am frequently asked how early in life should nasal deformity operations be attempted. I may say here that this question would not be asked so often if skilled attention had been given at once to the injuries of the nose so common during childhood, for these are responsible for most of the cases of nasal obstruction and deformity that demand surgical attention at a time of life when we would prefer to avoid operative interference, while the developmental forces of Nature are so active. But these cases are with us, and something must be done to relieve the nasal obstruction and to rectify the distorted framework, so that the action of these forces will be directed along normal lines. In my opinion this should be done as early as possible, otherwise the distortion assumes the importance of a congenital

deformity which is always more difficult to cope with as age advances. The nature of the surgical interference in children must be decided upon in each individual case, for the indications vary. No tissue should be sacrificed if we can possibly avoid it. This refers especially to the septum, which, as I have previously pointed out, exerts such an important influence in determining the shape of the adult nose. All of the distorted parts must be placed in a normal position and held there by a suitable splint until union occurs. If it is absolutely necessary to use a transplant, autogenous bone must be chosen, as this is a living tissue and capable of growth after transplantation. I have cases that show that normal development proceeds where periosteum-covered bone is implanted in contact with live bone in the young.

Where there is extensive destruction of the soft tissues of the nose, it is necessary to use flaps. I have found that the skin of the forehead, pedicled at the inner angle of the orbit, serves the purpose best. It may be necessary to introduce a transplant of bone, but this should be done subsequently. I have found that there is no special advantage in implanting the bone sometime before the flap is cut, this had best be done after the flap has become established in its new position and its vascular connections are secure. In cutting flaps I am using a method which I introduced several years ago. First, a paper pattern is made of the defective area to be covered, then a duplicate of this in adhesive plaster is made an ample margin for flap contraction being allowed. This is placed over the area to be included in the flap, the pedicle corresponding to the main source of blood supply. This pattern does not slip, its edge is easily followed by the knife and great accuracy in the shape and size of the flap is secured. The primary treatment of a skin flap is a very important matter and lack of attention to this has caused many a well-performed operation to result in failure. The following precautions should be closely observed. The pedicle should be as broad as possible and should include the chief blood supply. The flap should always include the subcutaneous tissues, as these contain the blood vessels. The flap should not be bent upon itself at too acute an angle, and there should be no compression of the blood vessels, either by a bandage or by making it into a tube, as has been advised by some. I believe that the making of a flap into a tube constricts the blood vessels, even though the base be cut broad, for I have seen some of these tube flaps lost. Furthermore, there is no need for this novel procedure, for not only are the raw surfaces of a flap amply protected by a thick coating of vaseline, but it has been conclusively demonstrated that the integrity of the blood-vessels is preserved by this agent. In suturing down the flap, as few stitches as possible should be made and

nity. Human nature varies but little whether it be in the wilds or the urban community. The problems of congestion, infection and epidemic will always arise when people gather together in large communities. These are less often a source of worry to a man whose territory is vast.

Secretaries throughout the union were all keen in enlisting common support on the part of the medical fraternity for the establishment of better health standards. Again human nature is much the same. We find men who feel it their civic duty to get their fellow physicians together to support educational work, to establish clinics and to fulfill their destiny as their brother's keeper. There is another large group who feel that in doing their daily dozen, looking after the sick in their immediate community and following the usual monotony of a busy doctor they are fulfilling as great a requirement. Each group can hardly survive without the assistance of the other. At every conference there is a type which is peculiar to each state. There is present the man who is keenly alive to the needs of the profession and who is willing to make the sacrifices of better organizing his work and to give his brother physician from other states the benefit of this experience. In time this man is a certain source of reference for the other states who have not yet met the same problems.

There was a delightful feeling of fellowship at the Chicago conference. It was interesting to note that many states have different types of machinery to accomplish the same results. There must be some good reason for this else the form of procedure would be more uniform. The same man was practically doing the same work even though called by some other name.

Periodic health examinations came in for careful consideration. The proper solution of this problem must take time but in gathering various sources of information in conference the American Medical Association is doing yeoman service. They are seriously anxious to correlate data to date.

Dr John Jennings of Kings wrote an excellent paper representing the work that Kings has thus far done. Dr Bryan of Maine reported that they had been busy with the problem now for many years. Pennsylvania has done considerable along this line. It is difficult to standardize the record of physical examinations so as to satisfy each individual. Lay organizations and insurance com-

panies who are anxious to secure all available statistics require a wealth of material which a busy practitioner can hardly take the time to get. Irrespective of what type of record is decided on a beginning has to be made somewhere. A careful physical examination will not require so much a super knowledge of medicine as a careful and painstaking thoroughness in the way in which it is done.

The conference brought out the fact that the Medical profession have a real obligation in making proper physical examinations and being ready to make these when the lay persons shall spread the gospel among the laity.

It is well worth recording that the Publicity Department of the American Medical Association is extremely cautious as to the way any news is given out from headquarters. Great care is shown that no one but authorized individuals shall talk with the press and nothing but facts be given. The result is that the report in Chicago, printed following the conference, gave an excellent description of what actually took place.

Dr W D Haggard, President of the American Medical Association stressed keenly his interest in periodic health work. The medical profession will have to be careful that the lay advertising does not get so far ahead of them that they are unable to meet the situation when it is properly launched. An important point which has been so frequently stressed in our own JOURNAL and by other organizations doing this work, has been the need for taking proper time for a complete examination, emphasizing the fact that an examination to be thoroughly made requires removing the clothing so that the patient may get an accurate and painstaking examination, and assuming nothing but that we examine our patient thoroughly and carefully and follow abnormalities to their ultimate conclusion.

It was also stressed that preventive health work was distinctly an examination of the apparently well and that too much attention should not be laid upon the fact that every person who was examined had a definite pathology already developed,—in other words, that we are examining healthy people and not sick ones.

We can assure our fellow practitioners in the State of New York that when the physicians of the United States are gathered together in conference they represent a healthy group of sturdy men whose ideals and earnest efforts to benefit mankind are an inspiration.



# EDITORIALS



The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

Editor-in-Chief—ORRIN SAGE WIGHTMAN, M D,

New York

### COMMITTEE ON PUBLICATION

E ELIOT HARRIS, M D, *Chairman*

New York

WILLIAM H ROSS, M D

Brentwood

DANIEL S DOUGHERTY, M D

New York

Executive Editor—FRANK OVERTON, M D

Patchogue

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

President—NATHAN B VAN ETEN, M D

New York

First Vice President—WILLIAM H. ROSS, M D

Brentwood

Second Vice President—FREDERICK H. FLAHERTY, M D

Syracuse

Speaker—E ELIOT HARRIS, M D

New York

Vice Speaker—GEORGE M FISHER, M D

Utica

Secretary—DANIEL S DOUGHERTY, M D

New York

Assistant Secretary—HOWARD GILLESPIE MYERS, M D

New York

Treasurer—CHARLES GORDON HEYD, M D

New York

Assistant Treasurer—JAMES PEDERSEN, M D

New York

### CHAIRMAN, STANDING COMMITTEES

Arrangements—EDWARD R. CUNIFFE, M D

New York

Legislation—HENRY L K. SHAW, M D

Albany

Public Health and Medical Education,

CHARLES A. GORDON, M D, Brooklyn

Scientific Work—ANDREW MACFARLANE, M D

Albany

Medical Economics—WILLIAM WARREN BRITT, M D Tonawanda

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer) the ex President and the Councilors of the District Branches.

First District—JOHN A. CARD, M D

Poughkeepsie

Second District—JOSEPH S THOMAS, M D

Flushing

Third District—CHARLES P. McCABE, M D

Greenville

Fourth District—HORACE M. HICKS, M D

Amsterdam

Fifth District—NELSON O. BROOKS, M D

Oneida

Sixth District—GEORGE H. FOX, M D

Binghamton

Seventh District—WILLIAM I. DEAN, M D

Rochester

Eighth District—HARRY R. TRICK, M D

Buffalo

COUNSEL  
GEORGE W. WHITESIDE, Esq., 27 William St  
Telephone, Broad 1744

New York

ATTORNEY  
ROBERT OLIVER, Esq., 27 William St

New York

### EXECUTIVE OFFICER

JOSEPH S. LAWRENCE, M D

51 Chapel Street, Albany

### SECTION OFFICERS

Medicine  
Chairman—L. WHITTINGTON GORHAM, M D  
Secretary—WARDNER D. AYER, M D

Albany

Syracuse

Surgery  
Chairman—EDWARD S. VAN DUYN, M D  
Secretary—GEORGE E. BRILEY, M D

Syracuse

Albany

Obstetrics and Gynecology  
Chairman—ALFRED C. BECK, M D  
Secretary—NATHAN P. SEARS, M D

Brooklyn

Syracuse

Pediatrics  
Chairman—ROGER H. DENNETT, M D  
Vice Chairman—ARTHUR W. BENSON, M D  
Secretary—JOHN AIKMAN, M D

New York

Troy

Rochester

Eye, Ear, Nose and Throat  
Chairman—EUGENE E. HINMAN, M D  
Secretary—JAMES W. WHITE, M D

Albany

New York

Public Health, Hygiene and Sanitation  
Chairman—ARTHUR D. JACQUES, M D  
Secretary—LEO F. SCHIFF, M D

Lynbrook

Plattsburg

Neurology and Psychiatry  
Chairman—CLARENCE O. CHENKY, M D  
Secretary—THOMAS K. DAVIS, M D

Utica

New York

For a list of the Officers of the county medical societies, see October 15 JOURNAL, advertising page xviii.

For list of District Branch Officers, Standing Committees and Special Committees, see October 15 JOURNAL, advertising page third cover

## THE ANNUAL SECRETARIAL CONFERENCE AT CHICAGO

The American Medical Association has shown rare foresight in gathering the secretaries from various states of the union at Chicago for the annual conference. This year the dates of November 21st and 22nd were assigned for this work. The editors of the various State Association Journals were likewise included in the program. It takes an occasion of this sort to bring out the vast differences which exist in the various states of the union. One goes with an idea that standardization is the ideal but one comes away convinced that the highest type of organization is the one which meets the local needs of the individual most satisfactorily.

When the licensure for the practice of medicine was in its infancy the various State Boards of Examiners established different standards in order to enable a physician to practice. It has been the

endeavor of the Federal authorities to bring these standards up to a definite point of common efficiency. As the plan has worked out we are glad to note that there are better doctors throughout the whole United States due not only to higher requirements and classification of Medical schools but also to the fact that the State Board of Examiners throughout the union are more nearly alike in their high requirements.

It was interesting to hear a physician from Wyoming state that in a number of counties in that state there was no resident physician. To be sure much of this county territory might have been covered by mountain and valley and more or less unoccupied but the fact remains that the type of medicine he would have to practice in so vast a district would not have quite the same significance as a physician practicing in a large commu-

ordinate with that of the commanders of artillery and engineers, and he is consulted in every maneuver made by the army

A physician is as important in civic life as in the army. He belongs on the local Board of Education. He is learned in science as well as in medicine, and can judge of what is practical and what is visionary in the curriculum. The sanitation of the school buildings and grounds, the medical examination of the pupils, the services of the school nurse, and the physical trainer,—these are a few of the medical matters in which a physician can render essential service to the school.

A physician belongs on the Board of Directors of his local bank. Health, both physical and mental, is a vital factor in a borrower's credit, and sanitation enters into the value of real estate collateral for a loan. Healthfulness is a vital asset in values of property with which banks have to deal. A bank needs the services of a physician quite as much as those of a lawyer.

The church opens a door of honorable service to the physician. The doctor and the minister of the Gospel both deal with things which money

and fame cannot secure, and both promote the qualities of courage, steadfastness, faith, and uprightness which make life endurable and worth living.

A physician also belongs in politics,—not for the sake of selfish officeholding and of salary grabbing, but because of its opportunity for public service. Especially are doctors needed in legislative halls. Their presence is also needed at hearings before local boards, especially on matters pertaining to health. Physicians generally are beginning to realize their duties in the political field, and are carrying their activities much further than merely passing resolutions.

Is it wise that a family doctor should be active in the school, the bank, the church and politics? Will his participation in these activities interfere with his medical practice and his standing among his medical colleagues and the people generally? For an answer consider the civic activities and connections of the leaders in the Medical Society of the State of New York, the District Branches and the county societies. The same characteristics which influence them to give their services to medical societies also impel them to be leaders in civic affairs.

---

## BUILDING THE HEALTH STRUCTURE

A great Health Structure is in process of making by three groups of builders,—the practising physicians, the official departments of health, and the lay organizations engaged in health and social service. The building has gone up irregularly as a group has added here a watch tower and there a work room, and elsewhere an exhibition hall.

The common foundations of all parts of the Structure were formed generations ago with the enduring stones of science which belong to all who will quarry them. The ground floors were built and occupied by physicians who sometimes complained of being disturbed by the construction that others were undertaking above them. The official departments of health builded turrets from which they could observe the fields to which the physicians claimed the exclusive right. And then lay organizations began to build walls connecting the towers, and to construct windows and hallways, and to put in telephones so that all the occupants could visit and talk together, and work and live as a harmonious whole.

The Health Structure is not complete, and in all probability it never will be. Old parts will continually be torn down and new constructed, the building will always resound with the din of hammering, the passageways will often be blocked with old rubbish and new cement, and there will ever be some confusion and incon-

venience. But the building is taking shape, and physicians are moving up from the lower floors and are occupying rooms in the towers and the upper courses of the walls, and they are finding the apartments pleasing and the outlook alluring.

Each of the three groups of workmen who are building the Health Structure has held annual meetings to draw up plans for the year's work, and the outer doors of the assembly rooms have sometimes been closely tiled. But a more brotherly spirit of cooperation is now prevailing. The discussions in the annual meeting of the Medical Society of the State of New York are largely on public health and preventive medicine. The annual conference of health officers is addressed by eminent clinicians on ways of dealing with preventable diseases of adult Americans who worship the god of personal independence, and only last week practicing physicians formed a goodly percentage of those attending the annual conference of lay health workers under the leadership of the State Charities Aid Association and the Trustees of the Milbank Fund.

The outlines of the builded parts of the Health Structure already stand out clear and beautiful, and with them as a basis, the several groups of workmen are eagerly striving to execute the plans drawn on a common trestle board through the united wisdom of their grandmasters.

## LEGISLATORS AND PETITIONS

During the coming session of the Legislators the law makers will be deluged with petitions for and against proposed laws. The legislators are fully aware how the signatures are obtained and how slightly many of the signers are interested in the contents of the petition. Nevertheless the petitions have far more influence than may at first be suspected,—and here is how it comes about.

Every legislator reads his mail to at least the extent of finding out what his letters are about. He also looks carefully at the signatures to see that he does not overlook anybody of prominence.

The legislator looks at petitions in the same way. He glances at their contents and then scans carefully the names of the signers. If he finds the names of a few prominent persons whom he knows, he gives careful heed to their wishes. He knows that prominent business men, office holders, and even judges on the bench are prone to sign petitions without giving due thought to what they do, and yet he does not ignore their written desires.

Many legislators are swayed by the signatures of prominent persons who have no real interest in that for which they ask, but the legislator takes no chances. He remembers that the person of power has asked him to do something, and he is influenced by the request. The more conscientious a legislator is, the more likely is he to give heed to the petitions.

In one County the opponents of the Practice of Medicine Act got up a petition asking their legislative representative to support the legalization of a cult whose practitioners had almost no educational qualifications. The legislator found on it the names of a surrogate and a prominent bank president, and he said, "These men signed the petition, and there must be some virtue in what they seek."

The fact was that a prominent politician whose son-in-law was a practitioner of the cult, said to each signer, "Many unqualified persons are posing as healers, and this petition asks that all who practice the system shall be licensed in order to keep out the incompetent,"—and Mr. Prominent Person signed on the dotted line.

What can doctors do to counteract these petitions? Obviously, they too should get out petitions and have them signed by prominent persons, also get prominent persons to write personal letters to their legislators asking that all who practice the healing art should possess a single standard of educational qualification.

It is reasonable to expect that the physicians of New York State could each secure an average of one letter from a prominent person. That would make 1,600 letters or 80 to each legislator, and those would be no ordinary letters such as the legislators throw in the waste basket, they would be personal letters from prominent people whose opinions the legislators respect.

## THE PHYSICIAN IN CIVIC AFFAIRS

Dr. A. H. Palmer, of Marlboro, Ulster County, whose funeral was held on October 22nd, was held in high esteem by his fellow townsmen because he was "active in almost every important community movement," according to an appreciation of his life printed in the Marlboro Record. He was a leader in medical societies, a member of the Board of the Methodist Church, Vice-President of the Marlboro Bank, and "one of Marlboro's most beloved and loyal citizens." He was much more than a physician treating individuals. He gave his services to his community along those civic lines for which his training as a physician had fitted him.

The evolution of medicine has developed the principle of a physician's civic responsibility. Many conditions which a doctor treats are the result of social conditions,—of factory life, poor housing, polluted water supply, or uncontrolled cases of contagious disease. Shall a doctor say, "these conditions are beyond my control, and I will have nothing to do with them, but will stick strictly to my own business of treating the sick

who call me?" The time has gone by when a doctor can say that conscientiously. The people look to him for advice and leadership in educating the people regarding the dangers of such conditions as dirty milk, and arousing them to institute an efficient system of milk inspection.

Modern health and efficiency require that physicians shall take their proper place of leadership in all phases of civic affairs. It is theirs to lead in all health matters of a community, just as it is the duty of the minister of the Gospel to take the lead in morals, and of the civil engineer to lead in matters pertaining to good roads and bridges.

A physician has his place in every phase of civic life of a community. His position today is like that of a medical officer in the Army. A generation ago a physician was merely tolerated in the army, and he had no rank or authority. He had achieved rank with little authority at the outbreak of the World War. He emerged from the World War with both rank and authority, and now has an honored place on every staff co-



ordinate with that of the commanders of artillery and engineers, and he is consulted in every maneuver made by the army

A physician is as important in civic life as in the army. He belongs on the local Board of Education. He is learned in science as well as in medicine, and can judge of what is practical and what is visionary in the curriculum. The sanitation of the school buildings and grounds, the medical examination of the pupils, the services of the school nurse, and the physical trainer,—these are a few of the medical matters in which a physician can render essential service to the school.

A physician belongs on the Board of Directors of his local bank. Health, both physical and mental, is a vital factor in a borrower's credit, and sanitation enters into the value of real estate collateral for a loan. Healthfulness is a vital asset in values of property with which banks have to deal. A bank needs the services of a physician quite as much as those of a lawyer.

The church opens a door of honorable service to the physician. The doctor and the minister of the Gospel both deal with things which money

and fame cannot secure, and both promote the qualities of courage, steadfastness, faith, and uprightness which make life endurable and worth living.

A physician also belongs in politics,—not for the sake of selfish officeholding and of salary grabbing, but because of its opportunity for public service. Especially are doctors needed in legislative halls. Their presence is also needed at hearings before local boards, especially on matters pertaining to health. Physicians generally are beginning to realize their duties in the political field, and are carrying their activities much further than merely passing resolutions.

Is it wise that a family doctor should be active in the school, the bank, the church and politics? Will his participation in these activities interfere with his medical practice and his standing among his medical colleagues and the people generally? For an answer consider the civic activities and connections of the leaders in the Medical Society of the State of New York, the District Branches and the county societies. The same characteristics which influence them to give their services to medical societies also impel them to be leaders in civic affairs.

---

## BUILDING THE HEALTH STRUCTURE

A great Health Structure is in process of making by three groups of builders,—the practising physicians, the official departments of health, and the lay organizations engaged in health and social service. The building has gone up irregularly as a group has added here a watch tower and there a work room, and elsewhere an exhibition hall.

The common foundations of all parts of the Structure were formed generations ago with the enduring stones of science which belong to all who will quarry them. The ground floors were built and occupied by physicians who sometimes complained of being disturbed by the construction that others were undertaking above them. The official departments of health builded turrets from which they could observe the fields to which the physicians claimed the exclusive right. And then lay organizations began to build walls connecting the towers, and to construct windows and hallways, and to put in telephones so that all the occupants could visit and talk together, and work and live as a harmonious whole.

The Health Structure is not complete, and in all probability it never will be. Old parts will continually be torn down and new constructed, the building will always resound with the din of hammering, the passageways will often be blocked with old rubbish and new cement, and there will ever be some confusion and incon-

venience. But the building is taking shape, and physicians are moving up from the lower floors and are occupying rooms in the towers and the upper courses of the walls and they are finding the apartments pleasing and the outlook alluring.

Each of the three groups of workmen who are building the Health Structure has held annual meetings to draw up plans for the year's work, and the outer doors of the assembly rooms have sometimes been closely tiled. But a more brotherly spirit of cooperation is now prevailing. The discussions in the annual meeting of the Medical Society of the State of New York are largely on public health and preventive medicine. The annual conference of health officers is addressed by eminent clinicians on ways of dealing with preventable diseases of adult Americans who worship the god of personal independence, and only last week practicing physicians formed a goodly percentage of those attending the annual conference of lay health workers under the leadership of the State Charities Aid Association and the Trustees of the Milbank Fund.

The outlines of the builded parts of the Health Structure already stand out clear and beautiful, and with them as a basis, the several groups of workmen are eagerly striving to execute the plans drawn on a common trestle board through the united wisdom of their grandmasters.



# MEDICAL PROGRESS



**Human Intestinal Parasites as a Cancer Inciting Factor**—Willy Meyer (*American Journal of the Medical Sciences*, October, 1925, clxx, 4), as a result of an intensive study of the literature of cancer, emphasizes the utter improbability of the existence of a specific causative cancer micro-organism. Continued study of the literature has deepened that conviction, but has not discouraged the author from trying to gain an insight into the genesis of the disease. He discusses the relation of ova, larvae and worms to cancer incitement, having selected them for special consideration, not so much because of the interest attaching to them *per se*, but rather as representatives of all the multifarious factors known to have set in motion, in one instance or another, a train of events which terminated in the cancerous tumor. Summarizing his survey of the question with reference to ova, he says that precancerous lesions, that is to say, nonhealing superficial ulcerations, are produced by the spiked ova of the *Bilharzia* parasites in the bladder, the bowels, the rectum, and the genital tract. But even ova having a smooth surface may become contributory factors in the production of precancerous lesions, as, for example, when liver flukes and ascaris worms deposit ova in the gall-bladder, in the bile ducts, or in the ducts of the pancreas. The lesions due to the migration of larvae in the system, the author says, appear neither sufficiently severe nor sufficiently lasting to produce a precancerous condition, although, when there are frequently repeated massive larval invasions through the skin, as in the case of the hookworm or of schistosoma, or in cases of massive auto-infection (tapeworm), the migration of the larvae may cause lesions having cancerous potentialities. In contradistinction to migrating larvae, encapsulated larvae are commonly found capable of becoming the inciting factors of precancerous conditions. It is possible that the toxins emanating from encapsulated larvae may likewise be cancer-inciting factors. Dead adult liver flukes, enclosed with their ova and with cellular detritus in nodules of the biliary system or in the pancreas, also adult ascaris worms that have invaded the ducts of these organs, may possibly by the combination of mechanical pressure, foreign body irritation, and toxins produce therein a precancerous state. But cancer-inciting factors, while capable of initiating a so-called precancerous state, evidently do not govern the behavior of the tissue during this state, for the appearances in the tissue arousing suspicion may be aggravated, may become stationary, or may recede after the initiatory irritation has ceased to exist.

**The Results of Operative Treatment of Malignant Disease of the Breast.**—H P Winsbury White (*Practitioner*, October, 1925, cxv, 4) has followed up patients operated upon between 1900 and 1913, and has succeeded in obtaining the desired information in 92 cases. In studying the cases in which death occurred within three years of the operation for signs making a bad prognosis a certainty, one or other of the following signs was found in every instance: (1) Fixation of the growth to the pectoral fascia or muscle, (2) fixation of the growth to the overlying skin, (3) palpable axillary glands, (4) microscopical evidence of growth in the axillary glands. A study of the patients who survived for more than ten years showed that, with one exception, the same rule held good. There is no doubt that fixation of the growth to the deeper structures is a physical sign which almost assures a bad prognosis in cases which may otherwise be considered operable. The microscopical demonstration of the carcinoma in the glands does not render the outlook anything like so grave as might at times be supposed. With regard to fixation of the growth to the skin, and the mere palpable enlargement of the glands, many of the long survival cases had both of these signs present, so that in the absence of the unfavorable indications previously mentioned, these must not be looked upon as making the outlook more serious, unless clinically there are manifestations that the glands are undoubtedly carcinomatous. The author concludes that in operable cases, while recognizing certain features as making a bad prognosis a matter of certainty in some cases, and as highly probable in others, the outlook is always a matter of conjecture, in spite of the most radical operations.

**The Toxic Effects of Lead**—W Blair Bell, W R Williams and L Cunningham (*Lancet*, Oct 17, 1925, ccx, 5329) have observed the toxic effects in the human subject of measured quantities of lead administered intravenously at known intervals, some 200 patients in all having received injections. The lead was given to inhibit the growth of cancer cells, in carrying out Bell's method of the non-operative treatment of malignant growths, hence the accuracy of these observations which makes them important in any consideration of lead poisoning. The changes in the red blood cells consist in a punctate basophilia which may appear within a few hours of the initial dose, anemia with its accompanying polychromasia, anisocytosis and poikilocytosis occur later, and may be only temporary or, if bone marrow be involved, may persist. Leucocytosis has frequently been observed, especially shortly

after an intravenous administration of lead, leucopenia occurs occasionally, but neither of these phenomena appears to be constant. A slight relative lymphocytosis may occur, but this is not generally marked. There is a definite increase in the number of granular forms of leucocytes. Anemia is a consequence of the long-continued administration of lead, and is accompanied by the usual symptoms of that condition—headache, lassitude and palpitation. The blue line at the gum is rarely seen when lead is administered intravenously. Nausea and vomiting appear to be dependent upon the amount of lead administered, but occur after a smaller total quantity, when given in massive doses, than after a larger total amount given by long-continued administration of small doses. Intestinal colic occurs with considerable frequency after the administration of massive doses, it is not seen after the long-continued administration of a smaller quantity of lead. Psychopathies may occur after the intravenous administration of lead, but they are rare. The retina may be affected, when this occurs it is probable that it is a concomitant of renal involvement. The toxic effect of lead on the kidneys is sufficiently frequent and of such magnitude as to require the greatest caution in the administration of this drug. In general it is found that the functional impairment caused by many small doses is less in degree, but more permanent than that caused by occasional large doses. The earliest indications of renal failure are diminution in the quantity of urine secreted and the occurrence of albuminuria and edema. A rise in the blood-urea does not occur, as a rule, until the damage is sufficiently great to be detected clinically. As in nephropathies due to other causes, it is difficult to correlate functional impairment with pathological change. Pathological changes in the liver are not so marked as in the kidney, and the main impairment of function seems to be connected with the bile-producing mechanism. In view of these many untoward consequences of the administration of lead, it is obvious that the use of this poison in the treatment of cancer is a method that should never be attempted by those who have not complete laboratory facilities at their disposal, and who have not studied for some time the actual treatment of patients at the hands of experts. The author has since published the details of his cancer treatment. This will be reviewed in this department when available.

**The Origin and Significance of Postural (Orthostatic) Albuminuria.**—James W. Russell (*Lancet*, October 23, 1925, ccix, 5327) points out two sources of fallacy which often interfere with the recognition of cases that are strictly orthostatic in nature. It is usually held that the urine passed immediately on getting out of bed by a patient suffering from orthostatic

albuminuria is invariably free from albumin. But this statement is incorrect of many genuine cases. The albumin excretion set going by the upright position continues, and sometimes increases for half an hour or more after the return to bed. A second source of fallacy lies in the fact that during diuresis the upright position loses its effect on the excretion of albumin, for this reason it is never safe to depend upon the absence of albumin from a single plentiful specimen of urine. From a study of a series of scarlet fever patients Russell concludes that many patients suffering from scarlet fever, who present no albuminuria during the period of rest, develop an orthostatic albuminuria immediately after getting up. Some of these albuminurias persist for a considerable time or even permanently. Some cases of recognized scarlatinal nephritis are ultimately represented by an albuminuria of the orthostatic type. Orthostatic albuminuria may follow other forms of specific infection, or even, though rarely, arise as an end-result of a mild acute nephritis of the ordinary type. The proportions of serum globulin and serum albumin are not constant in cases of either orthostatic or nephritic albuminuria, and do not enable a differential diagnosis to be made. It is suggested that in many cases the orthostatic reaction is the result of slight renal damage, though it may occur from mechanical causes. Some response to posture occurs in most cases of nephritis, and possibly in all forms of albuminuria.

**The Nature of the Eclampsogenic Protein.**—Alexander Hynd presents in the *Lancet*, October 31, 1925, ii, 5331, a contribution to this vexed question, his findings being based on a study of the urinary proteins in 26 cases, 12 of which were diagnosed by the clinician in charge as albuminuria of pregnancy, while 14 were described as of the eclamptic type. In the 12 cases of "albuminuria of pregnancy" without convulsions the specific rotation of the urinary albumin averaged  $-55.81^\circ$ , and thus agreed for that found for human serum albumin under similar treatment, namely  $-54.47^\circ$ . A similar close agreement in specific rotation, namely  $-54.27^\circ$ , was found in five cases of proteinuria not associated with pregnancy. On the other hand the 14 cases of eclampsia were sharply divided into two groups, one group having an average specific rotation of  $-56.37^\circ$ , and the other group of eight having an average of  $-38.5^\circ$ . The optical activity of the former group agrees well with that of serum albumin ( $-54.47^\circ$ ), while that in the latter approximates closely to that of cow's lactalbumin ( $-47.17^\circ$ ). Accordingly it is suggested (a) that in certain types of eclampsia the urinary albumin may be mainly lactalbumin, (b) that eclampsia may be an anaphylactic reaction due to the circulation in the blood of this foreign protein, and

(c) that the mammary gland may be an important factor in the causation of eclampsia. It may be, for example, that normally small amounts of lactalbumin may find their way into the blood stream during pregnancy, the usual result being the establishment of an immunity to this protein. When, however, this immunity is slight and a sudden discharge, from any cause, of a large amount of lactalbumin occurs and breaks through the immunity, eclampsia is very likely to result.

**Influence of Hypnotism on the Renal Function**—Heilig and Hoff give the results of some experiments conducted in the psychiatric clinic of Wagner-Jauregg, Vienna. The same authors had already reported the ability to influence by hypnosis the composition of the gastric juice, the motility of the stomach and the progress of chymification. In the present research similar efforts were made to alter the secretion and composition of the urine. The subjects were placed in the hypnotic state in the recumbent position. They comprised chiefly healthy female attendants and were, of course, willing volunteers. They were given only the ingesta commonly employed in renal testing—chiefly weak tea in definite amounts. The method consisted in suggesting to them in a variety of ways that they were well, happy, etc., on the one hand, and ill and miserable on the other. Under the former suggestion they were shown to retain water, to gain weight, to retain chlorides and phosphates, etc. Under the unpleasant suggestions the reverse was seen—diuresis, waste of chlorides and phosphates and lost weight. The fluctuations in weight were of course slight, varying with the behavior of the water. There is no evidence adduced to show that the metabolism was affected, all of the fluctuations being explained by the behavior of the renal secretion.—*Deutscher med Wochenschrift*, September 25, 1925, 11, 39.

**Double Action of Insulin.**—Muller and Wiener continue their work on the intracutaneous action of insulin. In addition to the action of the hormone when thrown directly into the veins it has been learned that still more remarkable and quite separate power of destroying sugar is exerted through the vegetative nervous system, when a little insulin is injected parenchymatously into any organ well supplied with the latter. When injected directly into the circulation insulin simply destroys the excess of sugar already formed, and has incidentally a theoretic disadvantage, for if it overacts against the sugar the body reacts by producing more sugar. But exhibited intracutaneously the action of the hormone is exerted on the glycogenic function of the liver, and the result is that the dextrose is changed to glycogen, so that sugar disappears from the blood as in the first case. In this second form of action the dose used seems im-

material, a minute quantity sufficing. When the substance is injected entirely into the veins this action is not exerted at all, and in the intracutaneous exhibition there is no glycolysis in the blood. But when subcutaneous injection is practiced both actions are present, although the glycogenic function is less in evidence than glycolysis. The authors draw no conclusions which bear on practice. Intracutaneous injection would seem to mean an economy of dose, while the preventive scope of the action seems superior in theory to the mere glycolytic property of insulin in the circulation. The subcutaneous route is seen to combine both actions although in a very different degree. It is of interest to note that some of the laboratory work is being carried out at Columbia University, New York.—*Münchener med Wochenschrift*, Oct 2, 1925.

**Insulin in Uremia and Cholesterinemia**—Flandin points out that the power of insulin to reduce blood dextrose may be applicable to other blood ingredients when present in excess. Indeed, animal experiment has shown that insulin can reduce the amount of substances believed to be pathogenic in excess, as urea and cholesterin. The author selected a case of chronic nephritis with albuminuric retinitis in which there was a blood urea content of 2.20, which could not be lowered by strict diet. He injected insulin and found that after from 15 to 30 injections it was possible to reduce the urea to 1.20 with corresponding clinical improvement. He kept this patient down to this level for six months, at which time his service ended. His successor stopped the insulin treatment, apparently as a crucial test of its value, and the patient rapidly became worse and in three weeks was dead.

In regard to cholesterinemia Professor Chauffard has recently shown that albuminuric retinitis cannot develop unless there is an excess of blood cholesterin. Whatever the value of insulin in uremia it seems to have a field in this form of retinitis. Chauffard appears to have caused the disappearance of the lesion in at least one case, and in Flandin's case.—*Le Bulletin Médical*, September 2-5, 1925, 11, 36.

**Glucose Infusions and Insulin in the Preparation of Poor Surgical Risks**—David Fisher and Edmund H. Mensing (*Boston Medical and Surgical Journal*, October 15, 1925, 16) state that recent developments of the use of glucose infusions and insulin in preoperative acidosis, in shock, and in starvation, have given the internist and surgeon an effective method whereby a poor or apparently hopeless risk can, in a comparatively short time, be transformed into a good or fair risk. In the authors' hands this method has proved effective in 18 cases of shock. A sterile solution of C. P. glucose is used in 10 to 15 per cent strength,

500 to 1,000 cc being given. For every two grams of glucose injected one unit of U20 insulin is administered. The total amount of insulin to be given having been estimated, one-half of this amount is injected subcutaneously when one-third of the total glucose solution has entered the veins, and the remainder of the insulin is given after the administration of the glucose has been completed. The entire time occupied by the administration of the glucose should be at least 90 minutes. Glucose and insulin are indicated not only in the type of cases above mentioned, but also in patients whose preoperative condition is good, but who are to undergo a serious operation, in which some difficulty is anticipated.

**Pseudoparesis Due to Fat Embolism**—Von Sarbo of Budapest relates a case which is probably unique. On the day following a severe compound fracture in a middle-aged man, for which amputation was eventually required, a cerebral crisis developed during which the patient remained unconscious for six days and awakened with an acute psychosis. The surgeon made the diagnosis of fat embolism of the brain. The symptoms which developed suggested a diagnosis of either progressive paralysis or traumatic psychosis, and the consulting neurologist ruled out the early diagnosis of fat embolism. Another neurologist made a diagnosis of typical progressive paralysis, and the author, called in at the same time, at first concurred in this opinion. But the Wassermann blood and spinal fluid tests proved negative throughout and the author returned to the original diagnosis—multiple fat embolism. The psychosis gradually cleared up and the patient is now engaged in his regular business. Study of the literature of cerebral fat embolism does not appear to show a parallel case, and the entire literature of the subject is meagre. *Klinische Wochenschrift*, October 1, 1925, iv, 40.

**Nature of Death after Fat Embolism**—Paul and Windholz read a paper on this subject before the Pathological Society of Vienna (*Wiener klinische Wochenschrift*, Oct 1, 1925), in which they gave an autopsy report of a woman who died of uremic coma following a compound fracture. A typical uremic ulcer was found in the ileum. Nevertheless, there were no evidences of chronic nephritis as such. The kidneys, as well as numerous other structures, were the seat of multiple fat embolism and the number of emboli was greater here than elsewhere—sufficient evidently to inhibit the renal functions. The authors now injected marrow fat repeatedly in rabbits and found invariably a retention in the blood of nitrogen sufficient to conform with that present in fatal human uremia. In addition there was a disappearance of blood sugar similar to that produced by insulin and due to interference with the glycogenic function of the liver. It is known, however, that

many animals can tolerate injections of bone marrow, and we know little of the nature of this immunity, but it is evident that the cerebral symptoms of fat embolism are not due entirely to local embolism. Other factors can contribute and the fat itself may, through its catabolic products, set up an auto-intoxication.

**Clinical Value of Some Recent Tests for Liver Function**—Howard F. Shattuck, John C. Brown and Marjorie Preston (*American Journal of the Medical Sciences*, October, 1925, clxx, 4) have made a comparative study of some of the newer and more promising tests for liver function, in a clinical material comprising 173 patients. The Fouchet test proved unreliable in their hands for detecting minor grades of bilirubinemia. In other respects the van den Bergh test served very well in its place. The van den Bergh test was found to have distinct value in the study of liver function and jaundice. Positive results with both reactions indicate impaired liver function, but the extent must be determined by the icterus index or dye test. It helps as a specific qualitative test for bile pigment to control readings of the icterus index in the zone of latent jaundice. It distinguishes between hemolytic and obstructive jaundice. The study seemed to indicate that the icterus index is the most useful single functional liver test for clinical work. It is easily and quickly performed, unobjectionable to the patient and free from danger. Its greatest value is in the diagnosis of cases of cholecystitis and cholelithiasis without clinical jaundice. It is a distinct aid in distinguishing between obstructive jaundice due to malignancy and catarrhal jaundice by showing whether the jaundice is increasing, diminishing, or stationary. It is helpful in the diagnosis of cirrhosis and malignant metastases in the liver, though apparently less so than the dye retention test. It may indicate the degree of cardiac decompensation. It serves as a guide to toleration by the liver of arsenicals in the treatment of syphilis. It will determine whether obstructive jaundice has been relieved by operation and it will aid in the differentiation of the primary and secondary anemias. The Rowntree-Rosenthal dye test is of supplementary value in measuring liver function. For clinical work it is more complicated, more objectionable to the patient and may not be entirely free from danger. It seems, however, to be of greater value than the icterus index in the diagnosis of cirrhosis and malignant metastases in the liver. In surgical cases with jaundice, the dye test helps to determine the degree of damage to the liver parenchyma, and hence the surgical risk. Its greatest value apparently is in the diagnosis of liver disease in patients without jaundice. Here a positive result points to liver involvement, a negative result helps to rule it out.



# LEGAL



By GEORGE W. WHITESIDE, Esq.  
Counsel, Medical Society of the State of New York

## FRACTURE OF THE HUMERUS—VOLKMANN'S PARALYSIS

On the 22nd of February a boy about four years of age, while playing on the street, fell and sustained an injury to his arm and hand. On the following day the defendant physician was called to render service to the boy. In an action of malpractice against this physician it was charged that he was negligent and careless in his treatment and care of the boy, in that he had failed properly to set the fracture of the boy's arm and had improperly bandaged the same, that he failed to apply the necessary attention or administer the necessary medicines and appliances to bring about a good result, and that by reason of the defendant's alleged carelessness the hand and fingers of the patient became paralyzed and diseased, the hand becoming absolutely useless and the general health of the boy being impaired. It was also claimed that the boy had permanently lost the use of the injured hand and arm, and damages were sought for these injuries. An action was also instituted by the father to recover for medical expenses and loss of his son's services.

It appears that on February 22nd, at the time of the fracture to the boy's right elbow, he was treated by a physician who had X-rays taken. The defendant was called in on the evening of the following day, at which time he was told that another physician had, at the time of the injury, put the arm up in a temporary splint. Upon examination on February 23rd, the defendant found the arm in full extension, with marked swelling at the elbow. He removed the cotton bandages and wooden splint that had been previously put on by the other physician. The splint that was then on the arm was an anterior-posterior splint extending from the wrist to the shoulder. The defendant then slightly manipulated the arm to determine the extent of the fracture and flexed it to an angle of about 15 to 20 degrees. Because of the swollen condition he ceased further manipulation of the arm. At that time he placed the arm in slight flexion and reinforced it with a temporary splint and bandage. He also advised the parents that it was a very bad fracture, as it was at the elbow joint, and that it might not be possible to reduce it without an anaesthesia and that X-rays must be taken.

On the following morning, February 24th, at the office of a roentgenologist, the defendant met the patient and his parents, where X-rays were taken. The X-rays showed a marked separation

of the fragments at the site of fracture. The defendant then reduced the fracture in the office of the roentgenologist and had an X-ray taken after the reduction. This X-ray showed the fragments in good position.

Because of the swelling and the failure of reduction for a period of forty-eight hours, it was necessary for the defendant to use pressure to hold the arm in marked flexion. He applied a metal splint held in place by strips of adhesive plaster. On the same evening he called at the patient's home to determine the amount of pressure, so that the circulation would not be interfered with. There was no swelling of the fingers at this time and the color of the hand and arm was good and there was no complaint from either the patient or his parents. Instructions were then given to the parents to watch the arm and if there was any increase in the swelling immediately to notify the defendant. He further told them to call upon him in four or five days, at which time he would have further X-rays taken.

On February 28th he again met the patient, with his father, at the office of the roentgenologist, removed the bandage and metal splint and had further X-rays taken at that time, which showed the bones in good apposition. The metal splint was re-applied and the arm redressed, being kept in its former position.

The seriousness of that type of fracture and the danger of complications, such as the impairment of the hand and ankylosis of the joint, were explained to the parent. The defendant likewise advised the parents of the necessity for early manipulation and passive and active motion of the injured member.

On March 3rd the boy, accompanied by his father, called at defendant's office. Upon examination there was found a slight erosion of tissue at the point of the elbow and also at the wrist, due to excessive odema and the pressure of the adhesive plaster on the arm. He advised the father to bring the boy to his office daily, but both the parents being engaged in business they didn't find it possible to do so, and therefore, the patient was brought to the defendant at intervals of every two or three days until the end of March. The physician repeatedly endeavored to impress upon the parents the necessity for daily treatment of the injured arm, and also gave the father instructions to be carried

out at home in the manipulation of the hand and arm. Toward the end of March the boy developed a Volkmann's paralysis due to the non-manipulation of the arm and, in the defendant's opinion, due to the excessive edema which had taken place in the first forty-eight hours. At this time he advised the father to consult a specialist. At the first appearance of the Volkmann's paralysis the defendant tried to extend the fingers by bandaging them with splints. The parents failed to consult a specialist until about ten days after the defendant had advised them to do so. The specialist who was consulted advised the parents that the boy was developing a Volkmann's contraction of the fingers, and prescribed manipulation, massage, hot and cold bathing and keeping the fingers extended on splints, and that the massage be done by a proper masseur, and furnished the name of a masseuse to the parents. However, the parents failed to procure the services of this masseuse until several weeks later, and then had her massage the boy's arm every five or six days instead of daily. The masseuse likewise was compelled to discontinue her services to the boy, as the parents refused to follow the advice of daily massage. The mother, on one occasion, when giving the arm a hot water bath as prescribed, had the water too hot and because of the lowered sensitiveness of the arm, caused the arm to be burned. The child was not seen by the defendant after April 19th.

Another specialist was consulted by the parents, who had an X-ray taken of the arm. To him the picture indicated that a nerve controlling the motion of the wrist and hand was being

pressed on by the ends of the bone at the point of fracture, which might have produced the Volkmann's paralysis. This specialist, when asked by the parents, refused to recommend an operation and referred them to a nerve specialist and recommended that an examination be made before operating. This specialist recognized, from his examination, that the fracture was a difficult one to reduce.

The child was thereafter taken to a clinic, where he was receiving baking and massage treatment about three times a week. A physical examination of the child made on July 22nd showed that he was an anemic, undernourished boy about four years of age, that the right elbow showed moderate swelling at the joint, irregularity and thickening of lower end of humerus, the joint action slightly restricted, flexion limited to 90 degrees, extension to about 125 degrees, supination limited to 50 per cent, pronation greatly restricted, on the anterior surface there was an irregular, thick scar about  $1\frac{1}{4}$  inches by  $\frac{1}{2}$  inch. The examination further disclosed atrophy of the muscles of the forearm, with diminished sensation. There was likewise atrophy and diminished sensation of the right wrist, hand and fingers. The wrist was stiff, the fingers at the time were extended on a Jones splint, no contractures being present, and there being slight movement of the fingers.

When these actions came on for trial they were on the calendar for several days, and not being answered on behalf of the plaintiffs, the court dismissed the complaints, terminating the same in favor of the defendant.

---

### BURN FROM HOT SAND BAG IN OPERATION

A physician, upon examination of a seven-year-old boy, found a condition of mastoiditis warranting surgical interference and advised an immediate operation. Arrangements were made and the boy was removed to a hospital where, in the early afternoon, the physician prepared to operate upon him. Upon his arrival at the operating-room he found the boy on the operating-table fully prepared for the operation, both the boy and table being draped with sterile dressings and the necessary props. The mastoidectomy was performed without any untoward results.

Upon the day following the operation the mother of the boy called the surgeon's attention to a slightly reddened area upon the child's back at a point between the shoulders. At this time the reddened area was about the size of a twenty-five cent piece. This condition became progressively worse, the area suppurated, and there was a sloughing of the tissues. It took several months

of treatment by the surgeon and another physician before the abrasion had completely healed.

A suit was instituted against the surgeon and the hospital charging them with negligence in the preparation of the child for the operation, and specifically charging that in placing the child upon the operating-table sandbags, which were either hot or saturated with iodine, were used, thereby causing the burn to the patient's back.

The action finally came on for trial and after the introduction of the plaintiff's testimony the complaint was dismissed as to both the physician and the hospital.

If the surgeon in this instance were held liable for the result complained of, then in no case could a surgeon rely upon the nurses and various hospital assistants in the preparation of a patient for operation without subjecting himself to possible personal liability.



# OUR NEIGHBORS



## MEDICAL SOCIETY OF NEW JERSEY

The Medical Society of New Jersey held its 159th Annual meeting June 18th to 20th, 1925, in Atlantic City, and the official transactions have just come to us in the form of a supplement to the September issue of the Journal of the Medical Society of New Jersey. We were interested in looking up information concerning the organization of the Medical Society of our sister State.

The Society has 2,227 members, while 1,340 doctors listed in the State are not members. The annual dues are \$10, but the Society receives about \$27,000 as its total income from all sources, including advertisements in its Journal.

The organization of the Medical Society of New Jersey is much like that of New York State. There are 21 county medical societies, and 5 councilor districts. A board of trustees manages the finances of the Society. One of the principal committees is that on Welfare, which manages the legislative activities of the Society. Last year it sponsored a bill restricting the use of the title "doctor" to those who have the necessary educational qualifications. The report says: "The bill failed despite every effort on the part of our Society, and of many influential citizens whose only object was the protection of the public in health matters by guaranteeing to the people that the title 'doctor' meant that the person using it was qualified by special training to treat the sick. Your Welfare Committee has decided by a majority vote to recommend that the 'Doctor Title' bill be reintroduced at the next session of the Legislature. It is the duty of every member of the Society to get behind this measure. We shall succeed or fail in proportion to the aid received from the individual members of the Society."

The Society employs an Executive Secretary at a salary of \$10,000 annually, but it allocates this salary under three items corresponding to the Secretary's triple duties:

1 Secretary of Welfare Committee	\$2,000
2 Publicity Executive	5,500
3 Editor of State Journal	2,500
	<hr/>
	\$10,000

The Welfare Committee demands intensive work of the Executive Secretary during the time of the legislative session.

As Publicity Executive, the Executive Secretary promotes medical education among the people. He devotes considerable space in his annual report to a discussion of methods of newspaper publicity, and points out a difference

of opinion between newspaper editors and the doctors regarding what is news. He also refers to the news value of a challenge issued by a Newark cultist to the United States Public Health Service to submit to a test to determine the relative smallpox immunity of vaccinated and unvaccinated persons.

The Executive Secretary also lists among his activities his visitation of county medical societies, and the stimulation of their members to take up periodic health examinations, and other activities of a semi-civic nature.

The Executive Secretary is responsible for editing the Journal of the State Society. One feature of the Journal has long been the appointment of a "Reporter" for every county medical society. Regarding the work of the county reporters, the Editor says:

"We have succeeded in bringing the publication of County Society reports right up to date and each monthly issue of the JOURNAL now carries the reports of every County Society meeting held during the preceding month, this record has been maintained since February and there is no good reason why it should not be continued indefinitely."

The Editor makes the following report regarding a department on post graduate reading:

"The first innovation attempted in the Journal, and which insofar as I know has never been used in such manner before, was the establishment of the 'Observations from the Lighthouse' an attempt to present monthly a few suggestions for postgraduate reading on some medical topic."

This department in the September issue consists of a three-page review of the Tonsil Question.

The Editor also reports on the establishment of a department called "Esthetics," which the Editor says is "Devoted to the relationship between medicine and the other arts and sciences, to the end that the physician shall not permit himself to become entirely detached from the rest of the thinking world nor entirely submerged in his own affairs."

This department in the September issue consists of a scientific poem on the cellular development of man.

The Executive Secretary also reports on another new department, that of Medical Economics, which in the September issue consists of a sermonette on "Enjoying One's Job."

The New Jersey State Medical Society defends its members against malpractice suits, partly by providing the counsel, and partly through co-



operation with a company that furnishes indemnity insurance. Only a minority of the members carry indemnity insurance.

The State Medical Society favors the group insurance plan by which each member will take indemnity insurance in a specific insurance company. The Committee on Medical Defense reported:

"Since this insurance has been in force, there have been issued 1,387 certificates to different members. Last year there were issued 582 certificates, and out of 2,200 members or thereabouts there are only 582 who are now insured under this Group Plan. The rest of the members are still operating under the old Medical Defense plan. The Chairman of the Judicial Council has drawn attention to this in his report and has urged the necessity of having all the members take out the group insurance policies.

"Perhaps the members of this Society are not as yet cognizant of the fact that under the old form of medical defense, that is, the form which existed before this insurance scheme went into effect, the doctors are not protected excepting to the extent of \$250 in the lower court. Now we have had some experiences of that kind, and I don't think the members ought to rely upon it. They should go into this scheme whereby they can be defended and also be indemnified. The price of this medical defense, or at least the price of the premium is reasonable enough,—it is \$16 for a \$5,000 limit, and \$21 for a \$10,000 limit, and \$27 for a \$25,000 limit. For a man to pay \$27 a year to be protected to the extent of \$25,000 a year must be a great comfort to him."

The Committee makes the following recommendations:

"That the members of the Society, who are not insured under the group form of indemnity insurance, avail themselves at once of its advantages.

"That component county societies having independent group contracts be urged to unite with the State Society, such union will result in stronger organization for medical defense and reduction in the cost of insurance."

Regarding malpractice suits, the Chairman of the Judicial Council says:

Your Council has been impressed with the number of suits started or threatened against our members. We have also observed that these cases are generally against the best practitioners and many of them started after an attempt has been made to collect a long standing bill. We feel that the present medical defense plan of our State Society is not only inadequate but also misleading to the members. Your Judicial Council is almost helpless in the matter of doing anything to aid. We are of the opinion that some new plan of medical defense should be adopted. Each and every member of the Society should protect himself with a policy that will cover his needs.

"We should caution our members not to do anything that will aid and abet in the starting of a suit against a brother practitioner, because a careless remark is often the cause of much trouble."

The Chairman also suggests cooperation of each County Medical Society with the County Bar Association in the hope of obtaining an informal tribunal of lawyers and physicians which would weed out unworthy cases.

A sub-committee on medical expert testimony reported in favor of an expert appointed by the court to testify regarding the medical aspects of a case.

The State Society is interested in reciprocity with Pennsylvania in the recognition of hospitals for the training of internes in order to qualify them for taking the State Examinations.

It is also interested in the Board of Examiners for licensing medical practitioners and is also planning an extensive system of Graduate Medical Education. (See adv. page xiv.)

The rules of the New Jersey State Society evidently impose the penalty of suspension from the State Society or county medical societies for those that fail to send their State dues within a specified time. This rule gave rise to considerable discussion in the Annual Meeting.

In general, the doctors of New Jersey are wrestling with the same problems that their New York confreres are considering. While the methods differ somewhat in the two States, the final results are similar.



# NEWS NOTES



## THE MEDICAL SOCIETY OF THE COUNTY OF QUEENS

A regular meeting of the Medical Society of the County of Queens was held Tuesday, October 27, 1925, at the Eagle Palace, Jamaica, the President, Dr Courten, in the chair. The President announced the appointment of a Committee to revise the by-laws, consisting of Dr Chalmers, Chairman, Drs Keet, Boettiger, Smith and Lavelle, and a Committee on nominations of officers, consisting of Dr F G Riley, Chairman, Drs Whelan, Distler, Barber and Howard. Notice was also given to amend the by-laws so as to provide for the election of a Secretary and a Treasurer. The following candidates were elected to membership.

Drs Thomas M D'Angelo, Abraham Herzog, Theodore Lint, Johnston MacLeod, David Matus, Frederick Grantham Meynen, Thomas S Morton, W J Quinn, William J Smith, T Raymond Surber, Nathan Uris, and Dr Benjamin D Reuben was received by transfer from the Medical Society of the County of Oneida.

Dr F G Riley reported for the Committee on Graduate Medical Education, that arrangements had been made for Friday afternoon lectures twice a month, and that plans were under way for the announcement of clinical courses to be offered at the various hospitals in the borough.

By direction of the Comitia Minora the secretary read four communications from Dr S D Hubbard, of the Division of Illegal Practice of the Department of Health, concerning investigations of the several alleged illegal physicians in the Borough of Queens.

The Committee on nominations announced the following nominations:

For President, Denis E McMahon, Vice President, Joseph S Thomas, Secretary, Ernest E Smith, Treasurer, James M Dobbins, Censors, Henry C Eichacker, Wilham J Lavelle, Walter C A Steffen.

Delegates to State Society: Denis E McMahon, Ernest E Smith, Carl Boettiger.

Alternate Delegates to State Society:

William H Jessup, W Guernsey Frey, Jr, Thomas P McCann, James R Reuling, Charles W Martin, Henry C Eichacker.

In Scientific Session, the society met jointly with the Queensboro Tuberculosis Association. Dr Herman Robbins read a paper on the "Control of Malnutrition in School Children." The

paper was a brief report of careful, painstaking work done by Dr Robbins with a special Class of about 100 malnourished children in one of the city schools. As a result of the work which consisted in weekly nutrition class sessions, with parents in attendance, reports by children on food taken, lunches at school, rest periods at school and at home, the group of children gained in weight on average 4.6 times the average weight gained in a control class of the same number of children.

An interesting discussion followed in which Dr Carl Laws, Professor of Pediatrics, Long Island Hospital Medical College, Dr Charles Prest, Secretary, Queensboro Tuberculosis Association, Dr M M Vinton, Dr W C A Steffen, and Dr L M Rohr took part.

Dr Foster Murray in his paper on "Collapse Therapy in Pulmonary Tuberculosis: Its Indications and Limitations," pointed out that the various procedures used are intended to promote rest to the lung involved. Types of cases suitable for Artificial Pneumothorax are: (1) Chronic Progressive cases which fail to improve under rest, i. e., clinical symptoms persisting as do the physical signs and radiographical findings. (2) Cases with caseation and cavitation. (3) Caseous tuberculous pneumonia and bronchopneumonia. (3) Cases where because of economic or emotional conditions, time is important. (5) Cases that improve under other treatment, but are not cured. In these cases the treatment is given for from 2 to 5 years, depending upon the type of case and consists in the introduction of filtered sterile air into pleural cavity, so that the lung is compressed. A contra-indication to the treatment is active lesions of considerable extent in opposite lung. Among the limitations of the treatment are the occurrence of adhesions and fluid.

More radical measures considered are phrenotomy and thoracoplasty.

After the reading of the papers, Dr W W Britt, Chairman of the Committee on Economics of the Medical Society of the State of New York, spoke briefly on the nursing problem, periodic health examinations and Workmen's Compensation Law.

After a vote of thanks to the speakers of the evening, the meeting adjourned. Collation followed. Attendance 90.

## MEDICAL SOCIETY OF THE COUNTY OF NIAGARA

The Annual Meeting of the Medical Society of the County of Niagara was held Tuesday, November 10th, at the Tuscora Club, Lockport

The Meeting was called together by President Schnell, and the minutes of the last meeting were read and accepted

The Annual reports of the officers and committee heads were read and accepted

The following officers were elected for 1926 President, H W Cramer of Lockport, Vice President, Frederick Leighton, Secretary-Treasurer, G L Miller, Censors, C W Clendenning, F A Walden, R P Barry, Delegates to State Society, W A Peart, F J Schnell

The following applications for membership were presented, favorably acted upon by the censors, and they were voted members of the Society Drs Jennie E. Mabey, Jesse R. Harris, Duane C Johnson, Guy P Philbrick, Irwin M Walker

The membership expressed a desire to hear

from the State Society the exact position of our state malpractice insurance with special reference to the need for the increase in premiums, the position of commercial companies in the State, and the relationship between the State Council and these private companies, in case of suit of a member carrying commercial insurance.

A plan for the prosecution of irregular practitioners was discussed at some length and referred to the Censors for consideration

Dr Britt, Chairman of the State Society's Committee on Medical Economics, was introduced as the speaker Dr Britt gave a practical and explicit talk on the aims of his committee in regard to the subject of "Periodic Health Examinations of the Well"

The discussion upon this subject was so voluminous and divergent as to undoubtedly convince Dr Britt that his talk was interesting, and his subject vital in the opinions of the general practitioner

---

## MEDICAL SOCIETY OF THE COUNTY OF SULLIVAN

The first lecture of a post graduate course for the Medical Society of the County of Sullivan was given in Liberty on November 11, by Dr Samuel Tirman of the Long Island College Hospital, Brooklyn Dr H M Pointexter, Secretary of the Society, sent out a descriptive appeal to the members, and says

"The course is organized and conducted by the Medical Society, your own organization It does not come from above It is not a paternal arrangement It is your own society, therefore we expect you to share and receive all the benefits it offers you, and we also expect those that are not members of the County Medical Society to see this thing in the proper light, and we urge them and expect them to enroll in the Sullivan County Medical Society, a social, scientific, economic society for their benefit and for their use

"Wednesday, November 11, the first course will be given on cardiology The lecturer and instructor will be Dr Tirman of the Long Island College Hospital Multiple stethoscope will be utilized, so that while Dr Tirman examines a pa-

tient and explains the various adventitious sounds of the heart, all physicians present can listen in at the same time

"We ask all the members of the County Medical Society, as well as physicians, non members, but residing in the County of Sullivan, to bring their patients suffering from heart disease to this clinical course Dr Tirman will examine your patient, give diagnosis and treatment You and your colleagues will be greatly benefited by it, and still more your patient"

The afternoon was devoted to a clinic on hearts, and the multiple stethoscope enabled all the doctors to listen at the same time, and the demonstrator to be sure that the sounds were actually being delivered by the instrument.

The evening program consisted of a black-board talk and demonstration in cardiology Over twenty doctors were in attendance The President of the Society, Dr Rayevsky, is planning other lectures in cooperation with the Committee on Education of the State Society

---

## MEDICAL SOCIETY OF THE COUNTY OF CATTARAUGUS

The bi-monthly meeting of the Medical Society of the County of Cattaraugus was held in the Masonic Parlors, Salamanca, November 10, 1925

The Committee, Drs W B Johnston, M C Hawley, J Z Gaston, J E K Morris and S H Bennett on Post graduate Medical Instruction, which was appointed at the meeting held September 8th, reported in favor of the plan The report was unanimously adopted and the matter was

referred back to the Committee to make the necessary arrangements with the State Society

Dr Frank H Richardson of Brooklyn gave a very interesting and instructive address on "Infant Feeding" The doctor's address was brimful of practical suggestions and facts gathered from his large experience in dealing with babies The members of the society expressed their keen appreciation of the address



# THE DAILY PRESS



The New York *Herald-Tribune* has recently printed a series of accounts of the arrest of a dealer in hashish, and of his disclosure that he obtained the drug from plants growing in the midst of New York City. The items suggest thoughts along the lines of history, philology, and economics as well as of toxicology.

Hashish is under the ban of the police because it is a narcotic poison. It is widely used in India and Arabia by smoking or as a confection, in order to produce a nervous excitement which is usually accompanied by pleasing visions. It is peculiarly adapted to the contemplative tastes of the Eastern people, for it produces an enormously prolonged sense of time, so that a minute seems a whole day. Another peculiarity of the delirium is that its form may be directed to a great extent, along lines of wealth, for example, or sensual gratification. This fact was utilized by Arab robber chiefs who gave their followers hashish, in order to excite them to murder. The English word "assassin" comes directly from the Arabic *hasheesh*, and carries with it a volume of history of robberies, murders and feuds in the Arabian deserts.

The word "hashish" in Arabic means hay, and suggests that the old Arabs had a sense of humor very much like that of the modern American who says that his favorite brand of tobacco composed largely of hay.

Hashish was known as a narcotic in the most ancient days of history. It is called *Cannabis indica* in the pharmacopeia. The word "cannabis" in ancient Greek goes back through the Persian and Sanskrit to the most ancient languages. Coming down toward modern times, the same word with changes which follow well known etymological laws comes down through the Russian and the Balkan languages, and appears in the Anglo Saxon as "henep," and in modern English as "hemp." This is an example of a considerable number of words such as god, father, house and cow that help to prove the ancient Aryan origin of modern European people.

*Cannabis indica* is the hemp plant from whose inner bark rope is made. It was one of the earliest sources of coarse cloth. Our word "canvas" is "cannabis" slightly changed, and "to canvass" originally meant to sift through a sieve of coarse canvas, hence to examine carefully.

Hemp will grow in almost every land in the temperate zone, and was extensively grown in the Middle West, until cheaper sources of cordage fibre were available. It will also grow wild on rubbish heaps, in which case it probably springs from waste hemp seed fed to canary birds.

The newspaper reports state that the prisoner arrested in New York led the police to his source of supply in plants growing in old rubbish heaps in the Sunnyside yards of the Pennsylvania Railroad in Long Island City. A few plants were a gold mine to the prisoner, who made cigarettes from the leaves and sold them at a dollar apiece.

It is not at all strange that poisonous plants should be found on rubbish heaps and other waste places in cities and villages. *Stramonium* is a big branching plant that belongs to the *belladonna* family, and grows in profusion in nearly every old barnyard and rubbish heap. It has often caused death, and was formerly smoked for the relief of asthma. Patches of *belladonna* itself are often found sprawling over the grasses by the seaside. The big branching plants of *hemlock* are common in fence corners, and the deadly *veratrum viride* is abundant in some swamps, looking like tall plants of skunk cabbage.

The *Herald-Tribune* of November 7th quotes Dr. Carleton Simon as follows:

"Although it is the oldest of all habit-forming narcotic drugs, its cultivation and sale are not prohibited by the Federal Harrison drug act. Except for medicinal purposes, however, its distribution is forbidden by ordinances in this city and some other cities and localities, such as Massachusetts, California and Dallas.

"That it is a great danger," commented Dr. Simon, "is fully recognized by the Mexican government, which has legislated against it, but, strangely enough, not by our own. In the Mexican underworld and throughout our Southwest the dried *cannabis indica* leaves are used in the form of cigarettes, a few drafts of which will stupefy the unaccustomed. It produces a feeling of lightness and puts the addict into a sort of ecstasy. This is followed by hallucinations and then comes a sleep of a dozen hours. After this the hashish user awakens with a dreadful headache, nausea and a desire for more of the drug.

"A variety of effects follow each other rapidly then, so rapidly, indeed, as to produce a sense of great prolongation of time. Ten minutes, for instance, will seem to the addict like a long hour filled with agreeable sensations. It produces a sort of double consciousness, and gives small spaces the semblance of tremendous proportions. The habit of taking this drug is very quickly formed, and it is specially productive of criminal tendencies. Confusion of thought and abnormal inclinations appear, ultimately driving its users insane."

## EUTHANASIA

News items from a small town in Colorado have described the trial of a doctor for chloroforming his daughter, thirty-four years old, who was an imbecile from birth,—blind, deaf, dumb, nearly paralyzed, and subject to convulsions. The particular reason given by the father for his act was that he was in poor health and feared that he could no longer give his daughter proper care. He seems to have had an unreasoning abhorrence of his daughter becoming a public charge.

The trial resulted in a disagreement of the jury, which stood 11 to 1 for acquittal. The Brooklyn Eagle, November 13th, says editorially: "Nearly everybody who has watched the case wonders not that Dr. Blazer goes free, but that he was not acquitted with flying colors. Society has no desire to punish such a man as Dr. Blazer. But society has a distinct reason for making euthanasia killings infrequent."

These editorial sentiments seem to be shared by the members of a church in Denver, who, according to an Associated Press report, voted in favor of euthanasia on a brother member, a prominent man who has an incurable disease and wishes to die. The bishop of the church announced that the vote was an official act of the church, and was based on love and affection for the sufferer.

The attitude of both the newspaper and the Denver church is opposed to that of physicians. Euthanasia is a cowardly way of escaping responsibility, and physicians cannot admit its justification.

It is one thing to express a wish that death might remove the burden of pain and care from an incurable sufferer and his family, it is quite another thing to summon the aid of death. Medical science provides other means for relieving suffering. Physicians consider it a privilege as well as a duty to administer sedatives which effectively relieve pain and suffering, and they are always ready to cooperate with the clergy in applying the consolations of the church, and to add their own words of encouragement and comfort. They will ease the latter days of the sufferers, but they will never hasten the coming of the Angel of Death.

Society as well as physicians will not sanction euthanasia in any form. What is the alternative? It is evidently that society should provide the means for caring for the imbeciles and the incurables who are great burdens to their families. Modern sciences, and sociology are perfectly sufficient to provide institutional care whose comforts exceed those available in the best homes. The promotion of these institutions is the doctor's answer to the question of the infliction of euthanasia.

## MEASURING THE SOUL

One report of the trial of the euthanasia case stated that a possible line of defense to be offered

was that the imbecile victim had no soul, and was therefore not a human being. On the same day the newspapers carried a story that a French scientist had measured the soul. These incidents bring up the question, what is the soul?

The popular as well as the scientific and medical conception of man is that he is composed of two elements, body and soul. We know the body, or physical part of our being, by means of its effects on our senses. Whatever affects our senses is physical. All knowledge is founded on impressions received through the senses. Experiments in proof of the existence of the soul are attempts to record impressions of the soul on our physical senses, which are imperfect and are adapted to receive only a small range of impressions which other animals seem to receive. A dog, for example, has its power of scent highly developed, and an ant seems to gain information by a means of a highly developed sense of feeling in its feelers.

What the Frenchman seems to have done is to measure some kind of electrical emanation from the body, and after allowing for all known sources of influence, he concluded that what is left is the soul.

Other experimenters have attempted to photograph the soul at the instant of its flight from the body, and they get a ghostly smudge which they interpret as the picture of the soul.

As the receptive powers of man's senses are increased by the telescope, the spectroscope, the microscope, and the radio, so does he penetrate into the physical depths of what was formerly interpreted as the exclusive realm of the spiritual soul. We can be certain that whatever we can see, or measure, or handle is not the spiritual part of our being. It may be that, if man had a dog's acute sense of smell and the ant's sense of touch, he could penetrate even further into the unknown physical world, but he would not be any nearer to the recognition of the soul.

## SEEING WITH THE SKIN

The New York Sun, November 10th, announces that a French scientist has discovered four girls who have skins so sensitive that they can read ordinary books by means of their sense of touch while their eyes are blindfolded. Similar reports elsewhere are vague and indefinite, and state conclusions only. The opportunities for error and wrong interpretations are numerous, and when the experiments are repeated by trained investigators, the subjects fail to perform their wonders.

Newspaper reports of reading by means of the skin appear every few months. They come from so-called scientists who are not medical men or even psychologists, and they are usually ascribed to foreign sources, the farther they are away, the better chance have the reports to survive.



# BOOKS RECEIVED



Acknowledgment of all books received will be made in this column and this will be deemed by us a full equivalent to those sending them. A selection from this columns will be made for review, as dictated by their merits, or in the interest of our readers.

- THE NERVOUS CHILD** By HECTOR CHARLES CAMERON, M.A., M.D., F.R.C.P. Third Edition 12mo of 233 pages, with 8 illustrations London, Humphrey Milford, New York, Oxford University Press, 1925 Cloth, \$2 30 (Oxford Medical Publications)
- DISEASES OF THE HEART** By SIR JAMES MACKENZIE, F.R.S., M.D., F.R.C.P. Fourth Edition Royal octavo of 496 pages with 342 illustrations London, Humphrey Milford, New York, Oxford University Press, 1925 Cloth, \$9 00 (Oxford Medical Publications)
- THE EARLY DIAGNOSIS OF THE ACUTE ABDOMEN** By ZACHARY COPE, B.A., M.D., M.S., Lond., F.R.C.S., Eng Third Edition. Octavo of 233 pages with 28 illustrations London, Humphrey Milford, New York, Oxford University Press, 1925 Cloth, \$3 80 (Oxford Medical Publications)
- THE HISTOLOGY OF THE MORE IMPORTANT HUMAN ENDOCRINE ORGANS AT VARIOUS AGES** By EUGENIA R. A. COOPER, M.D. Octavo of 119 pages, with illustrations London, Humphrey Milford, New York, Oxford University Press, 1925 Cloth, \$4 00 (Oxford Medical Publications)
- COMMON DISORDERS AND DISEASES OF CHILDHOOD** By GEORGE FREDERIC STILL, M.A., M.D., F.R.C.P. Fourth Edition Octavo of 965 pages with illustrations London, Humphrey Milford, New York, Oxford University Press, 1924 Cloth, \$7 50 (Oxford Medical Publications)
- NEUROLOGICAL FRAGMENTS** By J HUGHLINGS JACKSON, M.D., F.R.S., F.R.C.P. With Biographical Memoir by James Taylor, M.D., F.R.C.P. and Including the "Recollections" of the late Sir Jonathan Hutchinson and the late Dr Charles Mercier Octavo of 227 pages London, Humphrey Milford, New York, Oxford University Press, 1925 Cloth, \$3 75 (Oxford Medical Publications)
- PRACTICAL OBSTETRICS** By E. HASTINGS TWEEDY, M.D., F.R.C.P.I. and G T WRENCH, M.D., in collaboration with BETHEL SOLOMONS, M.D., F.R.C.P.I. Fifth Edition. Octavo of 617 pages with 159 illustrations London, Humphrey Milford, New York, Oxford University Press, 1925 Cloth, \$6 25 (Oxford Medical Publications)
- LIVING ORGANISMS An Account of Their Origin and Evolution.** By EDWIN S GOODRICH, F.R.S. 12mo of 200 pages with illustrations London, Clarendon Press, New York, Oxford University Press, 1924 Cloth, \$2 00
- CHILD HYGIENE.** By S JOSEPHINE BAKER, M.D., Dr P.H. Octavo of 534 pages New York and London, Harper and Brothers, 1925 Cloth, \$5 00 (Harper's Public Health Series)
- THE DEGENERATIVE DISEASES Their Causes and Prevention** By LEWELLYS F BARKER, M.D and THOMAS P SERUNT, M.D Octavo of 254 pages New York and London, Harper and Brothers, 1925 Cloth, \$4 00 (Harper's Public Health Series.)
- SOCIAL PSYCHOLOGY** By KNIGHT DUNLAP Octavo of 261 pages. Baltimore, Williams and Wilkins Company, 1925 Cloth, \$4 00
- ARTIFICIAL SUNLIGHT AND ITS THERAPEUTIC USES** By FRANCIS HOWARD HUMPHRIES, M.D (Brux.), F.R.C.P (Edin.), M.R.C.S (Eng), L.R.C.P (Lond.), L.M (Rot., Dublin), D.M.R. and E (Cantab) Second Edition. Octavo of 201 pages with illustrations. London, Humphrey Milford, New York, Oxford University Press, 1925 Cloth, \$2 75 (Oxford Medical Publications)
- RADIUM Its Therapeutic Uses in General Practice.** By G H. VARLEY, M.D (Oxon) 12mo of 103 pages. London, Humphrey Milford, New York, Oxford University Press, 1924 Cloth, \$1 75 (Oxford Medical Publications)
- THE CHEMICAL AND PHYSIOLOGICAL PROPERTIES OF THE INTERNAL SECRETIONS** By E. C. DODDS, Ph.D., B.Sc., M.B., B.S. and F DICKENS, M.A., Ph.D. Octavo of 214 pages London, Humphrey Milford, New York, Oxford University Press, 1925 Cloth, \$2.50 (Oxford Medical Publications)
- THE NURSING OF EYE CASES** By LOUISE KINGHAM, S.R.N. 16mo of 16 pages London, Humphrey Milford, New York, Oxford University Press, [1925] Paper, \$30
- HISTORY OF MEDICINE.** By Dr MAX NEUBURGER. Translated by ERNEST PLAYFAIR, M.B., M.R.C.P., in two volumes Vol 2, Part 1 Octavo of 135 pages London, Humphrey Milford, New York, Oxford University Press, 1925 Paper, \$2.25 (Oxford Medical Publications)
- DISEASES OF THE NOSE, THROAT AND EAR, MEDICAL AND SURGICAL.** By WILLIAM LINCOLN BALLENGER, M.D. Revised by HOWARD CHARLES BALLENGER, M.D. Fifth Edition. Octavo of 1080 pages, illustrated with 551 engravings and 32 plates Philadelphia and New York, Lea and Febiger, 1925 Cloth, \$10 00
- THE INTERNAL SECRETIONS OF THE SEX GLANDS The Problem of the "Puberty Gland"** By ALEXANDER LIPSCHÜTZ, M.D. With a Preface by F H. A. MARSHALL, F.R.S. Octavo of 513 pages, with 142 illustrations Baltimore, Williams and Wilkins Company, 1924 Cloth, \$6 00
- THE MEDICAL ASPECTS OF CHEMICAL WARFARE.** By EDWARD B VEDDER, Lieut. Colonel, M.C., U.S.A. With a chapter on the Naval Medical Aspects of Chemical Warfare, by DUNCAN C. WALTON, Lieut. Commander, M.C., U.S.N. Octavo of 327 pages Baltimore, Williams and Wilkins Company, 1925 Cloth, \$6.50
- PRACTICAL PHYSIOLOGICAL CHEMISTRY** By SYDNEY W COLE, M.A. Sixth Edition. Octavo of 405 pages. Baltimore, Williams and Wilkins Company, 1920 Cloth, \$4 00
- THE EFFECTS OF IONS IN COLLOIDAL SYSTEMS.** By DR LEONOR MICHAELIS 12mo of 108 pages Baltimore, Williams and Wilkins Company, 1925 Cloth, \$2.50.
- AN APPROACH TO SOCIAL MEDICINE.** By FRANCIS LEE DUNHAM, M.A., M.D. Octavo of 242 pages Baltimore, Williams and Wilkins Company, 1925 Cloth, \$4 00
- VITAL CAPACITY OF THE LUNGS A Handbook for Clinicians and Others Interested in the Examination of the Heart and Lungs Both in Health and Disease.** By J A. MYERS, M.S., Ph.D., M.D. Octavo of 140 pages Baltimore, Williams and Wilkins Company, 1925 Cloth, \$3.25

# BOOK REVIEWS

**GYNÉCOLOGY WITH OBSTETRICS** A Text-Book for Students and Practitioners By JOHN S FAIRBAIN, M.A., B.M., B.Ch., F.R.C.P., F.R.C.S. Octavo of 769 pages, illustrated. Cloth, \$8.00 London, Humphrey Milford, 1924 (Oxford Medical Publications)

This text-book is unique in that within its covers one may find all the essential facts of gynecology and obstetrics. Stressing the importance of a knowledge of midwifery as essential to the practice of gynecology the author quotes "The obstetrician and gynecologist is the great example of the unity of medicine and surgery in actual practice. Here is the full integration."

Though frankly a text-book, there is a very interesting historical review, and a plea for recognition of midwifery as a branch of Preventive Medicine of great importance. All our text-books on obstetrics might well carry similar chapters. The book is well done, and particularly valuable for the student who desires to find a large amount of information in what the author calls, "water tight compartments" C. A. G

**HIRSCH'S "COMPEND OF GENITO-URINARY DISEASES AND SYPHILIS,"** Including their Surgery and Treatment. 4th Edition Revised. 44 illustrations. Cloth, \$2.00 By CHARLES S HIRSCH, M.D., Urologist to the Jewish Hospital, Mt. Sinai Hospital, and Eagleville Hospital for Consumptives. Out Patient Dept., Philadelphia. P. Blakiston's Son and Co., Philadelphia, 1924

This fourth edition of a concise and comprehensive work is brought up to date. It is intended primarily for the student or for the busy practitioner who has no easy access to a library for reference. A list of one hundred questions are appended for the student's use.

AUGUSTUS HARRIS

**AN INTRODUCTION TO PRACTICAL BACTERIOLOGY, AS APPLIED TO MEDICINE AND PUBLIC HEALTH** A Guide to Bacteriological Laboratory Work for Students and Practitioners of Medicine. By T J MACKIE, M.D., and J E MCCARTNEY, M.D. William Wood & Company, New York, 1925 Price, \$3.50

This is an excellent handbook of practical bacteriology as it applies to medicine and public health. The authors have arranged the subject matter in accordance with their method of teaching, and the book is easily read and understood.

After a general introduction, the book takes up immunity, an excellent chapter on the microscope, cultivation of bacteria, staining methods, special procedures and examinations, and then specific description and study of the various bacteria. I. COHN

**THE TECHNIC OF LOCAL ANESTHESIA.** By ARTHUR E. HERTZLER, A.M., M.D., Ph.D., LL.D., F.A.C.S. Third Edition. With 140 Illustrations. The C. V Mosby Company, St. Louis, 1925 Price, \$5.50

In writing a book on Local Anesthesia Dr Hertzler has a better than the average equipment in that he has made a special study of anatomy and again that he is a practicing surgeon with opportunity to test various methods

In his discussion of the drugs employed, he emphasizes the use of quinine and urea hydrochlorid, which is at variance with the custom of most men.

The study of the histologic changes in tissue when quinin is used is original and a valuable research.

The body of the book is taken up with a discussion of the best methods of inducing anesthesia for various operations. The use of Regional Anesthesia is not stressed. Operations on the perineum, rectum,

cervix and other operations are described at length under local but might better be done under caudal anesthesia.

On the whole the book is to be recommended, not so much to the beginner but to the man with some experience who is weighing the value of the various procedures S LLOYD FISHER.

**DIABETIC DIET** A Handbook for Diabetics. By A. DORIS MCHENRY, B.A., and MARJORIE M COOPER, B.A. Harper & Brothers, New York. 1925

This is a convenient manual for the use of the patient and the necessary information is presented in an attractive way. The chapter on Diabetic Recipes is comprehensive, covering about twenty-five pages

The book compares favorably with the others of its type and may be recommended as a simple but satisfactory volume W E. MCCOLLOM

**HANDBOOK OF OPERATIVE SURGERY** By SIR WILLIAM IELAND DE C. WHEELER, (Mod.) B.A., M.D., (Dub Univ.), F.R.C.A.S.I., F.A.C.S. (Hon.) Surgeon to Mercer's Hospital and the National Children's Hospital, Dublin. Fourth Edition, William Wood & Company, New York, 1925 Price, \$5.50

This fourth edition is a small volume well adapted to the need of students or practitioners who are preparing for examinations in operative surgery. It is also of value to the general practitioner for the purpose of acquainting himself with the varied types of procedure adaptable in surgical positions.

Original ideas of the author in the treatment of various conditions have been incorporated in the work.

The book is brought up to date by the addition of text on surgical questions which are the subject of discussion today HARRY KOSTER.

**HANDBOOK OF BACTERIOLOGY** For Students and Practitioners of Medicine. By JOSEPH W BIGGER, M.D., (Dublin), F.R.C.P.I., D.P.H., William Wood & Company, New York, 1925 Price, \$5.00

This addition to the text books on bacteriology can hardly be said to hold any unique position on a subject already so well covered by good texts of a like nature. The reviewer's impression of this text book is that brevity has been carried to an extreme. The book does, however, fulfil the author's aim, in that he has included and condensed, somewhat dogmatically, as he admits, most important topics, theories, and bacteria essential to an elementary understanding of bacteriology and immunity by a medical student.

The text is written in a brief, yet lucid style, amply and remarkably well illustrated by drawings, photographs and colored plates.

An outstanding feature of the book is the correlation between the various pathogenic organisms and the corresponding lesions produced in the animal organism.

S D KRAMER

**THE PRACTICAL MEDICINE SERIES**, comprising eight volumes on the year's progress in medicine and surgery Vol IV, Pediatrics, edited by ISAAC A. ABT, with the collaboration of JOHANNA HEUMANN, M.D. Series 1924 The Year Book Publishers, Chicago, Ill. Price, \$2.00

This little book deserves the highest commendation from every one interested in Pediatrics as a specialty, for the vast amount of readily accessible information it offers in such compact form.

Considering the numerous articles that find their way into press both at home and in the foreign literature, it is no easy matter to judge which material shall be

included and which omitted from a "collection of information which reflects the year's progress in Diseases of Children"

Among numerous other brief reports one finds here such helpful and "up to the minute" excerpts from studies on Diabetes, Goiter and Tuberculosis to more than justify its recommendation to one's Pediatric library. The chapter on Tuberculosis is quite complete and true to the style of its distinguished Editor, reads like an enchanted detective story, without sacrificing any of its scientific data. Of special mention in this connection is the paragraph on the Radiologic aspect of this ever new and baffling subject.

Followers of the ultra modern school will find "all the news that's fit to print" on such subjects as the Intravenous injections of Mercurochrome in the treatment of Pneumonia, also reference on Diathermy as a remedy for Pneumonia. The Editor's warning comment on these two remedies is highly endorsed.

It is delightful to find the detailed report of Zingher's study with the Dick test on normal individuals, also his work on measles. Quite naturally, recent studies on Infant feeding as well as breast feeding occupy a prominent part of the book.

He who has followed the Pediatric literature regularly will find this publication a handy and ready reference. He who for some reason or other, may have to "catch up" with the times, will surely find this little book a boon.

HARRY APFEL.

**MEDICAL EDUCATION, A COMPARATIVE STUDY** By ABRAHAM FLEXNER. The Macmillan Company, 1925. Price, \$2.50.

Actually a survey of medical education, but written in a most engaging way, and without the dry details ordinarily found in such a study, this book is a welcome addition to our critical literature. Stressing the fact that "Medical education cannot be described or discussed apart from general education," there is implied criticism of secondary education in this country. This is the important feature, although as a comparative study of medical education here and abroad, the book is comprehensive, well worth while, and very well done.

C. A. G.

**PROCEEDINGS OF THE INTERNATIONAL CONFERENCE ON HEALTH PROBLEMS IN TROPICAL AMERICA.** Held at Kingston, Jamaica, B. W. I., July 22 to August 1, 1924. By Invitation of the Medical Department United Fruit Company. Published by United Fruit Company, Boston, Mass., 1924.

This volume of the proceedings of the International Conference on Health Problems in Tropical America, held at Kingston, Jamaica, B. W. I., July 22 to August 1, 1924, by invitation of the Medical Department of the United Fruit Company, is a storehouse of information concerning not only the diseases common to the tropics but also contains articles on many conditions of disease present in more temperate climates. Carefully prepared papers on preventive medicine, tropical medicine, malaria, blackwater fever, yellow fever, intestinal parasites and the dysenteries, leprosy, pellagra, hookworm, tropical dermatology, the use of serums and other subjects are presented by men of international reputation in their subjects. No single book of recent publication contains so much on tropical disease as this volume, which has been made possible through the invitation and cooperation of the United Fruit Company. The discussions of the various papers contain comments upon the practical

aspects of the topic under discussion by the men working in different parts of the world and add materially to the value of these papers. The book is well printed and the illustrations are accurate and excellent. This publication is a valuable addition to medical literature.

HENRY M. MOSES

**THE DIAGNOSIS OF CHILDREN'S DISEASES, WITH SPECIAL ATTENTION TO THE DISEASES OF INFANCY.** By Professor Dr. E. FEER, Director of the University Children's Clinic, Zurich, Switzerland. Translated by CARL AHRENDT SCHERER, M.D., F.A.C.P. J. B. Lippincott Company, Philadelphia, 1925. Price, \$5.00.

The translation of this book into English for the first time adds a volume to the encyclopedia of pediatrics in this country that will be welcomed. To those who desire to stimulate their diagnostic acumen at the bedside of the sick infant or child and not rely so much on the laboratory, this work will be found immensely helpful. In other words, it is a book that deals with symptoms, not even differential diagnosis per se is stressed.

Professor Feer is one of the foremost teachers of pediatrics in Europe and this book is written in the style that he teaches. The most prominent symptom of a case is pointed out and the diagnosis is developed from it, laboratory methods being used only as a last resort. The text is supplemented by numerous illustrations from his own cases of the symptoms described.

THURMAN B. GIVAN

**METHODS AND PROBLEMS OF MEDICAL EDUCATION (First and Second Series),** Division of Medical Education, The Rockefeller Foundation, New York, 1924.

These new studies fill a long felt need. It is apparently the intention of the Foundation to publish from time to time contributions to Medical Education, which may be too long for the average journal, possibly of interest to only a limited group, yet of prime importance in the progress of medical education.

The first volume is devoted to teaching methods and physical plans of some of the great medical schools here and abroad, while the second deals with the sanitary survey. The text is English, French and German. Both volumes are intensely interesting.

C. A. G.

**RETINAL VENOUS THROMBOSIS. A Clinical Study of Sixty-two Cases Followed Over Many Years.** By R. FOSTER MOORE. Octavo of 90 pages. London, Geo. Pulman & Sons, 1924. Paper. (Forms Supplement No. 2 of the *British Journal of Ophthalmology*.)

Foster Moore has made one of those rare contributions to Ophthalmology which justly deserves the title of "contribution."

Anyone who has attempted to make a minute and detailed study of fundus changes over a long period of time for a single case with the object of collecting data realizes what a tremendous undertaking it is.

The painstaking and detailed manner in which Foster Moore has undertaken this clinical research places it among the highest types of investigations in any field of science. He takes his analysis up under particularly appropriate headings, as symptoms, causes of thrombosis, changes in veins after thrombosis, retinal hemorrhages, retinal exudates, visual acuity, visual fields, intraocular tension, acute glaucoma, evidences of obstruction without thrombosis and life prognosis.

Altogether, it is felt that every ophthalmologist should add this monograph to his library if he has any ambitions to be properly equipped to interpret the medical aspects of his subject.

J. N. E.



# NEW YORK STATE JOURNAL of MEDICINE

PUBLISHED BY THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

VOL. 25, No 25

NEW YORK, N Y

DECEMBER 15, 1925

## OBSERVATIONS ON THERAPEUTIC VALUE OF SCARLATINAL ANTITOXIN \*

FRANCIS G BLAKE, M.D., and JAMES D TRASK, M D

NEW HAVEN, CONN

IN previous reports <sup>1,2,3</sup>, on the therapeutic value of scarlatinal antitoxin presented in 1924, it was stated that the antitoxin produced a local blanching of the rash at the site of an intracutaneous injection in patients with scarlet fever, that it promptly neutralized the toxin and established an excess of antitoxin in the blood of patients following intramuscular injection in therapeutic doses, and that it appeared to bring about a rapid cure of the disease, as shown by a critical fall of temperature to normal and a rapid fading of the exanthem. Similar clinical results have recently been reported by Birkhaug,<sup>4</sup> Dick and Dick,<sup>5</sup> and Park.<sup>6</sup> Further experience now extending over a period of fifteen months has amply confirmed our previous observations, and has also made it possible to define with greater exactness the therapeutic value of the antitoxin in (1) uncomplicated scarlet fever, (2) scarlet fever with septic complications, and (3) post-scarlatinal sepsis. The data concerning the effect of the antitoxin in these three groups of cases will be presented in the first part of this report. In addition an effort has been made to determine as accurately as possible the amount of antitoxin required to cure scarlet fever promptly and with certainty in cases of varying degrees of severity. The observations concerning dosage will be presented in the second part of the paper.

### THERAPEUTIC EFFECT OF SCARLATINAL ANTITOXIN

In order to interpret satisfactorily the therapeutic effect of scarlatinal antitoxin in uncomplicated scarlet fever, in scarlet fever with septic complications, and in post-scarlatinal sepsis, it is necessary to keep in mind that uncomplicated scarlet fever is essentially a specific toxemia caused by a superficial infection of the throat

with *Streptococcus scarlatinae* without significant invasion of the body tissues by the organism, that scarlet fever with septic complications consists of the specific toxemia with an additional local or general invasion of the body by *Streptococcus scarlatinae* or other pyogenic organisms, and that in post-scarlatinal sepsis the specific scarlatinal toxemia has terminated, but the local or generalized infection of the tissues remains. The clinical symptoms caused by the specific toxemia are fever, accelerated pulse, nausea and vomiting, prostration, delirium, enanthem, exanthem and strawberry tongue, the clinical phenomena due to bacterial invasion of the tissues are represented by such conditions as purulent rhinopharyngitis, sinusitis, otitis media, mastoiditis, ulcerative tonsillitis, cervical adenitis, meningitis, arthritis, thrombophlebitis, and septicemia.

The time relationship of the toxic and septic aspects of scarlet fever and the increasing incidence and importance of the septic phase as the disease progresses are shown diagrammatically on Chart I, which has been constructed from data accumulated in the detailed study of over 100 cases of scarlet fever. The duration of the specific toxic phase, which is closely paralleled by the course of the rash, ordinarily varies from four

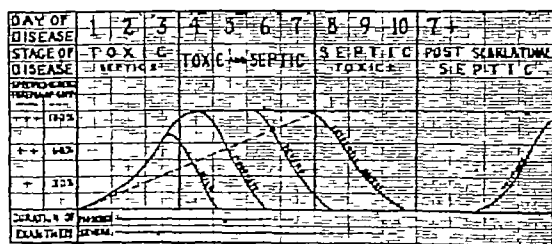


Chart I Diagram illustrating the presence of toxin in the blood during the specific toxemic phase of scarlet fever in mild to extremely severe cases, the increasing incidence and importance of septic complications as the disease progresses, and the appearance of antitoxin in the blood following the disappearance of toxin and the fading of the rash, even though the septic phase continues.

\* Read at the Annual Meeting of the Medical Society of the State of New York, May 12 1925

From the Department of Internal Medicine Yale University School of Medicine and the Medical Service of the New Haven Hospital.

to seven days but may be somewhat longer in very severe infections. During this period the specific scarlatinal toxin circulates in the blood and its presence can be demonstrated readily as shown by Trask and Blake.<sup>7</sup> Superimposed upon the toxic phase in an increasing proportion of cases as the disease progresses is the septic phase. In the cases studied only one-third of those coming under observation during the first three days of the disease had septic complications when first seen, in most instances relatively mild in nature, while two-thirds of those coming under observation from the fourth to the seventh day had septic complications, in many instances relatively severe. By the end of the first week local or generalized septic processes have become the most important factor in nearly all patients who are still sick and, even though these persist and become more severe, the specific scarlatinal toxemia rapidly terminates as shown by the disappearance of the circulating toxin and clinically by the fading of the rash. Not only does the specific toxemia disappear, but antitoxin may appear in the patient's blood in spite of the presence of severe sepsis and the septic process may continue to advance in spite of the fact that the patient has himself produced sufficient antitoxin to cure the specific toxic manifestations of scarlet fever. Since the fading of the rash parallels the disappearance of the specific toxemia, all patients with septic processes in whom the rash has gone should be considered to be in the stage of post-scarlatinal sepsis.

With the foregoing considerations in mind, it is clear that one must attempt to distinguish between the effect of the antitoxin on the specific toxic phenomena of scarlet fever on the one hand, and its effect on the septic aspects of the disease on the other, since the two processes are of distinctly different nature. If the serum is effective solely by virtue of its antitoxic properties it should promptly cure uncomplicated scarlet fever, it should likewise cure the specific toxic features of complicated scarlet fever but should only indirectly benefit the septic complications, and it should have little, if any, demonstrable effect in post-scarlatinal sepsis. If, on the other hand, the serum possesses both antitoxic and antibacterial properties, it should not only cure scarlet fever itself but also might have a direct curative effect on the septic complications.

**Therapeutic Results in Uncomplicated Scarlet Fever**—During the period covered by this report 57 cases of uncomplicated scarlet fever have been treated with Dochez's unconcentrated antitoxin by intramuscular injection. Of these 2 were extremely severe, 11 severe, 23 moderately severe, and 21 mild, 44 were treated on or before the third day of the disease, 13 after the third day.

All were promptly cured within 12 to 36 hours, irrespective of the severity or duration of the disease at the time of treatment. Chart II illustrates the invariable therapeutic result in uncomplicated cases.

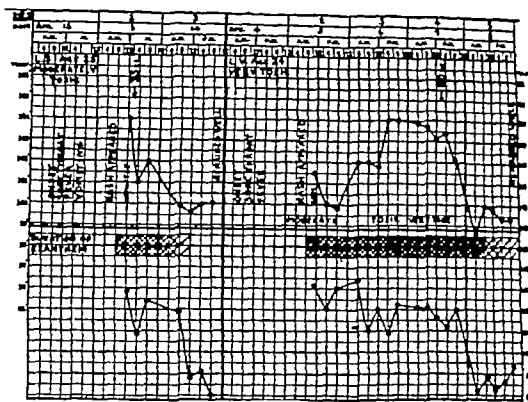


Chart 2 Critical cure of uncomplicated scarlet fever by antitoxin

**Therapeutic Results in Scarlet Fever with Septic Complications**—Forty-eight cases of scarlet fever with septic complications have been treated. Of these 10 were extremely severe, 18 severe, 13 moderately severe, and 7 mild, 22 were treated on or before the third day, 26 on or after the fourth day of the disease. Purulent rhinopharyngitis with or without sinusitis was present in 29 patients, suppurative otitis media in 11, cervical adenitis in 11, ulcerative tonsillitis or peritonsillar abscess in 9, mastoiditis in 2, thrombophlebitis and septicemia in 1, other miscellaneous conditions in 9. Forty-seven of these patients were promptly cured of the specific toxic phase of scarlet fever as shown by fall of temperature, rapid fading of the rash and prompt neutralization of the toxin of the blood. Their septic complications were not immediately cured but subsided more or less rapidly depending upon the nature, severity, and duration of the complication. One extremely severe case with purulent rhinopharyngitis, ulcerative tonsillitis, cervical adenitis, thrombophlebitis and septicemia who received a single injection of 40 cc of antitoxin on the fifth day died on the eighth day. Charts III, IV and V illustrate the effect of the antitoxin in complicated cases.

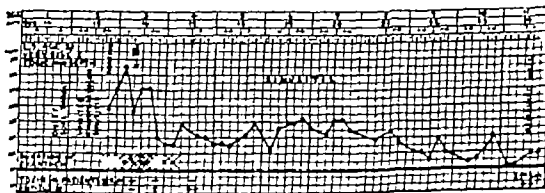


Chart 3 Critical cure of specific toxemia and gradual subsidence of septic complications in toxic and septic scarlet fever

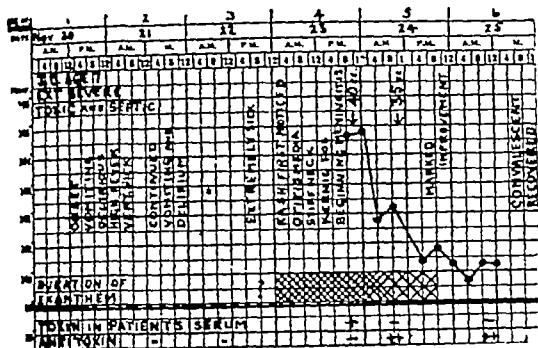


Chart 4 Critical cure of specific toxemia and rapid subsidence of septic complications (otitis media and meningitis) following treatment with antitoxin

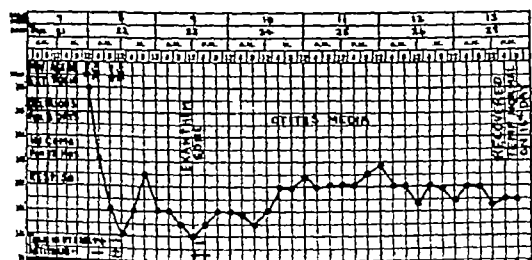


Chart 5 Critical cure of specific toxemia in extremely toxic and septic case treated on 7th day

### Therapeutic Results in Post-scarlatinal Sepsis

Seven cases of post-scarlatinal sepsis in whom the rash had completely faded have been treated. In none of these was it possible to demonstrate that the treatment had any influence on the course of the infection. If the serum is effective solely by reason of its antitoxic action, this result was to be expected since the specific toxic stage had passed and the patients, in some cases at least, already had a measurable amount of their own antitoxin circulating in the blood before treatment was administered. Chart VI illustrates the apparent ineffectiveness of the antitoxin in post-scarlatinal sepsis.

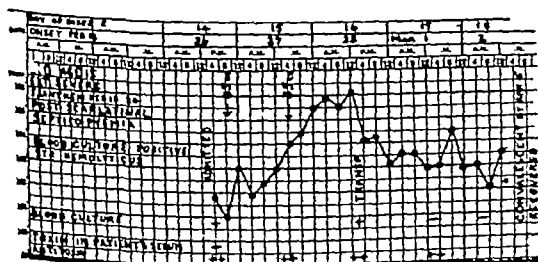


Chart 6. Failure of antitoxin in post-scarlatinal sepsis. Note the absence of toxin and presence of antitoxin in patient's blood before treatment

*Incidence of Complications and Sequelæ Following Treatment*—Of the 57 uncomplicated cases 5 subsequently developed complications as follows: mild non-suppurative cervical adenitis late in convalescence 2, otitis media 1, transient fibrinous pleurisy 1, and acute nephritis 1. All recovered satisfactorily. Of the 48 complicated cases 5 developed additional complications not present at the time of treatment. These were non-suppurative cervical adenitis and arthritis 1, otitis media 3, otitis media and mastoiditis 1. All recovered satisfactorily.

### AMOUNT OF ANTITOXIN REQUIRED TO CURE SCARLET FEVER

In view of the therapeutic results reported above and the well-recognized fact that sepsis plays an increasingly important rôle as the disease progresses, it is apparent that the goal to be attained in the treatment of scarlet fever with antitoxin is the prompt neutralization of toxin and simultaneous establishment of a considerable excess of antitoxin in the circulating blood of the patient as early as possible in the disease. The amount of serum required will vary with the size of the patient, the severity of the disease, and the antitoxin content of the serum used. In order to determine the amount of serum necessary to accomplish the desired result, the presence of toxin and antitoxin in the blood before and at intervals after treatment has been determined in a considerable series of cases of scarlet fever of varying ages and degrees of severity treated with ten different lots of serum of varying antitoxin content per cubic centimeter. The intramuscular route of injection, rather than the intravenous, has been employed because the intramuscular route will be more generally used in practice.

The presence of toxin in the patient's blood was determined<sup>†</sup> by the capacity of the patient's serum to produce a local reaction when injected into the skin of susceptible human volunteers, the presence of antitoxin by the capacity of the serum to produce a positive blanching test in patients with scarlet fever. The method of comparing the antitoxin content of different lots of serum was to determine the minimum amount of serum that would produce a positive blanching test. This has been designated the minimal blanching dose. For the sake of comparison with the method of antitoxin standardization advocated by the Dicks<sup>5</sup> and now in general use, the number of minimal blanching doses per c.c. has been translated into the number of skin test doses of toxin neutralized per c.c. and in turn into units per c.c.\* The relative strength of the different lots of antitoxin used is shown in Table I.

\* One unit equals the amount of antitoxin that will neutralize 100 skin test doses of toxin.

TABLE I—TITRATION OF THE COMPARATIVE STRENGTH OF 10 LOTS OF SCARLATINAL ANTITOXIN

Antitoxin Lot	—Titration of M B D—					Minimal blanching doses per c.c.	Skin Test doses of toxin neutralized per c.c.*	Units of antitoxin per c.c.
	01 c.c.	002	0004	00008	000016			
1 Dochez (conc.)	++	++	++	+	±	62,500 +	50,000 +	500 +
2 Dochez (unconc.)	++	++	+	±	—	12,500 +	10,000 +	100 +
3 A-77 (unconc.)	++	±	±	±	—	12,500	10,000	100
4 N Y S (unconc.)	++	±	±	±	—	12,500	10,000	100
5 357-9 (unconc.)	+	+	±	—	—	2,500 +	2,000 +	20 +
6 A-5 (conc.)	++	++	±	—	—	2,500 +	2,000 +	20 +
7 362-9 (unconc.)	++	±	±	—	—	2,500	2,000	20
8 U S (conc.)	++	±	±	—	—	2,500	2,000	20
9 351-9 (unconc.)	++	±	—	—	—	500 +	400 +	4 +
10 373-9 (unconc.)	+	±	—	—	—	500 +	400 +	4 +

\* These tests were not done by the authors, but are believed to be approximately correct within the limitations of the method.

As a basis for comparative study 30 cases treated with Dochez's unconcentrated antitoxin were first studied by this method. From the results which are shown in Table II, it is clear that 30 to 40 c.c. of a serum containing 12,500 + M B D per c.c. given intramuscularly is sufficient to neutralize promptly the toxin and establish an adequate excess of antitoxin in the blood of all mild or moderately severe cases of scarlet fever in both children and adults. In the 12 severe cases studied (Table III) amounts of serum ranging from 40 to 195 c.c. were used, usually in divided doses. Analysis of the results shows that the repeated doses were rarely necessary and that 40 to 80 c.c. in children, 70 to 120 c.c. in adults, of a serum containing 12,500 + M B D per c.c. may safely be considered the maximum doses required in severe cases.

CASE	AGE	CLINICAL SEVERITY	AMOUNT OF ANTITOXIN IN CC.	TOXIN IN HIS SERUM TAKEN PRIOR TO TREATMENT	ANTITOXIN IN PATIENT'S BLOOD BEFORE AND AFTER TREATMENT WITH ANTITOXIN								ANTITOXIN IN PATIENT'S SERUM TAKEN 24 HRS. AFTER TREATMENT	
					DAY OF DISEASE									
					2	3	4	5	6	7	8	9		
J.A.	12	MILD	35	++	+	+	+	+	+	+	+	+	+	+
M.I.	3	+	+	+	+	+	+	+	+	+	+	+	+	+
E.C.	5	+	+	+	+	+	+	+	+	+	+	+	+	+
H.C.	8	+	45	+	+	+	+	+	+	+	+	+	+	+
T.D.	6	+	50	+++	+	+	+	+	+	+	+	+	+	+
L.W.	10	MOD. SEVERE	30	+	+	+	+	+	+	+	+	+	+	+
F.D.	10	+	35	+	+	+	+	+	+	+	+	+	+	+
S.N.	6	+	40	+	+	+	+	+	+	+	+	+	+	+
H.B.	10	+	50	+	+	+	+	+	+	+	+	+	+	+
A.S.	25	MILD	35	+	+	+	+	+	+	+	+	+	+	+
F.M.	27	+	+	+	+	+	+	+	+	+	+	+	+	+
L.S.	25	MOD. SEVERE	+	+	+	+	+	+	+	+	+	+	+	+
P.F.	32	+	+	+	+	+	+	+	+	+	+	+	+	+
E.T.	12	+	+	+	+	+	+	+	+	+	+	+	+	+
E.C.	19	+	+	+	+	+	+	+	+	+	+	+	+	+
J.D.	17	+	40	+	+	+	+	+	+	+	+	+	+	+
H.F.	26	+	+	+	+	+	+	+	+	+	+	+	+	+
A.B.	33	+	+	+	+	+	+	+	+	+	+	+	+	+

TABLE II—Studies on Dosage in Mild and Moderate Cases of Scarlet Fever Treated with Dochez's Unconcentrated Antitoxin (1 c.c. = 100 + units)

Twenty-one patients have been treated with other lots of antitoxin. The relative strength of the different lots, dosage used, clinical effect, and observations on the presence of toxin and antitoxin in the blood of the patients before and after treatment (determined on 12 of the 21), are shown in Table IV. The results of this study are unequivocal and speak for themselves. They

CASE-	AGE-	CLINICAL SEVERITY	AMOUNT OF ANTITOXIN (cc.)	TOXIN IN SERUM (1 cc.)	ANTITOXIN IN PATIENT'S BLOOD BEFORE AND AFTER TREATMENT (1 cc.)												
					1	2	3	4	5	6	7	8	9	10	11	12	
M. R.	6	EXT. MILD	35	++	-	+	+	+	+	+	+	+	+	+	+	+	+
M. I.	7	MOD. SEV.	40	++	-	+	+	+	+	+	+	+	+	+	+	+	+
E. R.	5	EXT. MILD	40	++	-	+	+	+	+	+	+	+	+	+	+	+	+
H. C.	8	EXT. MILD	50	++	-	+	+	+	+	+	+	+	+	+	+	+	+
T. D.	6	EXT. MILD	35	++	-	+	+	+	+	+	+	+	+	+	+	+	+
L. W.	10	MOD. SEV.	40	++	-	+	+	+	+	+	+	+	+	+	+	+	+
F. D.	10	MOD. SEV.	35	++	-	+	+	+	+	+	+	+	+	+	+	+	+
S. N.	6	MOD. SEV.	40	++	-	+	+	+	+	+	+	+	+	+	+	+	+
H. B.	10	MOD. SEV.	50	++	-	+	+	+	+	+	+	+	+	+	+	+	+
A. S.	25	MOD. SEV.	35	++	-	+	+	+	+	+	+	+	+	+	+	+	+
F. M.	27	MOD. SEV.	40	++	-	+	+	+	+	+	+	+	+	+	+	+	+
L. S.	25	MOD. SEV.	40	++	-	+	+	+	+	+	+	+	+	+	+	+	+
P. F.	32	MOD. SEV.	40	++	-	+	+	+	+	+	+	+	+	+	+	+	+
E. T.	12	MOD. SEV.	40	++	-	+	+	+	+	+	+	+	+	+	+	+	+
E. C.	19	MOD. SEV.	40	++	-	+	+	+	+	+	+	+	+	+	+	+	+
J. D.	17	MOD. SEV.	40	++	-	+	+	+	+	+	+	+	+	+	+	+	+
H. F.	26	MOD. SEV.	40	++	-	+	+	+	+	+	+	+	+	+	+	+	+
A. B.	33	MOD. SEV.	40	++	-	+	+	+	+	+	+	+	+	+	+	+	+

TABLE III—Studies on Dosage in Severe Cases of Scarlet Fever Treated with Dochez's Unconcentrated Antitoxin (1 c.c. = 100 + units)

show that an antiscarlatinal serum to be therapeutically efficient in reasonable dosage should contain at least 12,500 M B D of antitoxin per c.c. or, in other words, should be able to neutralize at least 10,000 skin test doses of toxin per c.c. which is equivalent to 100 units per c.c. This is ten times as strong as the standard advocated by Dick and Dick.<sup>5</sup> They also show that a serum containing 2500 M B D per c.c. (2000 skin test doses neutralized per c.c. or 20 units per c.c.), which is twice as strong as the standard advocated by Dick and Dick,<sup>5</sup> is of very doubtful therapeutic value, and that one containing 500 M B D per c.c. (400 skin test doses neutralized per c.c. or 4 units per c.c.) is of no value.

ANTITOXIN	PLD	STD	AMOUNT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1150	1151	1152	1153	1154	1155	1156	1157	1158	1159	1160	1161	1162	1163	1164	1165	1166	1167	1168	1169	1170	1171	1172	1173	1174	1175	1176	1177	1178	1179	1180	1181	1182	1183	1184	1185	1186	1187	1188	1189	1190	1191	1192	1193	1194	1195	1196	1197	1198	1199	1200	1201	1202	1203	1204	1205	1206	1207	1208	1209	1210	1211	1212	1213	1214	1215	1216	1217	1218	1219	1220	1221	1222	1223	1224	1225	1226	1227	1228	1229	1230	1231	1232	1233	1234	1235	1236	1237	1238	1239	1240	1241	1242	1243	1244	1245	1246	1247	1248	1249	1250	1251	1252	1253	1254	1255	1256	1257	1258	1259	1260	1261	1262	1263	1264	1265	1266	1267	1268	1269	1270	1271	1272	1273	1274	1275	1276	1277	1278	1279	1280	1281	1282	1283	1284	1285	1286	1287	1288	1289	1290	1291	1292	1293	1294	1295	1296	1297	1298	1299	1300	1301	1302	1303	1304	1305	1306	1307	1308	1309	1310	1311	1312	1313	1314	1315	1316	1317	1318	1319	1320	1321	1322	1323	1324	1325	1326	1327	1328	1329	1330	1331	1332	1333	1334	1335	1336	1337	1338	1339	1340	1341	1342	1343	1344	1345	1346	1347	1348	1349	1350	1351	1352	1353	1354	1355	1356	1357	1358	1359	1360	1361	1362	1363	1364	1365	1366	1367	1368	1369	1370	1371	1372	1373	1374	1375	1376	1377	1378	1379	1380	1381	1382	1383	1384	1385	1386	1387	1388	1389	1390	1391	1392	1393	1394	1395	1396	1397	1398	1399	1400	1401	1402	1403	1404	1405	1406	1407	1408	1409	1410	1411	1412	1413	1414	1415	1416	1417	1418	1419	1420	1421	1422	1423	1424	1425	1426	1427	1428	1429	1430	1431	1432	1433	1434	1435	1436	1437	1438	1439	1440	1441	1442	1443	1444	1445	1446	1447	1448	1449	1450	1451	1452	1453	1454	1455	1456	1457	1458	1459	1460	1461	1462	1463	1464	1465	1466	1467	1468	1469	1470	1471	1472	1473	1474	1475	1476	1477	1478	1479	1480	1481	1482	1483	1484	1485	1486	1487	1488	1489	1490	1491	1492	1493	1494	1495	1
-----------	-----	-----	--------	---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	---

TABLE IV—Studies on Dosage with 10 Different Lots of Scarlatinal Antitoxin of Varying Antitoxin Content per Cubic Centimeter of Serum.

Study of the therapeutic value of scarlatinal antitoxin in uncomplicated scarlet fever, in scarlet fever with septic complications, and in post-scarlatinal sepsis has made it clear that the antitoxin in proper amount is a specific and efficient cure for uncomplicated scarlet fever. In scarlet fever with septic complications it likewise promptly cures the scarlet fever itself, but does not appear to have a direct or immediate curative effect on the complications. Even though it does not directly cure the septic aspects of the disease in this group of cases, it nevertheless does unquestionably benefit the complications, at least indirectly, presumably by curing the specific toxemia and thereby placing the patient in a position to overcome even serious complications to which he might otherwise succumb. The effectiveness of the beneficial influence on the complications probably depends in part upon the relative importance of the specific toxemia and of the septic process, and in part upon the nature, duration, and severity of the complication in the particular case at the time the antitoxin is given. It is shown clinically by the more or less rapid subsidence of complications following antitoxin treatment. In post-scarlatinal sepsis, on the other hand, it has so far been impossible to demonstrate that the antitoxin possesses any therapeutic value. It would appear, therefore, that the therapeutic value of antiscarlatinal serum is due largely, if not entirely, to its antitoxin content, rather than to any antibacterial properties which it may possess.

Of almost equal importance is the possible effectiveness of the antitoxin in reducing the incidence of complications and sequelæ in those who have not already developed them at the time of treatment. While subsequent complications have been exceedingly few in the group of cases reported and in no instance of a serious nature, it does not seem wise to express a final opinion in this matter until a much larger series of cases has been treated. The results have been sufficiently encouraging, however, to make it probable that the antitoxin will prove to be exceedingly effective in this respect.

It follows inevitably from the foregoing analysis of the therapeutic action of scarlatinal antitoxin that the only rational procedure is immediate treatment as soon as the diagnosis is made before the septic phase of the disease has developed or assumed a significant rôle. Under these circumstances a critical cure may be expected and the probability that complications will develop is small. In cases in which septic complications are present when the patient is first seen antitoxin should be given at once provided the rash is still present. Under these circumstances a prompt cure of the specific toxic features of scarlet fever may be expected and the complications, if not too serious, will more or less

rapidly subside. It should be emphasized in this connection that, even though the specific toxemia is cured, the temperature may remain more or less elevated because of the complication and that the continued fever should not be interpreted as a failure of the antitoxin to cure scarlet fever itself nor as an indication for additional antitoxin treatment *provided the rash has faded within 24 hours*. As already pointed out, little or no benefit may be expected from use of the antitoxin in cases of post-scarlatinal sepsis after the rash has disappeared. Chart 7 illustrates the therapeutic effect of the antitoxin.



Chart 7 Diagrammatic representation of the therapeutic effect of scarlatinal antitoxin. Lines without arrowheads show the natural course of events in untreated scarlet fever. Lines with arrowheads show the prompt disappearance of circulating toxin and appearance of antitoxin in the patient's blood and the more or less rapid subsidence of complications following treatment with antitoxin.

In order to obtain the best therapeutic results it is essential that sufficient antitoxin be given in one dose, not only to neutralize the toxin in the patient's blood, but also to establish promptly a measurable excess of antitoxin in the circulation. Theoretically this excess should be sufficient to last until the patient develops his own antitoxin. In the studies to determine the amount of antitoxin required to accomplish this result, the conclusions arrived at have been based solely upon the actual demonstration of an excess of antitoxin in the blood of the patients studied and not upon clinical impressions concerning the effect of the treatment on the course of the disease. It is true, however, that the therapeutic result, as was to be expected, coincided with success or failure in establishing an excess of antitoxin in the blood of the patient. The results of the study have led us to the conclusion that the basic therapeutic dose for intramuscular treatment should be at least 3000 units of antitoxin. Since 1 unit is that amount of antitoxin which will neutralize 100 skin test doses of toxin, 3000 units is an amount which will neutralize 300,000 skin test doses of toxin, or 30 c.c. of a serum which neutralizes 10,000 skin test doses per c.c. This figure is in marked disagreement with that advocated by Dick and Dick,<sup>6</sup> who state that an amount of antitoxin which will neutralize 20,000 skin test doses of toxin (200 units or 20 c.c. of

a serum that neutralizes 1000 skin test doses per c.c.) is a therapeutic dose. In our experience, as shown in Table IV, even three to four times this amount of antitoxin has failed to establish consistently an excess of antitoxin in the patient's blood or to exert any demonstrable influence on the course of the disease. On the other hand 3000 units as a basic therapeutic dose, is in exact agreement with the figure reached independently by Park,<sup>6</sup> who used the Dick test as a measure of whether or not sufficient antitoxin had been given in patients treated by him.

In view of the data presented above it is believed that satisfactory therapeutic results will be obtained only when an antitoxin sufficiently strong to neutralize at least 10,000 skin test doses of toxin per c.c. is employed. With antitoxin of this strength the following intramuscular dosage is recommended:

	Mild and Moderate	Severe	Extremely Severe
Children	30 to 40 c.c. (3000 to 4000 units)	40 to 60 c.c. (4000 to 6000 units)	80 c.c. (8000 units)
Adults	40 c.c. (4000 units)	60 to 80 c.c. (6000 to 8000 units)	80 to 120 c.c. (8000 to 12000 units)

#### CONCLUSIONS

1. Scarletinal antitoxin in proper amount is a specific and prompt cure for uncomplicated scarlet fever.
2. It indirectly benefits septic complications during the acute stage of scarlet fever presumably by curing the specific toxemia.
3. It has not been possible to demonstrate that it possesses any therapeutic value in post-scarlatinal sepsis after the rash has faded.
4. To be therapeutically efficient in reasonable dosage an anti-scarlatinal serum should contain at least 12,500 minimal blanching doses of antitoxin per c.c. or be able to neutralize at least 10,000 skin test doses of toxin per c.c.
5. The amount of toxin required to cure scarlet fever promptly and with certainty by intramuscular injection varies from 3000 units to 12,000 units (30 to 120 c.c. of a serum which neutralizes 10,000 skin test doses of toxin per c.c.), depending upon the size of the patient and the severity of the disease.
6. To obtain the best therapeutic results the full amount of antitoxin required in each case should be estimated and given at once as soon as the diagnosis is made.

#### REFERENCES

1. Blake, F. G., Trask, J. D., and Lynch, J. F., *Jour Am Med Assn* 1924, 82, 712.
2. Blake, F. G., *Bost Med and Surg Jour*, 1923, 191, 43.
3. Blake, F. G., *Trans Assn Amer Phys*, 1924, 39, 141.
4. Birkhaug, K. E., *Bull J H H*, 1925, 36, 134.
5. Dick, G. F., and Dick, G. H., *Jour Am Med Ass'n*, 1925, 84, 803.
6. Park, W. H., *Jour Am Med Ass'n*, 1925, 84, 1595.
7. Trask, J. D., and Blake, F. G., *Jour Exp Med*, 1924, 40, 381.

#### DISCUSSION

DR AUGUSTUS WADSWORTH.—I appreciate the privilege of opening the discussion on Dr Blake's paper, and also welcome the opportunity to report to you the work which we have done toward preparing serum for your use.

At the May meeting of the Association of American Physicians in Atlantic City last year, Dr Blake's report of the treatment of scarlet fever with the Dochez antiscarlatinal serum was so striking and so convincing as to the therapeutic value of the serum in the early stages of the disease that cultures were secured from Dr Dochez and the immunization of horses was started during the summer. About the same time, I wrote Dr Dick for transplants of his culture, hoping to compare the action of the serums produced with these different cultures, but I was unable to secure a transplant of the Dick culture. Our experience, until very recently, has therefore been limited to a study of the Dochez strain and of strains that we have been able to obtain from various sources.

Miss Kirkbride and Miss Wheeler have already presented at the recent meeting in Washington the results of their study of scarlatinal and other strains of hemolytic streptococci. They fortunately discovered that some goats are susceptible to the action of the toxin. This fact has permitted an intensive study of the action of these toxins and of their neutralization by antitoxin, which facilitates greatly the standardization of the scarlatinal antitoxin. The evidence in regard to the action of the serum which Drs Dochez, Blake, Trask and Lynch, and also Dr Birkhaug of Baltimore, have accumulated in the last year, together with the observations of Dr Park at the Willard Parker Hospital, leaves no question as to the efficacy of the serum treatment of scarlet fever in the early stages. The fall in temperature, disappearance of the rash and marked improvement in the symptoms—in short a true crisis—suggest very strikingly that the toxemia is neutralized, as it is in the treatment of diphtheria with antitoxin.

We have gradually accumulated a supply of the serum, and from results of our tests and the reports from Dr Blake, the serum which we have prepared by the method of Dochez is equivalent in potency to his serum. The serum has been available since November, but only in limited quantities. It is now being more generally distributed, chiefly in the larger centers of population and the more important district supply stations. Physicians, however, have not used the serum very generally, and only very few reports as regards its use have as yet reached us. These simply confirm those you have already heard.

I am especially interested in Dr Blake's very lucid explanation of the mechanism of the de-

velopment of scarlet fever infection and the action of the serum the early toxemia, the development of antitoxic immunity in the tissues, together with the later parasitic invasion in septic and complicated cases. This point of view affords a very sound basis for the study of the results of serum therapy as they accumulate. It interests me particularly because after all, the streptococci and pneumococci are so closely related that the study of their infectious processes should be very closely correlated. Thus it is that Dr Blake's observations on the streptococcus infection in scarlet fever in principle parallel the conclusions of experimental studies of pneumococcus infection, and the action of immune serum which I have reported from time to time since 1912, namely, that in pneumonia the disease is largely a toxemia complicated by parasitic invasion, and that the immune serum acts in a manner similar to antitoxin in diphtheria, neutralizing the toxic substances. The longer we study the action of antipneumococcus serum in pneumonia and antistreptococcus serum in scarlet fever, the more apparent will become the antitoxic action of these serums, the prognosis depending upon the character of the parasitic in-

vasion of the incitant. In pneumonia, however, the parasitic invasion takes place immediately, whereas in scarlet fever, according to Dr Blake's observations, it is preceded by a period of toxemia which permits of complete and immediate neutralization by the introduction of the serum. Such treatment may serve to prevent subsequent parasitic invasion, and the development of septic complications which, after it once becomes established, may not yield so readily to serum treatment. Intravenous injection will, of course, yield the most prompt results. The patient, however, should be safeguarded from the danger of anaphylaxis by a careful test of susceptibility to horse serum and desensitization with a small dose of the serum—one-fourth to one-half cc. subcutaneously. Intramuscular injections are absorbed a little more slowly, but the danger of anaphylaxis is less than with the intravenous method. It is doubtful if serum sickness can be avoided. It may well be that the concentration of the serum, which we find amounts to about three to four times, may be of value, but one must realize at the same time that the concentration of protein is considerable, two to three times that of normal serum.

## THE ENDOCRINE TREATMENT OF MENSTRUAL DISORDERS \*

TIMOTHY F DONOVAN, M D

BUFFALO N Y

THE successful endocrine treatment of menstrual disorders depends upon the diagnosis of the underlying endocrine disturbance. The signs and symptoms of the endocrine disturbance are usually present long before the appearance of the menstrual disorder. So it may be said that the most favorable time for the endocrine treatment of menstrual disorders is before the latter appear.

Underdevelopment of the uterus and menstrual disturbance result from functional impairment, disease, or removal of the ovaries, the pituitary, or the thyroid; and the conclusion is justified that normal uterine development and normal menstruation are the result of the coordinated activity of these glands.

The coordinated activity of the same glands is chiefly responsible for normal skeletal development. To the activity of the anterior lobe of the pituitary is due the growth of the flat and peaked bones and the shafts of the long bones, and the timely appearance and subsequent development of the bone nuclei for the carpal and tarsal bones and for the epiphyses are due to thyroid activity, while gonadal function brings about the union of epiphyses with shafts.

Practical use may be made of these facts in

the early diagnosis of endocrine disturbances which are known to be associated with menstrual disorders later in life.

The early diagnosis is so important, and a knowledge of it on the part of the general practitioner and the pediatrician are so essential, that I propose now to devote some attention to its discussion.

William Engelbach, in 1922, said that 70% of children whose birth weight exceeded 8 pounds, had a functionally deficient thyroid gland. Associated with this infantile obesity is delay in teething, walking, and talking.

That in infancy, as in adult life, obesity is not a constant finding in hypothyroidism is evidenced by the histories of two children.

Case 1—Infant S Female. Age 15 months. Referred by Dr Vincent Moscato, February 21, 1925. Full term baby, birth weight, 6½ pounds, breast fed for 6 months, difficult feeding case, constipated since artificial feeding began, no teeth, does not stand alone, walk, or talk, irritable, restless, and cries a great deal of the time, frequent colds.

Weight 23 pounds, pale, thin hair, very scant eyebrows with absent outer third, gracile hands with many white marks under the nails, moist eczema of hands.

Father is of eunuchoid giant type, with waist line obesity.

\*Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse, May 12, 1925.

a serum that neutralizes 1000 skin test doses per c.c.) is a therapeutic dose. In our experience, as shown in Table IV, even three to four times this amount of antitoxin has failed to establish consistently an excess of antitoxin in the patient's blood or to exert any demonstrable influence on the course of the disease. On the other hand 3000 units as a basic therapeutic dose, is in exact agreement with the figure reached independently by Park,<sup>6</sup> who used the Dick test as a measure of whether or not sufficient antitoxin had been given in patients treated by him.

In view of the data presented above it is believed that satisfactory therapeutic results will be obtained only when an antitoxin sufficiently strong to neutralize at least 10,000 skin test doses of toxin per c.c. is employed. With antitoxin of this strength the following intramuscular dosage is recommended:

	Mild and Moderate	Severe	Extremely Severe
Children	30 to 40 c.c. (3000 to 4000 units)	40 to 60 c.c. (4000 to 6000 units)	80 c.c. (8000 units)
Adults	40 c.c. (4000 units)	60 to 80 c.c. (6000 to 8000 units)	80 to 120 c.c. (8000 to 12000 units)

#### CONCLUSIONS

- 1 Scarlatinal antitoxin in proper amount is a specific and prompt cure for uncomplicated scarlet fever.
- 2 It indirectly benefits septic complications during the acute stage of scarlet fever presumably by curing the specific toxemia.
- 3 It has not been possible to demonstrate that it possesses any therapeutic value in post-scarlatinal sepsis after the rash has faded.
- 4 To be therapeutically efficient in reasonable dosage an anti-scarlatinal serum should contain at least 12,500 minimal blanching doses of antitoxin per c.c. or be able to neutralize at least 10,000 skin test doses of toxin per c.c.
- 5 The amount of toxin required to cure scarlet fever promptly and with certainty by intramuscular injection varies from 3000 units to 12,000 units (30 to 120 c.c. of a serum which neutralizes 10,000 skin test doses of toxin per c.c.), depending upon the size of the patient and the severity of the disease.
- 6 To obtain the best therapeutic results the full amount of antitoxin required in each case should be estimated and given at once as soon as the diagnosis is made.

#### REFERENCES

- 1 Blake, F. G., Trask, J. D., and Lynch, J. F., *Jour Am Med Assn* 1924, 82, 712.
- 2 Blake, F. G., *Bost Med and Surg Jour* 1923, 191, 43.
- 3 Blake, F. G., *Trans Assn Amer Phys*, 1924, 39, 141.
- 4 Birkhaug, K. E., *Bull J H H*, 1925, 36, 134.
- 5 Dick, G. F., and Dick, G. H., *Jour Am Med Ass'n*, 1925, 84, 803.
- 6 Park, W. H., *Jour Am Med Ass'n*, 1925, 84, 1595.
- 7 Trask, J. D., and Blake, F. G., *Jour Exp Med*, 1924, 40, 381.

#### DISCUSSION

DR AUGUSTUS WADSWORTH—I appreciate the privilege of opening the discussion on Dr Blake's paper, and also welcome the opportunity to report to you the work which we have done toward preparing serum for your use.

At the May meeting of the Association of American Physicians in Atlantic City last year, Dr Blake's report of the treatment of scarlet fever with the Dochez antiscarlatinal serum was so striking and so convincing as to the therapeutic value of the serum in the early stages of the disease that cultures were secured from Dr Dochez and the immunization of horses was started during the summer. About the same time, I wrote Dr Dick for transplants of his culture, hoping to compare the action of the serums produced with these different cultures, but I was unable to secure a transplant of the Dick culture. Our experience, until very recently, has therefore been limited to a study of the Dochez strain and of strains that we have been able to obtain from various sources.

Miss Kirkbride and Miss Wheeler have already presented at the recent meeting in Washington the results of their study of scarlatinal and other strains of hemolytic streptococci. They fortunately discovered that some goats are susceptible to the action of the toxin. This fact has permitted an intensive study of the action of these toxins and of their neutralization by antitoxin, which facilitates greatly the standardization of the scarlatinal antitoxin. The evidence in regard to the action of the serum which Drs Dochez, Blake, Trask and Lynch, and also Dr Birkhaug of Baltimore, have accumulated in the last year, together with the observations of Dr Park at the Willard Parker Hospital, leaves no question as to the efficacy of the serum treatment of scarlet fever in the early stages. The fall in temperature, disappearance of the rash and marked improvement in the symptoms—in short a true crisis—suggest very strikingly that the toxemia is neutralized, as it is in the treatment of diphtheria with antitoxin.

We have gradually accumulated a supply of the serum, and from results of our tests and the reports from Dr Blake, the serum which we have prepared by the method of Dochez is equivalent in potency to his serum. The serum has been available since November, but only in limited quantities. It is now being more generally distributed, chiefly in the larger centers of population and the more important district supply stations. Physicians, however, have not used the serum very generally, and only very few reports as regards its use have as yet reached us. These simply confirm those you have already heard.

I am especially interested in Dr Blake's very lucid explanation of the mechanism of the de-



roid nucleoprotein (1%) tablets were prescribed, because of the child's appetite, which had always been poor, particularly for breakfast. This was taken for 6 weeks, with an improvement in appetite and a gain in weight of 3 lbs. She was seen again on April 20, 1925. She was of normal height, but a few pounds underweight for her age. She was pale, flat-chested and had a protuberant abdomen. The nails of her gracile hands showed many white spots and ridging. Her teeth showed separation of the upper incisors, malocclusion of upper and lower lateral incisors and canines, and notching. Thyroid deficient patients show not only late dentition, but malocclusion, notching, absence of enamel, and early loss of teeth.

Spacing of the teeth is a pituitary sign, separation of uppers and sometimes of lowers, occurs in underactivity of the anterior lobe, and separation of uppers and lowers is a result of over-activity.

This child's osseous development was advanced for her years, so she was of a pituitary-thyroid type. Because of her chief complaint, loss of appetite, thyroid was again prescribed.

*Cases 6 and 7*—Two children, a boy and a girl, of different families, but of the same age (9 yrs.) and showing the same development of the hand and foot. Both showed the presence of all the carpal bones for the age, but they were underdeveloped. The epiphysis which should be complete at this age was fast appearing and was like a dot. The girl had a poor appetite, a frequent finding in subthyroidism, and the boy was a bed-wetter, a not uncommon complaint in this condition.

The thyroid enlarges after removal of the pituitary and the pituitary hypertrophies after removal of the thyroid, and there is clinical evidence that one attempts to compensate for the other.

The next patient is cited as an example of this compensatory effort and to point out the characteristics of the juvenile type of obesity (Engelbach). The juvenile type of obesity is of the posterior pituitary type and may be associated with under or over activity of the anterior lobe.

*Case 8*—M. L. Age 10 yrs 10 mos May 1, 1925, height 50 inches (52) weight 74 lbs (58.8).

She weighed over 9 lbs at birth, was breast fed for 13 mos, first tooth at 12 months, talked at 15 mos, and walked at 18 months. She had measles, pertussis and pneumonia. Gracile hands with many white spots. There was fat distribution in the waist and shoulder girdle. (The later pituitary cases show, in addition, pelvic or hip girdle obesity. This is in contrast to the thyroid distribution which is universal with supra- and infra-clavicular fat pads and dorsal wrist padding, and to the ovarian, in which, early, there is seen trochanteric padding, and later, mammary, mons, hip and thigh obesity.) The child's mother weighs 236 lbs at the age of 33 yrs, and has given birth to two other children whose

birth weight was between 9 and 10 pounds.

The patient's general condition was noted in an examination to determine the cause of a limp, for the relief of which she came to me. This limp had been present for about a year and was due to a condition of her right hip which was painless and associated with internal rotation and limited abduction. After a conference with Dr. A. W. Thompson, the radiologist, and Dr. A. A. Gartner, the orthopedist, it was decided that Perthes' disease was the most probable diagnosis. Perthes' disease is of unknown etiology and is characterized by flattening and broadening of the epiphysis with distortion of its ossifying centre, and irregularity in outline of epiphyseal cartilage. It would be interesting to know if any other such cases have been associated with the signs and symptoms of endocrine disorder.

At puberty, the graafian follicle and corpora lutea begin to function and menstruation appears. Menstruation appears at the age of 14 (Novak). But before considering the more common types of menstrual disorder associated with an endocrine disturbance, I wish to draw your attention to two things.

*First*—The different types of hypoplastic uterus: the fetal, the infantile and the sub-pubescent.

*Second*—The typical, radiographic findings in the terminal phalanges of the hand, seen in acromegaly, which consist of tufting and mushrooming. These changes indicate that, at some time, the anterior lobe of the pituitary has been overactive. Underactivity is the inevitable result of overactivity, and a patient showing these changes may actually be suffering from an underactivity of the anterior lobe. In the presence of these signs, how distinguish between over and underactivity?

The anterior lobe of the pituitary is concerned not only with skeletal and genital development but in maintaining the tone of skeletal muscle. With the anterior lobe in a state of overactivity the patient is unusually strong and energetic, but when underactivity is present, weakness and fatigue are marked. This fatigue is present all the time and made worse by exertion, in contrast to thyroid fatigue which is worse in the morning and gets better as activity increases.

*Case 9*—M. K. First seen in 1913, at the age of 5, for enuresis. The father is tall, thin, and of eunuchoid proportion, the mother is short with the pituitary type of fat distribution.

Birth weight—7½ lbs, first tooth, 11 mos, over 1 year old when she talked and walked. Breast fed for one month.

Shortly before, Blair Bell had reported relief of this condition, in 7 children, by thyroid feeding, and this child's complaint disappeared under the influence of daily doses of ½ grain of thyroid. In 1916, she complained of fatigue, anorexia and constipation. She was always a pale child with a fatigue posture, stoop-shouldered, flat-chested with a protuberant abdomen. Again

Mother is short, thin, and has a goitre

Radiographic study showed absence of 3rd cuneiform (1 yr) and underdeveloped carpal bones

Thyroid nucleoprotein (1%), t.i.d. was begun on Feb 24, 1925

On April 4th Dr Moscato reported that by March 6th the 1st lower incisor and on the 16th, the 2nd lower incisor had appeared, and an upper tooth was visible by April 4th. By April 1st the child was walking alone. He looked better, appetite and sleeping had improved and bowels were moving regularly. On May 8th—good color, walking, 4 teeth

Case 2—Baby, 4½ years. Referred by Dr Kruse

This child required incision and drainage of a suppurative cervical adenitis. We were fearful of giving him an anesthetic because of a history of convulsive seizure occurring over a period of 14 mos., which might be due to a status thymolymphaticus. Every other day he had been having slight seizures during which there was a temporary loss of consciousness and at intervals of three weeks general convulsions. He was a premature baby, his mother having had eclampsia

Birth weight 3½ lbs., first tooth at 14 mos., walked at 18 mos. and did not talk distinctly. He has always been constipated, cathartics used frequently. Radiographic examination showed no enlarged thymic shadow, but it did show delayed skeletal development

Thyroid nucleoprotein (1%) began on March 3, 1925

Report on May 9th—much brighter, bowels move daily, looks better, has had two slight seizures in ten weeks

Father and mother were both short and thin. Mother had a goitre

The next two cases are also in boys. Their histories, as well as that of the immediately preceding one, are given because they represent conditions which may be found in either sex

Case 3—This boy, W W., at the time of his admission to my service at the Emergency Hospital on July 18, 1924, was 6 years 7 months old. He had a compound depressed fracture of the right frontal bone, a compound fracture of the middle of the right femur, a simple comminuted fracture of the left femur. The depressed fracture was elevated and both lower extremities were temporarily immobilized in a double plaster spica. Later, the plaster was removed and traction used. On August 12th an open reduction of the right femur, and 10 days later a similar operation on the left femur, was done, two kangaroo tendon sutures were used on each side, immobilization again secured by plaster. Forty-six days after open reduction of the right femur, the cast on the right side was removed and non-union was found. This boy's gastro-intestinal

activity was sluggish, and after each meal there would be a marked abdominal distention. It was considered that these symptoms might be caused by a deficient thyroid secretion. Thyroid insufficiency is given as one of the causes of non-union of fractures. Radiographic examination of the hand showed the carpal development of 5½ years. On Sept 26th, the administration of Thyroid nucleoprotein (1%) tablets, t.i.d. was begun. Fourteen days of medication showed a decided improvement in his color, an improvement in intestinal activity and a lessening of the frequency of the abdominal distention. At the end of three weeks the union of both femora was firm and at the end of four weeks it was solid.

The mother was short and thin and had no goitre

Case 4—Boy, age 6 years. Admitted to the Emergency Hospital on February 5, 1923, with extensive third degree burn of right side of chest and inner side of arm. He was seen first on May 1, 1923. He had a severe acute bronchitis and looked very ill. He had had several such attacks in the past two months and two skin graftings were unsuccessful. The burned area, on May 1st, showed a dirty, unhealthy-looking granulation tissue. The local treatment was continued as before and cod-liver oil, which he had been taking for three weeks, was continued. The only addition to the treatment was thyroid residue M.V. t.i.d. By May 28th, he sat out of bed for the first time. Not only did his general condition and appearance improve, but, on his discharge from the hospital on July 15, 1923, all but a small area in the infraclavicular region was healed. His thyroid medication was given for about 3 months in all. In March 1925, at the age of 8 years, he returned to the hospital and Dr. Gallivan did a plastic operation for a contracted scar near the shoulder. A radiographic examination showed the carpal development of a 7 year old. This showed that he not only needed thyroid in 1923, but that he still needed it.

While this patient undoubtedly had a congenital functionally deficient thyroid gland, the condition was aggravated by the burn. Jacobson has shown that the toxins formed in extensive burns have a destructive action on thyroid tissue (McCarrison).

In these young patients, thyroid and pituitary deficiency may coexist. Engelbach and McMahon say that they are associated in two forms: the pituitary-thyroid and the thyro-pituitary. In the pituitary-thyroid, the pituitary, and in the thyro-pituitary, the thyroid is primarily involved. In the pituitary-thyroid, skeletal development is more, and in thyro-pituitary, less advanced than in the pure hypothyroid case.

Case 5—J J. Female—age 7 years—June 29, 1924

She was seen on June 29, 1924, when an infection of the leg was incised and drained. Thy-

felt it necessary to continue her work because she was the main support of younger brothers and sisters. The grippe infection undid all the improvement, a result seen in hyper- and hypothyroid individuals.

Her mother was short, thin, had a large goitre which had been present for years, and showed the same type of sella and terminal phalanges as the daughter.

*Case 12*—Mrs S B Age 25 yrs—February 16, 1920

Dizziness, constipation and irregular, scanty periods began after recovery from an influenzal pneumonia in 1918, following labor. Complaint amenorrhea for four months. Thyroid medication (residue MX tid) continued for five months was followed by the reappearance of normal menses and the disappearance of her other complaints. In December, 1924, she complained of dizziness falling out of hair, and constipation, in November the period was 5 days late and scanty, and the December one was 10 days overdue. Thyroid was given with an improvement in her hair and intestinal condition, but the menstrual delay this time was due to pregnancy as the presumptive signs of pregnancy were present. On January 20th there was no improvement in fatigue. She showed an alabaster skin, longitudinal ridging of the nails with many white spots under them and marked tufting. Anterior pituitary Gr V, tid was ordered. On April 22nd, she reported that the fatigue was practically gone and she felt much better than with her first pregnancy.

The anterior lobe feeding will be continued throughout pregnancy, because the pituitary enlarges during pregnancy, doubtless as a result of an increased demand. Thyroid will be added if she again shows signs of deficiency of that organ. This type of individual should be watched closely after pregnancy, as it is after labor that their menstrual disturbances are apt to appear.

*Case 13*—Mrs H Age 28 yrs May 15, 1924 Referred by Dr Marshall Clinton

Complaints were abdominal pain and tenderness, fatigue, headache, obesity, and amenorrhea.

The pain was severe and constant and in the lower abdomen and the tenderness was marked at both ovarian points. The fatigue was constant. The headaches were of two types a constant, vertical one, and a periodic one during which she felt as though there was a tight band about the head. In 1914, her weight was 135, in 1921, 185, and at the time of examination was 246½ lbs.

Menstruation began at 13 yrs, was of the 28 day type, lasted for 3-4 days, and was accompanied with severe pain for 2 days. Irregularity began after the birth of her only child in 1919. At first, the periods were from 2 to 5 months overdue and profuse, and during this time, pregnancy was suspected once, and a curettage was done some months later for the relief of the pro-

fuse flow. For the past 3 years menstruation was scanty. In 1923 she had a scant period in February and again in June. Since then she has had no period.

At the age of 4 years she had scarlet fever complicated with nephritis, between 10-12 years, severe attacks of measles, mumps, and chicken-pox, and at the age of 22 years an attack of influenza, which incapacitated her for 5 weeks.

Physical examination showed height, 5 ft 2 inches, weight, without clothes, 246½ lbs, fine scant hair, absent outer third of eyebrows, thyroid, normal in size and consistency, fine, white transparent skin, which bruised easily, feminine type of hair distribution, hypogonad hand with many white spots under the nails, and an atrophic uterus. There was shoulder, girdle, mammary, waist, hip, thigh and leg obesity, the measurement of the thighs at the level of the great trochanter, was 51 inches. At first, ovarian feeding was given later, from July 17, 1924, to February 2, 1925, ovarian and anterior pituitary extracts. As a result of this treatment, the constant abdominal pain disappeared, but she had severe pain at intervals of 28 days and lasting for 4 days. This was accompanied by a headache which was less severe than before. The constant headache had disappeared, the fatigue was less marked, her appetite, which had been very poor, had improved, but she had had no period. On February 2, 1925, ovarian was discontinued and posterior pituitary, gr ½, was given with the anterior pituitary. Two weeks afterward at the periodic time, her pains were less severe, she had profuse nose bleeds for 4 days with general great relief. In March and April she had a normal period, flowing 4 days, and had no pain, headache or clots. On March 23rd, glytutary pills were prescribed, one after meals.

On May 11th, her weight, with clothes, was 231½ lbs, a loss of 15 lbs in about 1 year. She felt well, her period was one week overdue, she had a severe headache, of short duration, the first in months. On May 9th, ovarian extract was prescribed with whole pituitary. Her only child when seen at the age of five and a half years was backward and suffered from enurism. His carpal development was that of a child of four.

Irregularity, with scanty or profuse periods, following pregnancy invites an examination to determine the presence of signs indicating disturbance of function of the endocrine glands.

You will have noted that the children whose cases were cited showed the stigmata of thyroid or pituitary deficiency or both, and that one or both parents showed evidence of endocrine disturbance. In other words, heredity is the potent factor in the development of these dyscrasias.

The use of glandular extracts will not change the laws of heredity, but their judicious use, where indicated, will minimize the evil effects of

improvement was seen under thyroid medication. In November 1919, when 11 yrs old, she was seen after a 2 year interval. Her mother had given the thyroid at intervals and the girl felt well, had a good appetite and her bowels were regular, but her pallor was still marked. Thyroid was continued and given regularly. In May 1921 (13 yrs of age) she showed secondary sex characters, complained of fatigue and showed a moderate enlargement of the thyroid, she had lost a few pounds and had a poor appetite. Ovarian extract was added to the thyroid. Two months later she had her first period, it was normal in every respect, and the goitre had disappeared. At the beginning of her regular and persistent treatment in November 1919, she was 4 ft 9 $\frac{3}{4}$  inches tall and weighed 70 lbs. In October 1922, she was 5 ft 2 inches tall and weighed 95 $\frac{1}{2}$  lbs. On May 2, 1925, she was 5 ft. 2 inches tall and weighed 110 lbs—no increase in height, but a gain of 4 $\frac{1}{2}$  lbs in 2 $\frac{1}{2}$  years. Thyroid, in the interval, had been given by the mother for a few weeks at a time. The periods have been regular and painless since puberty. Rectal examination showed a retroverted, infantile uterus.

This patient is an example of combined pituitary and thyroid underfunctioning, and illustrates the necessity for strict supervision and frequent examinations of these types of patients, and the wisdom of determining the type of uterus, at, or shortly after puberty, even if the periods are normal. Anterior lobe extract was prescribed not only to stimulate skeletal growth but development of uterus.

That stimulation of the growth of the uterus by anterior lobe extract is not a vain hope, is shown by the next history.

*Case 10*—N A. Single, 20 yrs. Seen, May 1924.

She complained of scanty, painful periods and fatigability and anorexia. Height, 5 ft 1 inch. Wt 100 lbs. "Boyish build."

Menstruation began at 14 years, it is 2-3 weeks late, with scanty flow for 3-4 days, and accompanied by very severe pain in the right lower abdomen. The patient spends the first two days of the period in bed. Influenza in 1920, after the dysmenorrhea became worse, frequently lasting through the entire period. On rectal examination an anteverted, infantile uterus was found. Anterior pituitary feeding has brought about regularity, more profuse flow and a decrease in duration and intensity of the pain, this now lasting no more than a few hours. Her uterus when examined two weeks ago was nearly normal in size. She had been under treatment about seven months.

Four months ago, thyroid was added because of the persistence of anorexia. Appetite has improved and the thyroid will be discontinued. The period this month was 2 days early, severe pain

for 4 hours. Ovarian extract will now be added to the anterior pituitary.

*Case 11*—Miss MacG. Age 24 yrs. Referred by Dr W C Johnson. This patient was first seen on October 24, 1924. She had the classical symptoms of exophthalmic goitre, which had been present since March, 1924. She weighed 9 lbs at birth, did not know about teething, talking, and walking.

Measles at 5 yrs, typhoid at 8 yrs, and influenza for two weeks at the age of 20 yrs. She says she "catches" everything.

Menstruation began at 11 yrs, always 3-5 days late, scant flow for two days, severe backache during period. Amenorrhea since June, 1924, when she flowed one week.

She was 5 feet 3 inches tall, weighed 138 $\frac{1}{2}$  lbs and showed mammary, waist, and hip obesity. Malocclusion of upper and lower teeth, fine, thin, white (alabaster) skin which bruises easily, hypogonad hand with gracile fingers, infantile retroverted uterus. The thyroid was uniformly enlarged, there were present marked exophthalmus and a fine tremor, with a pulse of 120. Because it seemed probable, in this case, that the exophthalmic goitre was the result of an effort to compensate for the ovarian and pituitary deficiency it was decided to try the effect of endocrine therapy before recommending operation.

From November 6 to December 30, 1924, she was given ovarian nucleo-protein, one tablet t i d. She had a period 31 days after beginning medication, which lasted for 2 days. By December 30th her tremor had disappeared, the goitre was smaller, her nervousness was less marked, the pulse was 116-120, the appetite was more normal. She still tired easily, but was sleeping better. On the 30th, anterior pituitary, gr V, was added to the ovarian. An on February 5th, the condition was as on December 30th. She had another period on January 16th and 17th, which was more profuse than the one in December. Her pulse was still 120. On February 5th, anterior lobe feeding was discontinued and adrenal whole gland, in the form of adrenal nucleo-protein tablets, was added to the ovarian medication for the "checking" effect on the thyroid secretion. By March 27th, her pulse was 90, she was feeling stronger, her weight was 140 and her waist measurement had decreased 4 inches.

Ovarian and adrenal medication stopped and whole pituitary given. During the two weeks she was taking this she felt very well. On April 12th an attack of grippe began. She had not continued with her medication during her illness. She was in bed for one week and remained away from work for one week longer. When seen on May 1st, her tremor had returned, her goitre was larger and she had a pulse rate of 128.

During all the time she was taking the glandular extracts she continued at work despite repeated admonitions that rest was imperative. She

## FUNCTIONAL ABNORMALITIES OF MENSTRUATION \*

By GEORGE M. GELSER, M.D.

ROCHESTER, N. Y.

**I**N discussing the functional abnormalities of menstruation, I want to emphasize the importance of a careful detailed history of all menstrual irregularities, as well as of all pelvic symptoms. Even minute variations in the menstrual function have their significance and by proper interpretation of these significant facts, one should gain a fair conception of the diagnosis before an examination is made. In doubtful cases, when the findings on examination are not conclusive, details obtained in the history may be of much more value in reaching a diagnosis than the physical findings.

In order to understand the abnormalities of menstruation, it is necessary to know the physiology and normal process of this function.

The modern conception of the physiology of menstruation is as follows: Assuming the average menstrual interval to be twenty-eight days, the graafian follicle ruptures and the ovum is discharged between the twelfth and fourteenth day of the intermenstrual interval. After the follicle ruptures, its capsule is transformed into the yellow corpus luteum. This consists of corpus luteum cells which are a real ductless gland and which produce hormones whose function is to produce the premenstrual thickening or hyperemia of the endometrium.

If the ovum is not impregnated, it dies at the end of fourteen or fifteen days, and when the ovum dies, the corpus luteum degenerates and becomes obliterated. If the ovum becomes impregnated, the corpus luteum persists at its height until the middle of gestation, after which it diminishes until delivery of the fetus, when it disappears. The function of the corpus luteum therefore is twofold: (1) it prepares the mucous membrane for menstruation, (2) it protects the pregnancy.

Menstruation is impossible if there is no regular process of ovulation and corpus luteum production. On the other hand, there may be ovulation in the ovary without menstruation because of a poor mucous membrane, atrophy, anemia, etc.

Immediately upon the death of the ovum the corpus luteum begins to degenerate. Then the endometrium, having lost its activating force, loses its hyperemia, and the relaxation of the pressure opens the ducts of the glands which have been distended with secretion. This then pours over the surface of the mucous membrane and produces the increased vaginal secretion which many women notice before the menstrual blood appears. The secretion of the glands contains a tryptic ferment which then digests the mucous membrane and bleeding commences. The

reaction of the uterus is alkaline, which allows the ferment to act, the vaginal secretion is acid and there no digestion takes place. Menstrual blood does not coagulate because it is mixed with trypsin which prevents coagulation. If there is too much blood or too small an amount of trypsin clotting occurs, but this is always pathological and there is normally an equilibrium between the blood and trypsin.

The ovary and corpus luteum are not the only factors in preparing for menstruation. The ovary is dependent on the other ductless glands, especially the hypophysis and the thyroid. The anterior lobe of the pituitary stands in close relation to the ovary and produces an hormone which furthers the action of the ovary. If this hormone is absent, the ovary does not function properly and the frequent condition of hypoplasia of the generative organs is probably due to a deficiency of this pituitary hormone.

Under the subject of functional abnormalities of menstruation might properly be classified the menstrual disturbances associated with general constitutional diseases, as tuberculosis, chlorosis, diabetes, etc.; those associated with mental diseases, excitement, worry, sudden shock, and also those resulting from chilling or wetting of the skin, change of climate, etc. These menstrual disturbances, however, are a part of the general systemic condition, and because of the short time allotted for this paper, I will take up only the abnormalities of the menstrual function itself.

First there are the variations of the menstrual interval peculiar to certain women who habitually have regular menses of the twenty-one, twenty-five, or up to thirty-five day type. These variations from the average twenty-eight to thirty day type are normal habit for these women and are due to the different time of rupture of the graafian follicle, probably from a hypo- or hyperactivation of the hypophysis. Another rather common variation is bleeding for one or two days at the middle of the intermenstrual period, which occurs at the time of rupture of the graafian follicle and is frequently accompanied by some abdominal pain.

Some women have a variation in the menstruation itself which occurs for one or two days, ceases for one or two days and then returns. This is due to an anatomical difference in portions of the endometrial glands and secretions whereby bleeding occurs in different portions at different times and may be over in one section before it has started in the other sections.

The functional disturbances of the ovary are of two kinds, hypofunction and hyperfunction. Frequently these functional disturbances are entities in themselves.

\* Read at the annual meeting of the Medical Society of the State of New York at Syracuse May 12 1925

such heredity, and will make more nearly normal the development of these children

The infant's thyroid contains little or no iodine, and its full functional activity is not attained until months after birth, so the thyroid needs of the child must be supplied through the mother's milk. But these subthyroid mothers are unable to nurse their children, or, if they are so able, the thyroid supply is not adequate for the child's needs. Cow's milk is substituted, the thyroid content of which, according to McCarrison, differs in kind and quantity from that of mother's milk.

If a woman's thyroid, and the same is true of the pituitary, is inadequate to properly supply her needs, the added burdens of pregnancy and lactation will certainly not increase the gland's functional capacity, so treatment of such women before, during, and after pregnancy is not only indicated—it is imperative.

I have seen thyroid feeding in a lactating woman increase the amount and improve the quality of her milk and change a fretful, unhappy nursing into a happy one. The woman had a goitre which was probably aggravated by chronically infected tonsils. And I have observed the difference in development brought about by thyroid feeding in one of two children of the same subthyroid mother. Both these children have been under my observation since birth, one for nearly ten, the other for almost eight years. The first, who weighed 9¾ pounds at birth, was breast fed for three weeks and was tardy in walking, talking, and teething, the second, after the mother's condition had been recognized and thyroid extract administered before, during, and after pregnancy, had a birth weight of 8 lbs., was nursed for seven months, with a development so nearly normal as to seem precocious, when compared to that of the elder child.

In the cases after puberty, restoration of endocrine equilibrium was brought about, judging from the improvement in the menses, by ovarian, thyroid, or pituitary feeding, and some of them required all three. This may explain, in part, the contradictory reports as to the efficacy of extracts of particular organs.

There are failures from the use of each and all of these extracts. Some of these failures are doubtless the result of a polyglandular sclerosis as described by Falta, and the explanation for others may be that properly prepared extracts are not given in adequate dosage over a sufficient period.

The cases after puberty are essentially pluriglandular. Even though the obvious signs point to involvement of one organ, careful observation will usually reveal additional, and no less obvious signs, pointing to involvement of the other glands.

The signs of ovarian deficiency are, besides the menstrual ones, dizziness, occipital headache,

"nervousness," hot and cold flashes, early there is trochanteric fat padding, and, later, a mammary, mons, hip and thigh fat distribution.

With thyroid involvement a goitre may or may not be present. The goitre may be associated with other symptoms of hyperthyroidism, or more frequently, in my experience, with those of hypothyroidism. The more frequent signs and symptoms of hypothyroidism are loss of hair, scanty eyebrows, pale or sallow complexion, crowded or maloccluded teeth with early decay, dry skin, fatigue worse in morning, anorexia, and constipation. Later, the characteristic thyroid obesity is seen, universal fat distribution, with supra and infra-clavicular fat pads, and dorsal wrist padding.

The anterior pituitary deficient may be short, tall or normal in height, but whatever the height, the relation of trunk to lower extremity is usually eunuchoid, this is a small head and receding chin, or there may be a prognathous jaw, spacing of teeth—upper, lower or both, hands, in which the phalanges are disproportionately long, with white (atrophic) marks under the nails, an alabaster skin, with either female or male hair distribution, loss of libido, and fatigue. With posterior lobe involvement, shoulder, waist and hip girdle obesity are seen late.

In the past year 52 cases of menstrual disturbances were seen in which radiograms were taken of the sella and of the hand. In these cases signs of pituitary deficiency were found in association with large and small sellae. The size of the sella is no indication of the size or functional capacity of the contained pituitary. In all the cases, however, some degree of tufting in the terminal phalanges, with or without mushrooming was seen, and the more marked the symptoms and the longer their duration, the more evident were these changes. So constant a sign must have some significance. As was pointed out before, the tufting and mushrooming are considered as evidence that overactivity of the anterior pituitary was present at some time. This associated with fatigue—constant and made worse on exertion—is taken as an indication that underactivity is now present and that anterior pituitary medication is needed. If there is present shoulder, waist and hip girdle obesity, extract of whole gland is given.

The outstanding lesson to be learned from these cases is this. Glands of internal secretion are not isolated organs, but each gland is to be considered an integral part of a interrelated chain of glands. Furthermore, that they affect and are affected by the nervous system and other organs of the body. With this broad conception of the subject one's attention is less apt to be concentrated on the presence of an obvious goitre, a menstrual disturbance, or dwarfism and gigantism as to neglect the study of the patient as a whole.

sults are obtained from the injection, intravenously, of ovarian extract, either of the whole ovary or of ovarian residue, without the corpus luteum. Small doses of thyroid extract, 1/10 to 1/4 gr., and extract of anterior pituitary, 1 to 2 gr., can be combined with the ovarian extract to advantage, as they stimulate the ovarian function and further its action. Corpus luteum extract is not used for hypofunction. The corpus luteum has two different substances, in the young developing corpus luteum is a substance called lipamine which incites the premenstrual hyperemia, but the mature yellow corpus luteum has a lipid, lutein substance which checks the bleeding. Therefore, for excessive bleeding of hormonal origin, good results are obtained from the use of corpus luteum extract, especially if combined with pituitrin, 1 c.c. Corpus luteum extract, therefore, is used for bleeding of hormonal origin either during puberty, during the period of menstrual life, or at the menopause. For the symptoms of ovarian insufficiency after the menopause, extract of whole ovary gives marked relief.

By far the most striking results in the treatment of functional ovarian disturbances, have been obtained by means of the X-ray. Radiation has been most commonly used for excessive bleeding, especially around the time of the climacterium, but more recently it is being used for functional bleeding at any time of life and also as a stimulant for treatment of hypofunctional conditions. This stimulating action of the X-ray is not quite certain but is probable.

Ovarian tissue is very susceptible to the X-ray, and with it one can kill all the ovarian follicles, producing a permanent amenorrhea. With a smaller dose one may kill not all the follicles and have a temporary amenorrhea, for two to three years. If a still smaller dose is used, one can effect the development of the corpus luteum and have less intensive menses but still preserved. With a full castration dose, one also gets the climacteric symptoms, but by using only 2/3 to 3/4 the castration dose, one can get amenorrhea without the climacteric symptoms, called exovulation, where the follicle cells are destroyed but not the lutein cells.

In this connection it is interesting to note that X-ray castration usually produces more marked climacteric symptoms when effected at the time of the menopause than in younger people, while the reverse is true with operative castration. For ovarian bleeding at the time of the menopause X-ray castration is the ideal treatment, but should however, be preceded by a diagnostic curettage to eliminate the possibility of uterine malignancy. For bleedings occurring before the age of the menopause, one can radiate the ovaries with varying dosage to obtain the results desired.

For hemorrhages occurring at puberty, one can radiate the ovaries in proper dosage, without any damage to the organs. Prof. Weibel treated fourteen cases of this type in patients between the ages of thirteen and twenty years, and had

positive effect with oligomenorrhea in eleven, while in three there was no effect because treatment was not continued. He states no harm is done to the ovary in this treatment and he has seen many cases of pregnancy following it. If pregnancy occurs too short a time after treatment, there is more danger of abortion, but if it occurs after two or three years interval, pregnancy is normal and the children are normal. He also believes the same effect can be obtained by treating only one ovary. One ovary can first be treated and then if no effect is obtained, the other side can be treated. In sixty-nine cases in which he treated only one ovary, he had good effect in 87.5%, with amenorrhea in 50% and oligomenorrhea in 37.5%.

For cases of hypofunction with amenorrhea and oligomenorrhea, one may get some effect by using small stimulating radiation to the ovary, but here one risks the danger of killing the ovarian function already present. However, results have been obtained in this way and Prof. Adler told me he had had two patients with amenorrhea and sterility who had become pregnant following small stimulating radiation to the ovary. The dosage for this is 1/6 to 1/8 of the castration dose.

By far the most striking results from X-ray treatment have occurred in the so-called essential bleeding or hæmorrhagica metropathia. This bleeding is purely of ovarian origin and responds very readily to radiation. Many women have been subjected to repeated curettages without relief, and even to hysterectomy because of this bleeding, who could have been relieved by simple radiation of the ovaries.

The most recent treatment in Vienna for most of the functional disturbances of the ovary, especially in young women, is by X-raying of the hypophysis. This is used for hypoplasias, amenorrhea, and dysmenorrhea, as well as for ovarian bleedings before the age of the menopause, and also for the hot flashes and nervous symptoms of the menopause. This work is still very recent and has not been generally accepted as yet, but it has been used for two years in the Wertheim clinic with good results.

In cases of severe bleeding where rapid relief is desired, this can be obtained by X-Ray radiation of the spleen. In Doederlein's Clinic at Munich all functional bleedings are treated by spleen radiation.

In connection with X-ray treatment, I want to sound a most emphatic warning against the indiscriminate subjection of patients to radiation of the ovaries. The essential prerequisites for this is an exact diagnosis and an understanding of what is to be accomplished, for without this one is only doomed to disappointment.

In conclusion I want to emphasize again the importance and helpfulness of a full detailed history of all menstrual abnormalities, for the finer gynecological diagnoses cannot be made without a thorough understanding of the functional, as well as of the pathological lesions.



amenorrhea, and sterility on the one hand and with idiopathic bleeding in the case of hyperfunction. Commonly, however, they are associated with gross pathological lesions and the recognition in a patient's history of the finer functional disturbances of the ovary are important factors in the differential diagnosis of pelvic disease. For instance, tuberculosis of the tube and ovary are very commonly associated with hypoplasia and amenorrhea. Likewise ovarian cysts and tumors are associated with hypofunction, due to the presence of cysts in the ovary interfering with the normal development of the graafian follicles. On the other hand, uterine myomata are associated with an ovarian hyperfunction.

Hypoplasia of the generative organs is very common, being present to a certain degree in about one-fourth of all women. In addition to the anatomical hypoplasia of the organs, the characteristic features are disturbances of menstruation, sterility and dysmenorrhea. Menstruation usually starts late, at sixteen to eighteen years, and is irregular, generally at long intervals and scanty, occasionally too frequent and increased.

Dysmenorrhea is of the spasmodic type which may be due to several causes, the chief of which is that in hypoplasia, the connective tissue is relatively increased over the muscle tissue and the uterine body is hard and tense. Therefore the distention from the menstrual hyperemia produces abnormal pain. Secondly, as the ovarian function is abnormal, the uterine secretion is abnormal and clots are formed which increase the pain. Thirdly, these women generally have a higher reflex irritability and any insult to the uterus provokes greater contraction and pain than normally.

Frequently the onset of puberty is accompanied with excessive bleeding which is due to the fact that the menstrual function is not yet well established and also to the absence of corpus luteum formation.

The menopause is accompanied with a loss of the ovarian function and is characterized by many manifestations of ovarian insufficiency, not only the common nervous and circulatory symptoms, but marked atrophy of all the generative organs. The increased relaxation of the uterine ligaments and supports accounts for the backache and the onset of prolapse which occur at this time.

Another common symptom after the menopause is pruritus vulvæ, which in the majority of cases, when not a symptom of diabetes, is due to a loss of the ovarian secretion and is relieved by administration of ovarian extract.

The bladder symptoms following the menopause have also been attributed to the climacteric disturbances of the sympathetic nerve, but I am more inclined to believe that these disturbances are due rather to the tissue relaxation and senile atrophy.

During lactation there is a physiological atrophy of the uterus which lasts until the seventh

month post partum, atrophy lasting longer than this is pathological. If lactation is prolonged beyond this period, there may result a long, pathological atrophy of the uterus and ovary with absence of ovulation. This condition may persist for years and result in a precocious menopause.

The most interesting of the hyperfunctions of the ovary is the so-called essential bleeding or metropathia hæmorrhagica, which is produced by hormones from the corpus luteum or from maturing follicles of the ovary. If follicles develop too rapidly there may not be any interval and there results a constant hyperemia of the endometrium with harming of the endothelial layer of the vessels, which become stretched, torn, and bleed. The endometrium is the bleeding part but the etiology is due to hormonal hyperemia. The continuous hyperemia may provoke an endometrial hyperplasia but, this hyperplasia is not the cause of the bleeding and curettage does not effect a cure. This endometrial hyperplasia is not inflammatory, or an endometritis, but is merely an hypernutrition.

Excessive bleeding also occurs very commonly around the time of the menopause. This may be due (1) to ripening of the graafian follicles without corpus luteum formation, (2) to insufficiency of the uterine muscle, perhaps with fibrosis and commonly associated with some enlargement of one ovary. This bleeding is characterized by longer, stronger, and perhaps more frequent menstrual periods but with no intermenstrual bleeding. It is commonly stated that any increased bleeding at the time of the menopause means the presence of malignancy, but this is not strictly true for excessive menstruation at the time of the climacterium is quite common and is differentiated from malignancy by the absence of intermenstrual bleeding.

In the treatment of functional disturbances of the ovary, great advancement has been made in recent years through the use of organotherapy and the X-ray.

For hypoplasia, measures to influence the general condition are helpful, as general hygiene, exercise, iron and arsenic, sitz baths, diathermy and anything which increases the circulation in the pelvis. These patients usually improve after marriage as a result of the increased pelvic hyperemia.

Considerable improvement in hypoplasia and hypofunction of the ovary has been obtained from the injection of ovarian hormones, but there is no absolute effect, as yet, such as occurs in treating myxedema with thyroid extract. In the presence of congenital atrophy of the ovaries, one gets no effect, for these hormones only stimulate glands which are present but which are not functioning perfectly. The history usually differentiates whether there is congenital atrophy or whether some ovarian function has taken place.

For amenorrhea and hypoplasia the best re-



that we inject is very toxic and the dose large, acceleration soon gives place to fatigue, to complete exhaustion, and finally to death, if relatively large doses are repeatedly given the condition of protein cachexia, observed in experimental animals, might supervene. Proper dosage on the other hand, results in transient but well marked stimulation without clinical apparent fatigue, and if continued for a period of time the alteration of acceleration and depression or metabolic processes becomes manifest in increased weight and general well being." Further he says, "if we fix very firmly the concept that non-specific therapy is purely a method of stimulation whereby all forces of cellular and humoral resistance are for a short period of time keyed to the highest pitch and by reason thereof, stimulation of this character is useless when the cells of the body are profoundly fatigued." Where a moderate reaction is desired Peterson advises the use of milk and if less general, but some focal effect is desired, Uddgren believes that milk with a low bacterial count is to be preferred.

Peterson also calls attention to the fact that the nonspecific reaction is a "diphasic reaction—the first effect being the intensification of the disease manifestation both generally and locally, the second being a constructive phase in which there occurs a general euphoria, a diminution of disease symptoms both generally and locally, with, at times, complete restitution to the normal. Generally speaking, he says, it has been found that the more severe the first phase the greater the clinical benefit. Therapeutic results cannot be expected when the organism is no longer capable of response to stimulation. When complete fatigue has been reached no amount of stimulation will avail and the additional burden imposed by the material injected can only harm the patient."

Even with intramuscular injections of milk, it is well to keep in mind the contraindications to the injections of the more active substances. Peterson says particular care must be observed to obtain a history of hypersensitiveness on the part of the patient—serum sickness, asthma, urticaria, angioneurotic edema, or of epilepsy or other grave nervous instability. Alcoholism, pregnancy, various cardiac lesions, and diabetes, are also recognized as contraindications to the use of protein therapy, but neither old age nor infancy is so recognized by some observers.

Sensitization to repeated intramuscular injections of milk seems to be rare, as few cases are reported, although it has been used rather extensively in Europe. This is thought to be due to the fact that the milk is boiled and so differentiated. Hecht made intracutaneous injections of milk in patients injected previously with milk and also in noninjected patients. There

was no difference in the skin response, nor was he able to demonstrate milk antibodies.

Two years ago, following a conversation with Dr. George Gellhorn on milk injections in pelvic inflammatory conditions, I introduced the treatment at the Woman's Hospital and to date we have used it in 111 house cases. The milk has been used intragluteally with an initial dose of 5 c.c. and then 10 c.c. every third or fourth day. In ambulatory cases in the out-patient department intradermal milk in 1 c.c. doses is used. These cases are not analysed in this series, but there is one or two house cases with intradermal injections which compare favorably with the intramuscular method. I have used as many as twenty consecutive doses in a single case, but most often from 6 to 8 injections, from which I believe we obtain the maximum of benefit, although occasionally a few more injections seem to be necessary.

We use Grade A whole milk and sterilize it in a water bath for one hour at 60 degrees centigrade or in the autoclave at 15 pounds pressure for 15 minutes. The bottles and corks are boiled for thirty minutes and sterile precautions are used in filling the containers. The sterile milk, in its container, is kept in the ice-box until used.

The technic of injection is to prepare the skin with tincture of iodine or alcohol and to introduce a sharp hypodermic needle, about one and a half inches in length, well into the gluteal muscles. If no blood escapes from the needle or is not obtained by suction of the syringe, then we are sure that a vessel has not been entered and we shall avoid a severe protein reaction, provided the needle is not displaced later when attaching the syringe. I feel sure that in 4 per cent of my series this precaution was not taken, for in this number there was more or less respiratory embarrassment, syncope, sharp pain referred to the back, abdomen, or legs, with rather marked erythema and in one case followed by a petechial eruption. Other precautions to be observed are to shake well the container so as to mix the cream and to draw the fluid directly into the barrel of the syringe, rather than to attempt to draw it through the small caliber of the needle. Further, to prevent the local initial pain, the fluid should be introduced rather slowly. In none of this series has it been necessary to resort to the use of novocaine, as advocated by some writers.

Following the injection there is at the site of injection more or less induration with pain for a few days, but it is never as troublesome as that following mercurial intramuscular injections, and in none of my series was there an abscess formation. Within a short time there is usually an increase in the subjective pain but marked relief within twenty-four hours after the first injection—sometimes delayed until after the sec-

# PROTEIN (MILK) INJECTIONS IN GYNECOLOGICAL INFECTIONS\*

By REGINALD M. RAWLS, M.D., F.A.C.S.

(From the Clinic of the Woman's Hospital.)

NEW YORK CITY

**D**URING the last thirty years, the treatment of pelvic inflammatory disease in women has varied from a policy of immediate operation to "a watchful waiting" policy. However, in the literature of the past four or five years there have appeared, from time to time, articles advocating a return to the policy of immediate operation even in acute conditions, but I believe I voice the sentiment of most American Gynecologists in advocating a period of palliative treatment and operations only after the subsidence of the acute symptoms with no recurrence following a rather vigorous bi-manual examination. Often pelvic inflammatory disease, especially gonococcal infection, will clear up entirely under palliative treatment, but when we have a mixed infection it is too often necessary to supplement it by a mutilating operation. Any aid to palliative treatment of pelvic inflammatory disease will be welcomed by all and such a measure I offer in the intramuscular injection of sterile cow's milk. It is no cure-all but fulfills almost, if not all, of the requirements of the ideal palliative treatment—in lessening the amount of acute suffering, lessening the number of mutilating operations, and, when operation becomes necessary, giving the patient an increased immunity to withstand the shock or to make more conservative operations possible.

It is impossible, in this article, to review the history, or the general and focal reactions of protein therapy and their assumed biological origin, but to those interested I would recommend the excellent little book of William F. Peterson<sup>1</sup> entitled "Protein Therapy and Non-specific Resistance" published in 1922 by the Macmillan Company. From a review of this book we find that during and following the period of specificity in therapeutics as inaugurated by Pasteur and Koch, and through the time of von Behring, Ehrlich, and Bordet, certain clinical observations were made which were the forerunners of what is now known as non-specific resistance.

Wright mentions several such instances that came to his attention. "I confess to having shared the conviction that immunization is always strictly specific. Twenty years ago, when it was alleged before the Indian Plague Commission, that antip plague inoculation had cured eczema, gonorrhea, and other miscellaneous infections, I thought the matter undeserving of examination. I took the same view when it was reported in connection with antityphoid inoculation that it rendered the patients much less sus-

ceptible to malaria. Again, seven years ago, when applying antipneumococcus inoculation as a preventive against pneumonia in the Transvaal mines, I nourished exactly the same prejudices. But here the statistical results which were obtained in the Premier Mine demonstrated that the pneumococcus inoculation had, in addition to bringing down the mortality from pneumonia by 85%, reduced also the mortality from other diseases by 50%. From then on we had to take up into our categories the fact that inoculation produces, in addition to direct, also collateral immunization."

Peterson says "our recognition of non-specific therapy really had its inception with the papers of Renaud, Kraus, and Ichikawa. Renaud pointed out the value of heterobacteriotherapy, Kraus definitely settled this point when he reported favorable results in puerperal infection treated with colon vaccine, and with this as a basis began the treatment of scarlet fever, plague, and septicemia. Ichikawa, independently, observed that when he treated paratyphoid cases with intravenous injections of typhoid vaccine, he obtained equally as good results as when it was used in typhoid cases."

From heterobacteriotherapy it was but a logical step to attempt intravenous injections of bacterial components and bacterial split products, then of protein split products of non-bacterial origin, and finally to the realization that any substance which was capable of inducing the shock reaction on the part of the patient would result in the same therapeutic change. Soon a number of agents were used and in 1916 Schmidt and Saxl introduced intramuscular injections of milk to induce a protein reaction, i.e. the typical rise in temperature observed following the injection of other agents.

There are many theories and much research available to explain the protein reaction but, quoting Gellhorn<sup>2</sup> who was the first to call attention, in this country, to the value of milk injections in gynecological diseases, "Protein substances, introduced 'pararenterally' that is, by subcutaneous, intramuscular, or intravenous injection, have the faculty of stimulating the cells to greater activity—of 'activating the protoplasm'. All cells of the body feel this rejuvenating influence but none more so than those cells which have been weakened or paralyzed by infection."

Quoting Peterson, "Protein therapy offers a potent, perhaps the most potent, method that we have at our command of altering the current of cellular activity in two diametrically opposite directions—acceleration of function and depression of function. If the agent

\* Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse May 13 1925

strange as it may seem, I have not done a posterior colpotomy for pelvic inflammatory disease during the time covered by this series. It has so happened that no cases presented themselves with a bulging cul-de-sac but all were of the class which formerly were treated by a waiting policy until there was function; by the use of intramuscular injection of milk these cases have cleared up with surprising promptness.

In the series of 78 cases observed from 4 to 21 months there were four cases of subsequent pregnancy—one has been delivered, one 6 months, another 7 months and the last 3 months pregnant. Three of these four cases were given milk injections for infectious post abortive or post puerperal and therefore mixed infections which usually respond unsatisfactorily to palliative treatment. Two had operative measures also but after their acute symptoms had been re-

lieved by the milk injections and thus made possible conservative work.

#### REFERENCES

1. Peterson, W. F.: Protein Therapy & Non-Specific Resistance, 1922. The Macmillan Co. New York.
2. Gellhorn, George: The Treatment of Pelvic Infections by Injections of Milk. *Journal of the Missouri State Med. Assoc.*, August, 1922, Vol. xix, p. 341.
3. Gellhorn, George: Milk Injections in Gynecology and Obstetrics. *American Jour. of Obst. & Gyn.*, Vol. viii, p. 535.
4. Barman, Ottakar; *Praktický lek*; Prague, III 1923, No. 1.

#### ADDITIONAL REFERENCES

- Ehrenfest, Hugo: Protein Therapy and Non-Specific Resistance (Collective Review) *American Jour. of Obst. & Gyn.* 1923, V 448.
- Mohler, Roy W.: Foreign Proteins as Adjuncts in the Treatment of Obstinate Pelvic Infections. *American Jour. of Obst. & Gyn.* ix 303.

## THE PROVISIONS FOR TEMPORARY CARE OF THE INSANE PENDING COMMITMENT IN NEW YORK STATE

By FRANK KIERNAN

Field Secretary of the State Mental Hygiene Committee.

THE question of what happens to insane patients or supposedly insane patients between the time they are taken into custody and the time they are placed in the State hospitals or discharged as not insane has long disturbed the State Hospital Commission. It became possible early this year for the State Mental Hygiene Committee to respond to the invitation of Dr. C. Floyd Haviland, Chairman of the State Hospital Commission, to make an investigation of the temporary care conditions at least in part of the State and endeavor to secure an improvement in those conditions where such improvement seemed imperative and feasible.

In Schenectady, where in the previous fiscal year, there were thirty-six cases who needed temporary care, they had been placed in quarters wholly unsuited for such patients and under supervision that was most undesirable. We have been able in Schenectady to carry the matter to the point where it is now practically assured that this summer there will be provided at the new City Hospital adequate quarters with, of course, the proper medical and nursing supervision.

In Canandaigua which includes a considerable part of Ontario County, we are in the way of effecting an arrangement whereby quarters for these cases will be provided at the Thompson Memorial Hospital.

In Glens Falls where hitherto these patients have always been kept in the city lock-up, they

are now to be cared for in a separate room in the City Hall with trained supervision by persons obtained through the Glens Falls Health Center.

In Auburn, we expect to have rooms provided in the new Auburn City Hospital where the patients will be under the supervision of a psychiatrist and receive the ministrations of the nursing service of the hospital staff.

These are typical of the arrangements that we have been able to make to date. We desire to take this occasion to state in the presence of the Health Commissioner that the Health Officers everywhere we have visited have given us 100% cooperation and support. The same is true of the members and secretaries of the local tuberculosis committees.

The law places upon the Health Officers the distinct obligation of providing "for the proper care treatment and nursing of such person pending the determination of his mental condition." This law seemed to have been predicated upon the assumption that the Health Officer is a conjurer who could produce such facilities by the waving a wand over a silk hat. This, of course is entirely out of the question. The Health Officer can provide only such facilities as are available in his locality. Our usefulness has consisted in assisting the Health Officers to convince the local Boards of Health, citizens and hospital authorities that this type of patient is equally deserving of proper care and treatment as any other sick person, and in this we think we can say that we have been successful.

\*Read at the Annual Meeting of the Medical Society of the State of New York at Syracuse, May 13 1925

ond injection The sense of well being experienced by these cases is remarkable, especially as previously it was necessary to use repeated doses of codeine or even morphine in addition to all other methods of palliative treatment

This fact is so constant in adnexal inflammation that my associate, Dr William T. Kennedy, suggested its use as a differential sign in suspected ectopic gestation. The series so far is too small to draw definite conclusions, but in 3 out of 4 cases the failure of the injection to relieve pain was found to be due to ectopic gestation. In these few cases there was an early relief of pain but with a recurrence rather than a cessation as in salpingitis

In the early injections there is usually a rise in temperature within 6 or 8 hours, from 2 to 4 degrees or more, above the usual afternoon rise, with a return in twenty-four hours to the pre-injection level. This rise in temperature is accompanied by a corresponding rise in the pulse rate. This may continue in some cases throughout the time of treatment but usually there is no reaction after the third to sixth injection

Accompanying this reaction there is an increase in the leucocytes from 1 to 10 thousand above the existing white count, or in the earlier injections there may be a leucopenia but usually with an increase of the polymorphonuclear cells. In some cases this reaction may be delayed for 48 hours, but usually it is earlier and will have disappeared by this time

In 10 per cent of my series there was a chilly sensation or a definite chill lasting as long as 10, 20, or 30 minutes, but usually not as severe as that following typhoid vaccine injections. In an additional 9 per cent notes were made of a rather high temperature with sweating, headache, restlessness, nausea and even vomiting

When we compare the early or immediate results in 96 cases with the late or end results in 78 cases under observation from four to twenty-four months, we find them practically identical (Table I). Therefore I feel

TABLE I—Results

<i>Immediate (96 cases)</i> (On discharge from hospital) ( or end of one month )		<i>End Results (78 cases)</i> (Cases observed 4 to 21 mos )	
Recovery	(37) — 38.5%	(30)	38.5%
Improvement	(52) — 54.0%	(42)	53.9%
No Improvement	(7) — 7.5%	(6)	7.6%

that my figures are conservative and compare favorably with, although not as good as Bittman's<sup>3</sup> who reports his results of milk injections in 573 cases of pelvic inflammatory disease as

Recovery	76 %
Improvement	20 %
No Improvement	4.0%

In order to be reasonably sure of our diag-

nosis and to rule out the cases with temporary pelvic congestion or hyperemia, I have arranged in table II the results in 52 cases with masses estimated in size from 3 to 12 cm

TABLE II—Results

<i>Immediate (52 cases)</i> (Masses 3 to 12 cm)		<i>Immediate (96 cases)</i> (all cases)	
Recovery	(16) — 30.8%	(37)	38.5%
Improvement	(34) — 65.4%	(52)	54.0%
No Improvement	(2) — 3.8%	(7)	7.5%

In a tabulation (Table III) of the degree of inflammation present in the 78 patients under observation from four to twenty-one months, we may be surprised at first glance to find the results of treatment in the acute and chronic are better than in the subacute conditions. This can be explained by the fact that unquestionably there were listed many cases under chronic that were really an acute exacerbation of an old pathological condition or this old condition made the patient more susceptible to a fresh infection which, from the history of the patient, was classified as chronic

TABLE III—(Degree of Inflammation in 78 cases observed for 4 to 21 months)

<i>Acute—34</i>		
Recovery	(14) — 41.0%	
Improvement	(20) — 58.8%	
No Improvement	(0) — 0.0%	
<i>Sub-acute—29</i>		
Recovery	(10) — 34.5%	
Improvement	(14) — 48.0%	
No Improvement	(5) — 17.0%	
<i>Chronic—15</i>		
Recovery	(6) — 40.0%	
Improvement	(8) — 53.3%	
No Improvement	(1) — 6.6%	

In Table IV we have compared the cases as to subsequent operations and their results

TABLE IV —

	<i>Immediate (96 cases)</i> (On discharge from hospital)	<i>End Results</i> (78 cases) 4 to 21 months
No Operation Required	(75)—78.2%	(37)—71.1%
Operation req'd or advised	(21)—21.8%	(15)—28.9%
Total Operations	(17)	(10)
*Hysterectomy		(3)—30.0%
Conservative Operations		(7)—70.0%

\* (One of the three hysterectomies was done because of a fibroid uterus)

In only three cases in this series were positive gonococcal smears reported and I feel that had the cases been seen earlier in their infections our end results would have been even more encouraging. Milk injections are of especial value in acute salpingitis, pelvic peritonitis, and the so-called "frozen" or "plaster of Paris" pelvis, and

## WHAT IS MEDICAL NEWS

Is what doctors talk about news? An excellent test is supplied by the listener. When a group of doctors get together and all try to talk at once, there is no listener, and this fact may prove that what the talker says is mere talk and has little news value.

Many a talker deludes himself and thinks he has made a great impression when the hearers about him are responsive, and try to tell him their own experience. But he may merely have touched the spring which loosens the torrent of the listeners' own talk,—and they may have got nothing at all from the speaker. If a listener is anxious to describe a case or tell a story, he is not receptive to new ideas, and the talker's speech is futile.

Real evidence of the value of a talk is attentive silence on the part of the listeners who are eager to catch every word of the speaker. Let some one relate a bit of real news, or tell about an illuminating case of sickness, then all the crowd will listen intently. The news value of talk can be judged by the degree of silent interest shown by the listeners who lean forward to catch every word.

A talker always implies a listener. If the talker speaks of real news, he will always have receptive listeners. The medical editor or reporter wishes to catch some of the ideas that are wasted in aimless talk and fix the more valuable ones in the Journal.

Neither talk nor news is of value unless it penetrates into the brains of the hearers or readers. How do the members of the Medical Society of the State of New York read their Journal? An expression that is often heard is "I look through the Journal and read what interests me." It is the object of the Editors to make all the contents of interest to all the members.

Do all the members know how to read the Journal to the best advantage?

A professor in the University of Wisconsin School of Journalism is planning a course on how to read a newspaper. A course is needed on how to read the New York State Journal of Medicine. The Journal consists of two parts, scientific articles, and reports of activities of the State Society and the county societies. These activities are as important as the scientific articles, and any one who reads them with reasonable care will learn of the immense amount of work which the officers and committees of the societies are doing not only for the advancement of public health and civic medicine, but also for the great benefit of the individual doctor. News of the activities of the State Medical Society is the great justification for the existence of the Journal. Members frequently write for information which is plainly stated in the recent issues of the Journal. A course on how to read the Journal could be summed up in the simple injunction to read it, and thereby get the full return for the member's money that is spent in producing the Journal.

It might be a good idea for a county society to devote the program of one of the meetings to the subject of how to read the Journal. Make it an experience meeting. Take the four latest issues of the Journal and let each member present tell what he has read. Possibly the leader would conduct a quiz on the contents of the Journal. The editors might even prepare and publish a series of questions on the contents of the Journal after the manner of the syllabi and questions which sometimes appear in the literary journals.

To suggest a course for readers might be considered as mere talk, but if it were adopted the members would learn how interesting and instructive medical society news can be, and the editors would catch a glimpse of the inner opinions of the readers.

---

## DESTRUCTIVE CRITICISM

When a physician eminent in his profession says that doctors are not taking full advantage of the opportunities offered to them by modern medical research, the announcement is proclaimed in the public press and is often interpreted as a condemnation of the medical profession. New medical discoveries are broadcasted from dozens of stations, and in a score or more of specialties the general practitioners can receive from one station at a time and for only a brief period. His practice covers all the specialties, and he never knows what sort of information he will need to use next. One doctor listens in at a lecture or medical journal, and if he gets nothing that he

can put to immediate use, he is not likely to tune in on other broadcasting stations.

The broadcaster in the research station reacts largely according to his temperament. He is manager of an institution that produces medical discoveries. His success depends on salesmanship quite as much as discovery. His discoveries must be delivered to the doctors and put to general use before they can be of benefit to mankind.

The psychology of medical salesmanship may be illustrated by the old story of the Turkish Sultan who consulted his two soothsayers. The first one said "All your friends will die before you," and was headed for his doleful predic-

# EDITORIALS

The Medical Society of the State of New York is not responsible for views or statements, outside of its own authoritative actions published in the JOURNAL. Views expressed in the various departments of the JOURNAL represent the views of the writer

## NEW YORK STATE JOURNAL OF MEDICINE

Business and Editorial Office—17 West 43rd Street, New York, N Y  
Telephone, Vanderbilt 0821

Published by the Medical Society of the State of New York under the auspices of the Committee on Publication

Editor-in-Chief—ORRIN SAGE WIGHTMAN, M.D.,

New York

Executive Editor—FRANK OVERTON, M.D

Patchogue

### COMMITTEE ON PUBLICATION

E. ELIOT HARRIS, M.D., *Chairman*

WILLIAM H. ROSS, M.D.

DANIEL S. DOUGHERTY, M.D.

New York

Brentwood

New York

## MEDICAL SOCIETY OF THE STATE OF NEW YORK

### OFFICERS

*President*—NATHAN B. VAN ETEN, M.D.

New York

*First Vice President*—WILLIAM H. ROSS, M.D.

Brentwood

*Second Vice President*—FREDERICK H. FLAHERTY, M.D.

Syracuse

*Speaker*—E. ELIOT HARRIS, M.D.

New York

*Vice Speaker*—GEORGE M. FISHER, M.D.

Utica

*Secretary*—DANIEL S. DOUGHERTY, M.D.

New York

*Assistant Secretary*—HOWARD GILLESPIE MYERS, M.D.

New York

*Treasurer*—CHARLES GORDON HEYD, M.D.

New York

*Assistant Treasurer*—JAMES PEDERSEN, M.D.

New York

### CHAIRMAN, STANDING COMMITTEES

*Arrangements*—EDWARD R. CUNIFFE, M.D.

New York

*Legislation*—HENRY L. K. SHAW, M.D.

Albany

*Public Health and Medical Education*

CHARLES A. GORDON, M.D., Brooklyn

*Scientific Work*—ANDREW MACFARLANE, M.D.

Albany

*Medical Economics*—WILLIAM WARREN BRITT, M.D.

Tonawanda

### COUNCIL

The above officers (with the exception of the Assistant Secretary and Assistant Treasurer), the ex-President and the Councilors of the District Branches.

*First District*—JOHN A. CARD, M.D.

Poughkeepsie

*Second District*—JOSEPH S. THOMAS, M.D.

Flushing

*Third District*—CHARLES P. MCCABE, M.D.

Greenville

*Fourth District*—HORACE M. HICKS, M.D.

Amsterdam

*Fifth District*—NELSON O. BROOKS, M.D.

Oneida

*Sixth District*—GEORGE H. FOX, M.D.

Binghamton

*Seventh District*—WILLIAM I. DEAN, M.D.

Rochester

*Eighth District*—HARRY R. TRICK, M.D.

Buffalo

### COUNSEL

GEORGE W. WHITESIDE, Esq., 27 William St.  
Telephone, Hanovia 4495

New York

### ATTORNEY

ROBERT OLIVER, Esq., 27 William St.

New York

### EXECUTIVE OFFICER

JOSEPH S. LAWRENCE, M.D. 51 Chapel Street, Albany

### SECTION OFFICERS

#### Medicine

*Chairman*—L. WHITTINGTON GORHAM, M.D.

Albany

*Secretary*—WARDNER D. AYER, M.D.

Syracuse

#### Surgery

*Chairman*—EDWARD S. VAN DUYN, M.D.

Syracuse

*Secretary*—GEORGE E. BEILBY, M.D.

Albany

#### Obstetrics and Gynecology

*Chairman*—ALFRED C. BECK, M.D.

Brooklyn

*Secretary*—NATHAN P. SEARS, M.D.

Syracuse

#### Pediatrics

*Chairman*—ROGER H. DENNETT, M.D.

New York

*Vice Chairman*—ARTHUR W. BENSON, M.D.

Troy

*Secretary*—JOHN AITKMAN, M.D.

Rochester

#### Eye, Ear, Nose and Throat

*Chairman*—EUGENE E. HINMAN, M.D.

Albany

*Secretary*—JAMES W. WHITE, M.D.

New York

#### Public Health Hygiene and Sanitation

*Chairman*—ARTHUR D. JACQUES, M.D.

Lynbrook

*Secretary*—LEO F. SCHIFF, M.D.

Plattsburg

#### Neurology and Psychiatry

*Chairman*—CLARENCE O. CHENEY, M.D.

Utica

*Secretary*—THOMAS K. DAVIS, M.D.

New York

For a list of the Officers of the county medical societies, see October 15 JOURNAL, advertising page xviii.

For list of District Branch Officers, Standing Committees and Special Committees, see October 15 JOURNAL, advertising page third cover

## CHRISTMAS

I saw a doctor wearing a trown,  
With his eyebrows up and his mouth turned  
down  
"How are folks this Christmas?" I greeted him  
"Distressingly healthy," he answered grim,  
"A few old chronics are all I see,  
"If no one gets sick or goes on a spree  
"A poor-house turkey 'twill be for me."  
And a cloud came over the sun

I saw another doctor that day,  
With a jolly round face and a breezy way  
"How are the sick folks doing?" said I  
"Delightfully hearty," he made reply  
"I sell them health and strength through the year  
'So they may enjoy their holiday cheer,  
"For Christmas is never a time to feel queer."  
And the sun shone warm and bright

# MEDICAL PROGRESS

**The Nature of Cancer, and Treatment of Malignant Growths by Lead**—IV Blair Bell (*Lancet*, November 14, 1925, ccix, 5333), in an address before the Academy of Medicine, Toronto, on November 10, described investigations carried out by a group of observers at the University of Liverpool, which are confirmatory of his hypothesis that cancer is a specific process, though not perhaps due to a specific cause. According to this theory, malignant disease in the human subject is a biological atavism. There is a time in the development of the ovum when somatic cell correlation and differentiation can hardly be said to exist, except potentially. At that early stage the trophoblast, of which the ovum is largely composed, is engaged in a struggle for existence, unless it can eat its way into the maternal tissues, the whole ovum will perish. The zygote possesses, therefore, the power of developing into cells of two types, the undifferentiated nutritive cells and the differentiated somatic cells. Normally the area in which the fetus is to develop grows rapidly, and *pari passu* the activities of the trophoblast, so far as plastic and invasive properties are concerned, are gradually arrested. Thus it appears that, when the elusive factor in somatic cell correlation becomes operative and ensures normal and differentiated development in the fetus, the growth of undifferentiated, "malignant," epithelium of the chorion is stayed. It is with the nature of this controlling factor that investigation is concerned. In view of the method of implantation of the ovum in the human subject, and of the origin of chorio-epithelioma, it seems reasonable to suppose that cells of somatic tissues, formerly normal may, through senility, injury, infection, or any of the other inciting and predisposing factors of cancer, slowly lose their power of obtaining or utilizing nutriment, and, as the process of starvation is a slow one, gradually adjust themselves to the altered and altering conditions by reverting to an earlier, undifferentiated, chorionic, nutriment-seeking type. It is possible that every cell in the body has this potentiality for atavistic reversion and once started on the perverted course, there is no reason why the de-differentiated somatic cells should be arrested, for like those of chorio-epithelioma, they are free from differentiated somatic control. In the search for confirmation of this hypothesis, a comparison was made between the chemical constitution of different tissues in regard to factors concerned in the growth processes. This study showed that chorionic epithelium and malignant cells have a water and phosphate value and a phosphate-cholesterol

ratio far in excess of that of normal tissues and innocent neoplasms. It has also been shown that permeability of the cell membrane is associated with a high phosphate value and a high phosphate-cholesterol ratio. Further, a high water content is actual evidence of permeability, and permeability is favorable to rapid growth. These are the essential features of malignant neoplasia and they are most noticeable in connection with chorionic villi.

In a search for a substance that will arrest or have a specific lethal action on cells which possess the chemical constitution associated with malignancy, the effect of various metals—beryllium, zinc, thallium, copper, thorium, lead—was studied. It was found that lead only is specifically active in regard to the chorionic epithelium, to the cells of cancerous growth, to normal embryonic growth, and to mature cells rich in phosphatides. Intravenous injections of lead have been administered in cases of human cancer. In two illustrative cases cited (carcinoma of the breast and widely disseminated abdominal sarcoma) apparently permanent cures were effected. On the other hand, in a case of sarcoma of the stomach treated by intravenous injections of lead the patient died with acute peritoneal symptoms and necropsy showed that the lead had caused total liquefaction of the stomach. In a case of rapidly growing post-cystoid carcinoma lead injections caused acute necrosis of the entire tumor, and the patient died from suffocation. The result in these instances may be confirmatory of the specific action of lead on malignant neoplasms, but it also hoists a danger signal and warns against the indiscriminate use of so potent a remedy. Blair Bell promises to publish his results in a series of cases, in an early issue of the *Lancet*.

**Periarterial Sympathectomy**—Ira Cohen (*Annals of Surgery*, November, 1925, lxxii, 5) reports 11 cases in which periarterial sympathectomy was performed for ulcer of the leg, gangrene of the toes, and thromboangitis. The operation consisted in the removal of the adventitia of the femoral artery, the site chosen being in Scarpa's triangle just below the division of the common into the superficial and deep femoral arteries. The superficial femoral artery is exposed and raised from its bed for a distance of 5 to 8 centimeters. With a fine scalpel an incision is made through the adventitia along the exposed vessel. The edge of the adventitia is picked up with fine forceps and freed by blunt dissection with a thyroid separator or small cranial elevator. When it has been freed for about half a centi-

tion The other one said "You will outlive all your friends," and was honored for his optimistic way of stating exactly the same prophecy

If the medical research worker and teacher is of a pessimistic temperament, he may say "We are turning out an abundance of new discoveries, but the doctors are not using them They are neglecting their opportunities and their patients continue to suffer from the lack of therapeutic measures which are available to those who will seek for them" This line of reasoning supplies the enemies of the medical profession with abundant ammunition for discrediting the doctors

On the other hand if the medical teacher has an optimistic temperament, he may say to the doctors, "Step up and see our new discovery Keep yourself up-to-date, and give your patients the benefit of the results of the latest medical research" This is the successful method of the committee on Public Health and Medical Education of the Medical Society of the State of New York It does not lend itself to propaganda against physicians, but it focuses one's attention on medical progress

Now let us consider the psychology of the

rivals of the physicians The cultists, too, are in the producing business, although the output is small, but their sales organizations are widespread and efficient Their salesmen say

"We cure where doctors fail Dr Blank, Professor of Medicine in the Peepul's University, says that doctors are not making use of medical discoveries Why not? Because they have lost confidence in their leaders, who give out only the information that suits them We have a medical discovery that is endorsed by Dr Blank who used it successfully on Miss Catch, the famous actress, and we will distribute it directly to you, so that you will not need to go to the doctors who are prejudiced against modern medical discoveries"

These salesmen have no difficulty in finding statements of prominent physicians in support of their insinuations of the failure of doctors It is good psychology to make your rival convict himself out of his own mouth It is good judgment for physicians to avoid expressions which may be quoted against the medical profession

Destructive medical criticism belongs only in one half of a compound or complex sentence whose other half balances the criticism with a constructive suggestion

---

### "TEACHING HOSPITALS"

One of the most striking forms of medical progress during the last five years has been the development of hospitals as centers for medical teaching This has come about largely through the adoption of monthly staff meetings by practically every hospital, both urban and rural The benefits of staff meetings have long been known, but physicians were individualistic, and many held to the old idea of private ownership of every case of sickness "No one shall tell me how to treat my cases in a hospital," was what many a doctor told his colleagues

The stimulus to lay aside one's prejudices and join with his colleagues in the free discussion of cases came from the American College of Surgeons when it began to publish its lists of approved hospitals To have his hospital approved was the ambition of every member of every staff

Staff meetings have long been familiar to those who practice in the hospitals of large cities, but they were novelties to the staffs in small cities and rural places, and their excellent effects were at once apparent It meant a revolution of thought when an individualistic doctor wrote histories of his cases and placed them on file where all his colleagues could see them It meant still more for him to be asked why his patient died and why he did not adopt a particular

method of treatment When a doctor expects to be asked embarrassing questions that reveal his ignorance, he prepares himself for the ordeal, and that means that he must study every case, for he knows not what complication may develop

Staff meetings have the praiseworthy characteristics of being real clinical meetings, in which every member must inevitably take part if he is at all active in the hospital A doctor may evade his duty in his county medical society, and take refuge behind the plea that he cannot write a paper or get up and make a speech, but in his hospital he is compelled to write history papers, and to make speeches justifying his diagnosis and treatments, and lo! he can do both as well as any one else

The staff meetings in many places are group meetings of county medical societies Some devote a whole evening to their meetings, and a few hospitals find it profitable to provide a supper for the staff

One of the most gratifying things about the staff meetings is that they are the spontaneous response of almost the entire body of physicians to an ideal simply stated by a group of doctors who had an outlook and a vision





# MEDICAL PROGRESS



**The Nature of Cancer, and Treatment of Malignant Growths by Lead**—W Blair Bell (*Lancet*, November 14, 1925, ccix, 5333), in an address before the Academy of Medicine, Toronto, on November 10, described investigations carried out by a group of observers at the University of Liverpool, which are confirmatory of his hypothesis that cancer is a specific process, though not perhaps due to a specific cause. According to this theory, malignant disease in the human subject is a biological atavism. There is a time in the development of the ovum when somatic cell correlation and differentiation can hardly be said to exist, except potentially. At that early stage the trophoblast, of which the ovum is largely composed, is engaged in a struggle for existence, unless it can eat its way into the maternal tissues, the whole ovum will perish. The zygote possesses, therefore, the power of developing into cells of two types, the undifferentiated nutritive cells and the differentiated somatic cells. Normally the area in which the fetus is to develop grows rapidly, and *pari passu* the activities of the trophoblast, so far as plastic and invasive properties are concerned, are gradually arrested. Thus it appears that when the elusive factor in somatic cell correlation becomes operative and ensures normal and differentiated development in the fetus, the growth of undifferentiated, "malignant," epithelium of the chorion is stayed. It is with the nature of this controlling factor that investigation is concerned. In view of the method of implantation of the ovum in the human subject, and of the origin of chorio-epithelioma, it seems reasonable to suppose that cells of somatic tissues, formerly normal may, through senility, injury, infection, or any of the other inciting and predisposing factors of cancer, slowly lose their power of obtaining or utilizing nutriment, and, as the process of starvation is a slow one, gradually adjust themselves to the altered and altering conditions by reverting to an earlier, undifferentiated, chorionic, nutriment-seeking type. It is possible that every cell in the body has this potentiality for atavistic reversion and once started on the perverted course, there is no reason why the de-differentiated somatic cells should be arrested, for like those of chorion epithelioma, they are free from differentiated somatic control. In the search for confirmation of this hypothesis, a comparison was made between the chemical constitution of different tissues in regard to factors concerned in the growth processes. This study showed that chorionic epithelium and malignant cells have a water and phosphatide value and a phosphatide-cholesterol

ratio far in excess of that of normal tissues and innocent neoplasms. It has also been shown that permeability of the cell membrane is associated with a high phosphatide value and a high phosphatide-cholesterol ratio. Further, a high water content is actual evidence of permeability, and permeability is favorable to rapid growth. These are the essential features of malignant neoplasia and they are most noticeable in connection with chorionic villi.

In a search for a substance that will arrest or have a specific lethal action on cells which possess the chemical constitution associated with malignancy the effect of various metals—beryllium, zinc, thallium, copper, thorium, lead—was studied. It was found that lead only is specifically active in regard to the chorionic epithelium, to the cells of cancerous growth, to normal embryonic growth, and to mature cells rich in phosphatides. Intravenous injections of lead have been administered in cases of human cancer. In two illustrative cases cited (carcinoma of the breast and widely disseminated abdominal sarcoma) apparently permanent cures were effected. On the other hand, in a case of sarcoma of the stomach treated by intravenous injections of lead the patient died with acute peritoneal symptoms and necropsy showed that the lead had caused total liquefaction of the stomach. In a case of rapidly growing post-cricoid carcinoma lead injections caused acute necrosis of the entire tumor, and the patient died from suffocation. The result in these instances may be confirmatory of the specific action of lead on malignant neoplasms, but it also hoists a danger signal and warns against the indiscriminate use of so potent a remedy. Blair Bell promises to publish his results, in a series of cases, in an early issue of the *Lancet*.

**Periarterial Sympathectomy**—Ira Cohen (*Annals of Surgery*, November, 1925, lxxxii, 5) reports 11 cases in which periarterial sympathectomy was performed for ulcer of the leg, gangrene of the toes, and thromboangitis. The operation consisted in the removal of the adventitia of the femoral artery, the site chosen being in Scarpa's triangle just below the division of the common into the superficial and deep femoral arteries. The superficial femoral artery is exposed and raised from its bed for a distance of 5 to 8 centimeters. With a fine scalpel an incision is made through the adventitia along the exposed vessel. The edge of the adventitia is picked up with fine forceps and freed by blunt dissection with a thyroid separator or small cranial elevator. When it has been freed for about half a centi-

meter along one side, the adventitia may be grasped with mosquito hemostats placed at intervals. Gentle traction on these clamps while using the separator will cause the vessel to rotate while the adventitia is thus peeled off until the thin fibrous coat is entirely free from the vessel and may be cut away. After this has been done the vessel is allowed to drop back into its bed and the soft parts are sutured. The operation is followed by immediate changes in the limb, contraction of the exposed vessel, subjective and objective coldness of the extremity, and diminution of the peripheral pulse. These changes last several hours and are followed by signs of dilatation of the peripheral vessels with subjective and objective increase in temperature and elevation of the arterial pulse pressure. These latter phenomena last five or six days or longer. Of the total 11 cases, 7 were of arteriosclerotic origin, 2 were thromboangitic, 1 was a case of trophic ulcer, and 1 was an ulcer complicating mild diabetes. Three patients were completely relieved of pain, 2 were slightly improved, and in 6 no benefit could be seen from the operation. The best results were obtained in patients with pain due to arteriosclerotic disease of the vessels of the legs. Priarterial sympathectomy causes definite changes in the peripheral circulation. The explanation of its action is not clear, and the indications for its use are not sharply defined. Success and failure were met with in seemingly similar cases.

To René Leriche belongs the credit of introducing this operation, an early if not the first case of which was reported by him in *La Presse Médicale* of 1920. The arterial decortication was done for the cure of an intractable ulcer in an amputation stump and was eminently successful. In a later communication (*Annals of Surgery*, October, 1921), he reported a number of successful sympathectomies for the relief of causalgia, Raynaud's disease, and various trophic ulcers. A. E. Halstead has reported a case diagnosed as one of endarteritis obliterans cured by Leriche's operation (*Journal Am Med Association*, January 20, 1923, lxxx, 3). Handley suggests periarterial injection of alcohol as an alternative to this operation (*Lancet*, July 15, 1922, ccii, p 173) and reports a case of incipient gangrene cured by his method.

**A New Method of Approach for the Removal of Deep-Seated Brain Tumors**—Walter E. Dandy (*Annals of Surgery*, October, 1925, lxxii, 4) presents a method by which tumors (principally ependymal tumors) situated within the brain substance can be exposed and ablated. The procedure involves resection of the so-called silent parts, even, if need be, lobes of the brain. A case is described of a dural epithelioma (a benign encapsulated tumor) arising from the cover of the cribriform plate, and occupying both sides of the cranial

chamber to an equal degree. The tumor was completely removed after a preliminary resection of the left frontal lobe. No loss of function of any kind followed the operation. Resection of a silent cerebral lobe is advocated, in part or whole, as a method for the removal of certain intracranial tumors known to be benign, and which are situated at such a depth as to be in large part or wholly hidden from view. For such tumors situated on the right side of the middle cranial fossa, preliminary resection of the temporal or occipital lobes would be justifiable, though, of course, contralateral homonymous hemianopsia would result. Section of the left occipital lobe posterior to the supramarginal and supra-angular gyri apparently leaves no stigmata other than a right homonymous hemianopsia. The inclusion of these sensory speech areas could hardly ever be justifiable.

The intracranial approach which Dandy describes is designed so as to avoid leaving scar on the forehead in front of the hair line. In general way it may be said that two small more or less U-shaped adjoining skin flaps, are used instead of a single large one, a middle limb serving both as the back of the anterior flap and the front of the posterior flap. The base of the anterior flap is directed toward the orbit, the base of the posterior downward toward the zygoma. The principle involved in the use of these two flaps can be variously modified. Dandy has been using this method of approach in practically every case of cerebral tumor or craniotomy for several years.

**The Value of the Leucocyte Count as an Aid to Diagnosis in Ectopic Gestation**—Lilian K. P. Farrar (*Surgery, Gynecology and Obstetrics*, November, 1925, xli, 5) has made observations on the leucocyte count in 150 cases of ectopic gestation, which she summarizes thus: (1) In ectopic gestation the leucocyte count fluctuates according to the amount of fresh blood being thrown into the peritoneal cavity and the rate of absorption. (2) The leucocyte count tends to drop quickly to normal as the blood in the peritoneal cavity is absorbed or walled in, 48 per cent of the 150 cases of ectopic gestation showed a normal leucocyte count before operation was performed. (3) The leucocyte count was normal in 29 cases of unruptured tubal pregnancy in which there was no free blood, and in 43 cases of ruptured pregnancy in which the blood was walled in. (4) The leucocyte count was an index in 150 cases to the amount of fresh blood in the peritoneal cavity and the polymorphonuclear leucocyte count was increased markedly only in cases having fresh blood in the pelvis, and increased in direct proportion to the amount of recent blood found at the time of operation. (5) The fluctuating leucocyte count, together with

the moderate elevation of temperature, differentiates ectopic gestation from a purulent salpingitis with its more uniformly high leucocyte count and fluctuating temperature (6) In cases of rupture of tubal pregnancy the steadily rising leucocyte count indicates active bleeding before the fall in the number of red cells or hemoglobin gives warning of the condition (7) The leucocyte count to be of diagnostic value must be taken at least daily, in critical cases even hourly, and used in conjunction with the history and clinical findings in the case

**Biologic Testing of Ovarian Preparations**—Zondek and Bernhardt of the Charité Hospital, Berlin, refer to the disadvantages inherent in ovarian substance in contrast with the thyroid, adrenal and pancreatic secretions, all of which contain active hormones which permit of a biological standardization It is evident that somehow a hormone must be present to explain the results of ovarian grafting We know beyond doubt that at least one dynamic action can be assigned to ovarian substance, for when castration has lowered the oxygen consumption of the woman by about 15 per cent, ovarian substance will sometimes make this deficit good again We may therefore assume that there is a hormone-like substance in the ovary and that its function is to stimulate oxidation A clinical case is reported to show that ovarian substance can cause the return of normal oxidation, although to demonstrate this truth it was necessary to supervise the metabolism of a castrated woman for two years or more Before using the home made preparation several marketed preparations were tested and found quite inert Modes of preparation and handling may, therefore, be at fault The authors are at present endeavoring to determine the identity of the hormone and isolate it—*Klinische Wochenschrift*, October 15, 1925

**Exanthema Subitum**—Seen originally in St Louis by Zahorsky and described by him under the name of roseola infantilis, in 1910, this affection was recognized later in Ann Arbor, New York, Cleveland, Houston and Detroit The first European cases were identified in Berne in 1919, and quite recently cases have been studied in Italy So far as known the affection has never been seen in Great Britain, France, or Germany Von Bokay of Budapest, who has seen 11 cases (*Deutscher med Wochenschrift*, Oct 11, 1925), regards exanthema subitum as an autonomous affection His own, like the cases seen by others, are remarkably true to type. The fever sets in suddenly in the midst of health and the patients remain relatively well despite the four days of fever which may reach 104°, and which usually ends on the fourth day by crisis Relapses may occur of the same length as the first attack. The

rash is of the measles type and always appears on the trunk, in certain cases also involving the head and extremities Authors have noted congestion of the buccal mucosa and pharyngitis The younger children seem more predisposed and while cases occur in massed incidence, contagiousness is feeble if present at all The affection is of no great clinical significance, but might of course mask some more serious condition Von Bokay says nothing of any causal factors and mentions no microorganisms The name bestowed on the disease was given in recognition of the suddenness with which the rash appears

**Respiratory Catarrh in Children**—The frequency of catarrhal troubles in the newborn is a matter of common observation, nevertheless one will read with surprise that one-half of all infants from three to six weeks of age suffer, in England at least, from nasal or bronchial colds This is the statement made by Richard C. Clarke (*Lancet*, October 24, 1925, ccix, 5330), who found in a study of his last 1,000 case-sheets that 499 young infants were already affected, and on questioning the mothers the usual answer was "Yes, 'e was born with it" These early infections tend to become chronic and are undoubtedly the cause of inadequate suckling, due to nasal obstruction, of the disease known as "tonsils and adenoids," and of chronic sinus troubles Of over 400 babies under four weeks old, who had nasal catarrh, the writer found that every one had signs of bronchial catarrh Once a child is bronchitic, every fresh cold causes exacerbation of the bronchial signs and symptoms The result is the bronchitic schoolchild and later the bronchitic adult The bronchitic child is severely handicapped, for attacks of bronchopneumonia occur with frequency, while measles, whooping-cough, and even the administration of an anesthetic present added risks in such a case The question of pathogenesis is bound up with the factors which control the spread of infectious disease In order to prevent this condition, the morbid dose of catarrhal organisms on the respiratory mucous membranes must be postponed as long as possible There can be no fear of the child missing the submorbid or immunizing dose. In order to avoid the morbid dose the mother should carry out antepartum nasal hygiene, and after delivery if she has acute catarrh, she should wear a folded handkerchief over the mouth and nose when attending the baby The same precaution should be adopted by nurses or other attendants To avoid the other main avenue of infection, the germ-laden atmosphere, is not difficult in the uncrowded house, but if the infant belongs to the overcrowded class it should either be kept out of doors or in a draught The latter point is insisted upon by the author who implies that children do not suffer discomfort from a moderate degree of cold

meter along one side, the adventitia may be grasped with mosquito hemostats placed at intervals. Gentle traction on these clamps while using the separator will cause the vessel to rotate while the adventitia is thus peeled off until the thin fibrous coat is entirely free from the vessel and may be cut away. After this has been done the vessel is allowed to drop back into its bed and the soft parts are sutured. The operation is followed by immediate changes in the limb, contraction of the exposed vessel, subjective and objective coldness of the extremity, and diminution of the peripheral pulse. These changes last several hours and are followed by signs of dilatation of the peripheral vessels with subjective and objective increase in temperature and elevation of the arterial pulse pressure. These latter phenomena last five or six days or longer. Of the total 11 cases, 7 were of arteriosclerotic origin, 2 were thromboangitic, 1 was a case of trophic ulcer, and 1 was an ulcer complicating mild diabetes. Three patients were completely relieved of pain, 2 were slightly improved, and in 6 no benefit could be seen from the operation. The best results were obtained in patients with pain due to arteriosclerotic disease of the vessels of the legs. Priarterial sympathectomy causes definite changes in the peripheral circulation. The explanation of its action is not clear, and the indications for its use are not sharply defined. Success and failure were met with in seemingly similar cases.

To René Leriche belongs the credit of introducing this operation, an early if not the first case of which was reported by him in *La Presse Médicale* of 1920. The arterial decortication was done for the cure of an intractable ulcer in an amputation stump and was eminently successful. In a later communication (*Annals of Surgery*, October, 1921), he reported a number of successful sympathectomies for the relief of causalgia, Raynaud's disease, and various trophic ulcers. A. E. Halstead has reported a case diagnosed as one of endarteritis obliterans cured by Leriche's operation (*Journal Am Med Association*, January 20, 1923, lxxx, 3). Handley suggests periarterial injection of alcohol as an alternative to this operation (*Lancet*, July 15, 1922, cciii, p 173) and reports a case of incipient gangrene cured by his method.

**A New Method of Approach for the Removal of Deep-Seated Brain Tumors—**Walter E. Dandy (*Annals of Surgery*, October, 1925, lxxvii, 4) presents a method by which tumors (principally ependymal tumors) situated within the brain substance can be exposed and ablated. The procedure involves resection of the so-called silent parts, even, if need be, lobes of the brain. A case is described of a dural epithelioma (a benign encapsulated tumor) arising from the cover of the cribriform plate, and occupying both sides of the cranial

chamber to an equal degree. The tumor was completely removed after a preliminary resection of the left frontal lobe. No loss of function of any kind followed the operation. Resection of a silent cerebral lobe is advocated, in part or whole, as a method for the removal of certain intracranial tumors known to be benign, and which are situated at such a depth as to be in large part or wholly hidden from view. For such tumors situated on the right side of the middle cranial fossa, preliminary resection of the temporal or occipital lobes would be justifiable, though, of course, contralateral homonymous hemianopsia would result. Section of the left occipital lobe posterior to the supramarginal and supra-angular gyri apparently leaves no stigmata other than a right homonymous hemianopsia. The inclusion of these sensory speech areas could hardly ever be justifiable.

The intracranial approach which Dandy describes is designed so as to avoid leaving scars on the forehead in front of the hair line. In a general way it may be said that two small, more or less U-shaped adjoining skin flaps, are used instead of a single large one, a middle limb serving both as the back of the anterior flap and the front of the posterior flap. The base of the anterior flap is directed toward the orbit, the base of the posterior downward toward the zygoma. The principle involved in the use of these two flaps can be variously modified. Dandy has been using this method of approach in practically every case of cerebral tumor or craniotomy for several years.

**The Value of the Leucocyte Count as an Aid to Diagnosis in Ectopic Gestation—**Lilian K. P. Farrar (*Surgery, Gynecology and Obstetrics*, November, 1925, xli, 5) has made observations on the leucocyte count in 150 cases of ectopic gestation, which she summarizes thus: (1) In ectopic gestation the leucocyte count fluctuates according to the amount of fresh blood being thrown into the peritoneal cavity and the rate of absorption. (2) The leucocyte count tends to drop quickly to normal as the blood in the peritoneal cavity is absorbed or walled in, 48 per cent of the 150 cases of ectopic gestation showed a normal leucocyte count before operation was performed. (3) The leucocyte count was normal in 29 cases of unruptured tubal pregnancy in which there was no free blood, and in 43 cases of ruptured pregnancy in which the blood was walled in. (4) The leucocyte count was an index in 150 cases to the amount of fresh blood in the peritoneal cavity and the polymorphonuclear leucocyte count was increased markedly only in cases having fresh blood in the pelvis, and increased in direct proportion to the amount of recent blood found at the time of operation. (5) The fluctuating leucocyte count, together with

the moderate elevation of temperature, differentiates ectopic gestation from a purulent salpingitis with its more uniformly high leucocyte count and fluctuating temperature (6) In cases of rupture of tubal pregnancy the steadily rising leucocyte count indicates active bleeding before the fall in the number of red cells or hemoglobin gives warning of the condition (7) The leucocyte count to be of diagnostic value must be taken at least daily, in critical cases even hourly, and used in conjunction with the history and clinical findings in the case

**Biologic Testing of Ovarian Preparations**—Zondek and Bernhardt of the Charite Hospital, Berlin, refer to the disadvantages inherent in ovarian substance in contrast with the thyroid, adrenal and pancreatic secretions, all of which contain active hormones which permit of a biological standardization It is evident that somehow a hormone must be present to explain the results of ovarian grafting We know beyond doubt that at least one dynamic action can be assigned to ovarian substance, for when castration has lowered the oxygen consumption of the woman by about 15 per cent, ovarian substance will sometimes make this deficit good again We may therefore assume that there is a hormone-like substance in the ovary and that its function is to stimulate oxidation. A clinical case is reported to show that ovarian substance can cause the return of normal oxidation, although to demonstrate this truth it was necessary to supervise the metabolism of a castrated woman for two years or more Before using the home made preparation several marketed preparations were tested and found quite inert Modes of preparation and handling may, therefore, be at fault. The authors are at present endeavoring to determine the identity of the hormone and isolate it—*Klunische Wochenschrift*, October 15, 1925

**Exanthema Subitum**.—Seen originally in St Louis by Zahorsky and described by him under the name of roseola infantilis, in 1910, this affection was recognized later in Ann Arbor, New York, Cleveland, Houston and Detroit. The first European cases were identified in Berne in 1919, and quite recently cases have been studied in Italy So far as known the affection has never been seen in Great Britain, France, or Germany Von Bokay of Budapest, who has seen 11 cases (*Deutscher med Wochenschrift*, Oct 11, 1925), regards exanthema subitum as an autonomous affection His own, like the cases seen by others, are remarkably true to type The fever sets in suddenly in the midst of health and the patients remain relatively well despite the four days of fever which may reach 104°, and which usually ends on the fourth day by crisis Relapses may occur of the same length as the first attack. The

rash is of the measles type and always appears on the trunk, in certain cases also involving the head and extremities Authors have noted congestion of the buccal mucosa and pharyngitis. The younger children seem more predisposed and while cases occur in massed incidence, contagiousness is feeble if present at all The affection is of no great clinical significance, but might of course mask some more serious condition Von Bokay says nothing of any causal factors and mentions no microorganisms The name bestowed on the disease was given in recognition of the suddenness with which the rash appears

**Respiratory Catarrh in Children**.—The frequency of catarrhal troubles in the newborn is a matter of common observation, nevertheless one will read with surprise that one-half of all infants from three to six weeks of age suffer, in England at least, from nasal or bronchial colds This is the statement made by Richard C Clarke (*Lancet*, October 24, 1925, ccix, 5330), who found in a study of his last 1,000 case-sheets that 499 young infants were already affected, and on questioning the mothers the usual answer was "Yes, 'e was born with it" These early infections tend to become chronic and are undoubtedly the cause of inadequate suckling, due to nasal obstruction, of the disease known as "tonsils and adenoids," and of chronic sinus troubles Of over 400 babies under four weeks old, who had nasal catarrh, the writer found that every one had signs of bronchial catarrh Once a child is bronchitic, every fresh cold causes exacerbation of the bronchial signs and symptoms The result is the bronchitic schoolchild and later the bronchitic adult The bronchitic child is severely handicapped, for attacks of bronchopneumonia occur with frequency, while measles, whooping-cough, and even the administration of an anesthetic present added risks in such a case The question of pathogenesis is bound up with the factors which control the spread of infectious disease In order to prevent this condition, the morbid dose of catarrhal organisms on the respiratory mucous membranes must be postponed as long as possible There can be no fear of the child missing the submorbid or immunizing dose In order to avoid the morbid dose the mother should carry out antepartum nasal hygiene, and after delivery if she has acute catarrh, she should wear a folded handkerchief over the mouth and nose when attending the baby The same precaution should be adopted by nurses or other attendants To avoid the other main avenue of infection, the germ-laden atmosphere, is not difficult in the uncrowded house, but if the infant belongs to the overcrowded class it should either be kept out of doors or in a draught The latter point is insisted upon by the author who implies that children do not suffer discomfort from a moderate degree of cold

**Glossitis As One of the Early Prodromes of Pernicious Anemia**—Tilger-Beckers of the surgical division of the Dental Institute of the University of Berlin traces the history of this subject from the original description of the disease by Biermer in 1868 (*Correspondenz-Blatt für Zahnärzte*, 1925, xlix, no 9). It was not until 1909 that William Hunter gave the subject a monographic consideration by collecting 112 cases of glossitis as an early symptom of the disease in question. In 1902 the same author had described a dozen personal cases and in 1909 he stated that in 75 cases of pernicious anemia seen during the preceding seven years every patient exhibited this glossitis. In Germany, Schaumann announced (1912) that in both Biermer's and tapeworm anemia there was a recurrent soreness of the mouth and throat. Others described subjective symptoms, burning of the tongue, which pursued a periodical course. These mostly subjective cases corresponded with the more objective finds of Hunter (although the latter sometimes speaks of "sore tongue" himself). The more recent German observers, as Zimmermann in 1917 and Sackheim in 1922, fully bear out the claims of Hunter that every case of true pernicious anemia exhibits the glossitis as an early symptom. Hunter even goes so far as to call Biermer's anemia "glossitic anemia." But apparently the general practitioner as a class has not yet grasped the diagnostic significance of this early glossitis. Subjectively the organ burns during eating and is very sensitive to acids and salt. Some patients are forced to give up smoking and lose their taste for spirits. The objective symptoms vary much with the stage of the disease, but as we are interested here only in the early stage, they are limited then to an intensive hyperemia with separate small foci of inflammation and disappearance of some of the papillae.

**Treatment of Bubonic Plague by the Bacteriophage**—D'Herelle, who discovered the bacteriophage at the Pasteur Institute, was sent to Indo-China in 1920, where he made a number of most virulent cultures of plague bacilli. *B. pestis*, like the dysentery bacillus, was regarded by him as peculiarly adapted for "phage" treatment, and as from small beginnings the latter made good on a large scale for bacillary dysentery it seemed reasonable to look for favorable results in plague treatment. As the latter disease was endemic in Indo-China the author expected to test his phage cultures upon it, but was ordered to Egypt and forced to entrust the task to a resident colonial surgeon with whom he left a number of ampoules. The next plague cases were given the phage culture, but also received the antiplague serum, so that the favorable outcome of the treatment could not be properly credited. D'Herelle remained in Egypt for a considerable time during which there was a small outbreak of plague. He

had his original cultures of the plague bacillus and prepared a new stock of the phage cultures which were tested on four patients, all of whom made good recoveries, although the disease has a notoriously high mortality. One injection within the first twenty-four hours seemed to be all that it was necessary to give, but if the disease is seen at a later period—as in one of the author's cases—the first injection should be repeated, once or twice if required. The virulent culture of the bacillus should be harmless as soon as the phage develops, and before testing it on patients the author tested it not only on laboratory animals but on his own person. There was no general reaction and the local reaction was inconspicuous. The author recommends for bubonic plague an early injection directly into the buboes. Should the phage cultures be tested in cases of pneumonic plague they would have to be given intravenously.—*La Presse Médicale*, Oct. 21, 1925.

**Apparent Cure of Choked Disc**—Heine of Kiel refers to cases of this affection in which there was no indication for trepanation, and in which the precise etiology was often obscure. Seventeen patients were treated indiscriminately with lumbar puncture, tuberculin and iodine. Two patients who seemed to have entirely recovered were adjudged to have suffered only from the so-called spurious papillitis, and were left out of consideration. The other fifteen patients were reckoned as apparently cured or with disease arrested, bearing in mind the axiom that the longer the observation period the smaller the proportion of actual cures. In regard to the nature of the lesion, seven out of fifteen of the patients were set down as having multiple sclerosis, two others were old syphilitics and one had a cerebellar lesion.—*Muenchener med. Wochenschrift*, September 18, 1925, lxxii, 38.

**Treatment of Rheumatoid Arthritis by Intramuscular Injections of Guaiacol, Iodine and Camphor**—S. Watson Smith (*British Medical Journal*, October 10, 1925, ii, 3380) reports that in nine cases of rheumatoid arthritis and articular fibrositis, other than of postinfective, gouty, or gonorrheal origin, he has obtained satisfactory results by the use of intramuscular injections of 10 per cent guaiacol, 10 per cent iodine, and 5 per cent camphor in oil, the camphor being added for its stimulating and analgesic effect. The initial dose was 0.25 cc and the scale quickly mounted until 1 cc was reached, this was then repeated every third day, or, when thought necessary, every second day. In no case was there any serious general reaction or after-effect. The author finds no record of the previous use of this method in rheumatoid arthritis.



# LEGAL



By **GEORGE W. WHITESIDE, Esq.**  
Counsel, Medical Society of the State of New York

## THE GOVERNMENT OF A PROFESSION

### III

We have previously referred to the operation of the Grievance Committee of the Bar Association of the City of New York as an example of effective government of the legal profession in New York County. Whilst that Association had during the period from 1913 to 1923 an average membership of about 3,000 members, the Grievance Committee considered and acted upon complaints against lawyers irrespective of their affiliation with the Association. In that period that Committee received 9,484 complaints, held 630 meetings, tried 703 cases, and presented to the Appellate Division for disciplinary action 267 cases. The Appellate Division disbarred 140 lawyers, censured 32 and suspended 42 from practice. To accomplish this work during that period the Committee had \$131,468 of net expense.

It is apparent that approximately 8,781 complaints brought were either adjusted by the Committee without trial or found to be without merit. It is likewise apparent that the innocent lawyer complained against received justice and the guilty were punished.

It is a record of this kind in the government of a profession doing justice to the accuser and the accused that has made the Grievance Committee of this Association enjoy public and professional confidence and support.

A separate committee has taken care of the prosecution of unlicensed practitioners of law and in that connection excellent results have been accomplished.

In the handling of this bulk of complaints, to accomplish these results, the cost has been on an average of \$14 a complaint. It seems to have been money well spent.

For almost one hundred years each incorporated medical society has had a board of censors and up to 1887 the functions under the law of the censors were "carefully and impartially to examine all students who shall present themselves for that purpose and report their opinion in writing to the president of the said society." The censors having been denuded of their examining authority by statute have become, through amendments, not of the law but of the constitution and by-laws of county and state medical societies, vested with functions of a disciplinary character. These functions do not extend beyond the exercise of disciplinary power against the members of such societies, and such powers are

restricted to the extreme penalty of dismissal of a member from membership.

It is true, however, that since 1907, under the law, there is nothing to prevent such board of censors from taking the initiative in the bringing of charges before the regents, but this policy has not been followed. The lack of power of the censors adequately to deal with complaints of the public and do justice as between accuser and accused, seems to be the weakness of a system of government of the medical profession through the agency of the boards of censors. As between physician and physician, in the settlement of ethical questions, the censors have functioned in many counties with effectiveness, and for many years in the County of New York the censors were the prosecuting agency to bring unlicensed practitioners of medicine to justice. Over a five-year period, between 1915 and 1920, the censors of the New York County Society considered complaints against 499 unlicensed practitioners and 107 complaints against registered physicians. The performance of this work in the absence of adequate legal machinery became too onerous and expensive to be continued.

When by statute in 1907 the board of regents were given jurisdiction over the practice of medicine with power to try licensed physicians and revoke their licenses, a step was taken in setting up machinery for the government of the medical profession. The judicial power so conferred upon this distinguished body was, however, one quite foreign to the powers which were granted to that body by the constitution of 1784 and which from time to time were confirmed by later constitutional provisions. The regents establish and maintain educational standards and supervise the operation of educational institutions and very properly they determine educational requirements for entrance to the various professions. They are a body in this state particularly who have earned high regard and public confidence. They are a body, however, of laymen who do not have that intimate touch with the problems of medical practice and professional ethical standards of medicine that are so well understood by medical men. They do not even attempt to function in disciplinary proceedings of medical men, except through a committee of the board of medical examiners. Whatever disciplinary functions have been exercised by the regents since 1907 have been, as far as the writer can discover, the revocation of certificates of physicians who have

been convicted of felony. This procedure is purely formal as the law operates itself to work such forfeiture. This body is not constituted nor has it had the background to act as a grievance committee of the medical profession, and with its multitudinous educational functions and duties there is serious doubt whether they would wish to exercise such power.

With the legal profession there has been a negligible amount of court action by clients against attorneys, with the medical profession there has been a constantly increasing amount of such litigation by patients against physicians. Over a period of ten years less than three per cent. of the complaints sent to the Grievance Committee of the Bar Association resulted in disciplinary proceedings against the accused in the Appellate Division. Had there been no such committee through which to filter out and discard the unmeritorious complaints and to segregate for action those justifying court proceedings, the aggrieved parties in large numbers of the 9,484 during the ten-year period would doubtless have resorted in the first instance to the filing of charges against attorneys with the Appellate Division direct. Such a procedure would have resulted in great publicity and injustice to many of the accused and unnecessary expense in defense.

Many cases now brought against physicians for alleged malpractice find their origin in the

desire of the dissatisfied and sometimes unscrupulous patient to vent his ill-will against a physician by causing him worry, anxiety and unpleasant publicity by instituting an action against him in the courts. Many such complaints could be heard by a commission on discipline of the medical profession as proposed in the bill recently submitted by the Medical Society of the State of New York and the merits resolved by the application of principles of truth, ethics and justice, rather than by appealing to a lay jury in court upon grounds of sympathy, prejudice or bias.

The great cry for years among the medical profession has been against the invasion of the realm of medical practice by the unlicensed brigands without. The protests against this unlawful practice have been ineffective in creating sufficient public sentiment to bring about adequate prosecution of the offenders. A system of adequate government of the profession within the profession should tend to elevate the standards of the profession, to protect the honest practitioner against the unfair competition of the unscrupulous and dishonest practitioner, should gain public support and confidence in the profession as a whole and should give to the profession's efforts to repel the invasion of the unfit and unlicensed such support, such confidence and such sanction as should make the practice of medicine by the unlicensed a problem easier to combat and more sure of solution.

### COLLES' FRACTURE

A woman of advanced years by a fall sustained a fracture of her left arm.

In an action of alleged malpractice it was charged that the defendant physician failed to discover the true condition of the patient's injury and negligently treated the fracture, resulting in a malformation of the injured member, causing the plaintiff to expend monies for further medical care and attention and preventing her from following her usual occupation for a period of about fourteen weeks. It was also claimed that the patient's injury was permanent in its nature and that the defendant physician had had X-rays taken of the injured arm but, upon demand from the patient, had refused to deliver the negative films to the patient.

The defendant when called to the patient's home, found that she was suffering from a Colles' fracture. After examination he had X-rays made of the injured wrist and in consultation with the roentgenologist reduced the fracture, applying proper casts. Inspection was made of the injured arm from time to time and after about four weeks, upon examination, the injured wrist was in good condition, with perfect supination and pronation of the hand. Thereafter callus formed at the site of fracture, at which fact the patient became disappointed and thereupon instituted an action of malpractice.

After numerous attempts by plaintiff's attorney to procure a settlement, the action coming on for trial a discontinuance was consented to, terminating the action in favor of the defendant.





## NEWS NOTES



### MEDICAL SOCIETY OF THE COUNTY OF OSWEGO

The 105th Annual Meeting of the Medical Society of the County of Oswego was held on Tuesday, November 17th. The meeting was well attended and the papers and discussions were of unusual interest.

The following officers were elected for the year 1926:

President, Arthur W. Irwin, Vice-president, Earl A. Mowry, Secretary, W. H. Kidder, Treasurer, Joseph B. Ringland, Delegate, Frank E. Fox, Censors, Frank E. Fox, Le Roy F. Hollis, Frederick W. Manly, David D. O'Brien, Frederick L. Sinclair.

A resolution was passed directing the adoption of the automobile emblem of the A. M. A. with the County Society's insignia incorporated.

A resolution directed the President to appoint physicians for service as examiners in the prospective pre-school age clinics of the State Department of Health.

In discussion of the matter of post-graduate study for members of the Society, attention was called to the fact that many physicians of the County are more accessible to Syracuse than to centers in the county, and that it might be better to make arrangements for physicians to investigate the possibility of having proper post-graduate training there. The matter was tabled.

A resolution of appreciation to the speakers was passed.

The administration of Dr. A. L. Hall having been particularly successful with two of the most interesting meetings ever held in the history of the Society, and with speakers of unusual prominence and ability, a resolution of commendation and appreciation was passed. Dr. Hall takes with him from office the gratitude of all who have attended the meetings arranged by him.

The paper presented by Dr. Haviland excited particular interest because it dealt in a most practical way with conditions which force themselves on the attention of all physicians, general practitioners and specialists alike. The paper not only clearly explained many of the not commonly understood factors in cerebral arteriosclerosis, but in a simple and painstaking way told us how to differentiate our cases and how to administer the right lines of treatment to the different classes. A resolution was introduced and unanimously passed asking that Dr. Haviland submit his paper for publication in the State Journal.

The paper of Dr. Potter was interesting and presented in a most fascinating manner. The discussion following its presentation was no less lively than those in other societies which have come after the presentation of similar papers by Dr. Potter. Regardless of the merits of the methods followed by this obstetrician, the Society feels deeply in his debt. Apart from his personal technique, he made statements which clarified numerous obstetric problems and which cannot but set us who heard him to thinking. All in all, his paper can be put down as one of the most valuable ever given before this Society.

As a somewhat novel feature of the meeting a supply of the various brochures issued by the State Department of Health, some from the press of the National Government, and numerous volumes and brochures published by the A. M. A. were on exhibit, with a nurse in attendance. The object was to more intimately acquaint physicians with the publication activities of these various agencies, and to show them what rich fields they had from which to draw material for their waiting-room tables. The exhibit included a copy of the last Directory of the A. M. A. and one of "The Medical Follies."

### BRONX COUNTY MEDICAL SOCIETY

A regular meeting of the Bronx County Medical Society was held at Hollywood Gardens, November 18, 1925. The meeting was called to order at 9 P. M., the President, Dr. Jacobs, in the Chair.

Election of candidates for membership being in order, it was moved and carried that the Secretary be instructed to cast one ballot for the following applicants for membership:

Drs. Joseph S. Brandstein, Daniel J. Dolan,

Joseph Epstein, Frederick L. Flynn, Max Pensak, Reuben Rapoport, Daniel F. Shields, James Sager Threlkeld.

Dr. Simeon A. Jacobs was reinstated.

Dr. L. A. Friedman, for the Committee on Public Health, reported with special reference to the proposed Periodic Health Examinations.

Dr. Cunniffe reported for the Building Committee. He stated that the members of the Comitia Minora and of the Building Committee have

pledged themselves to contribute to the Building Fund and urged the cooperation of all the members

Nomination of Officers for the year 1926 being in order, nominations were made for the Offices of President, First Vice-President, Second Vice-President, Secretary, Corresponding Secretary and Treasurer, and for the Board of Censors, Delegates and Alternates

It was moved and carried that the motion passed at the last meeting of the Society that a Special Meeting be called to consider the proposed By-Laws and the Building Fund be reconsidered and that we take up these matters at the regular December meeting of the Society

The Scientific Program then proceeded as follows

Diseases of the Nose and Throat of Special Interest to the General Practitioner, Sidney Yankauer, M D, New York

Otology in Relation to General Medicine, I M Heller, M D, New York

Diseases of the Eye in General Medicine, Percy Fridenberg, M D, New York

Moved, seconded and carried, that a vote of thanks be extended to the readers of these excellent Papers. The President expressed the appreciation of the Society to Drs Yankauer, Heller and Fridenberg

### ROCKLAND COUNTY MEDICAL SOCIETY

A special meeting of the Rockland County Medical Society was held at the Rockland Country Club, Sparkhill, on Wednesday, October 21st, 1925. Twenty-one members were present and the two candidates for Member of Assembly

Dr James A Kearney, attending ophthalmologist to the New York Polyclinic Hospital and the New York State Hospital for Crippled Children, reported a case of true filial teratoma and cyst in the orbit of a new-born child. There have been ten such cases reported in Europe, the last one 15 years ago. However, Dr Kearney's case is the first one to be reported in America. The child was seen ten minutes after birth and operation was performed three hours later. The mass was removed, leaving the entire eyeball intact. A series of most interesting lantern slides was exhibited, showing photographs of the child before, during and after the operation. Examination 1½ years later showed normal pupillary response and apparently normal vision. Dr Toms and other members of the Society thanked Dr Kearney for the privilege of listening to the

presentation of such a rare case, but said they were not in a position to discuss it

Dr George W Kosmak, attending surgeon to the New York Lyng-In Hospital, gave some very practical points on the conservative treatment of toxemias of pregnancy. His address was most comprehensive, covering as it did every phase of the subject, from the nausea and vomiting of early pregnancy to the method of handling cases of eclampsia

Dr Kosmak's paper was discussed by Drs Kline, Leitner, Sly and Dougherty

A rising vote of thanks was extended to the two speakers, and on motion both Dr Kearney and Dr Kosmak were made honorary members of the Society

An excellent chicken supper was served by the Steward of the Club. The medical practice bill was discussed by Dr Leitner, and both candidates for member of assembly expressed their willingness and determination to support and fight for the passage of the new bill

### MEDICAL SOCIETY COUNTY OF ESSEX

The Annual Meeting of the Essex County Society was held at the Lee House, Port Henry, October 6th, 1925

The President appointed the following Nominating Committee: Drs L G Barton, Jr, T J Cummins, T J Dowd

The following were placed in nomination

For President: Peter Noe, Willsboro, Vice President: W T Sherman, Crown Point, Secretary-Treasurer: H J. Harris, Westport, Censors: R T Saville, C B Warner, T J Cummins, Delegate to State Society: J P J Cummins, Alternate Delegate to State Society: M E Sargent

On motion duly made, seconded and unanimously adopted the Secretary cast one ballot for

the election of these officers. Motion made and seconded that the annual meeting of the Society be held at Moses-Ludington Hospital at Ticonderoga beginning with the 1926 meeting, to be voted on at the next meeting

#### Scientific Session

President's address—Dr A Gersen, retiring President

Derangements of the Knee Joint with operative technique—G W Turner, Orthopedic Surgeon, Royal Victoria Hospital, Montreal, P Q

Surgical Gallbladder—J P J Cummins, Ticonderoga

Certain Diseases of the Eye—H Gaus, Ticonderoga



# THE DAILY PRESS



## ARE DOCTORS REACTIONARY?

When any one wishes to promote a new system of healing he has no difficulty in finding destructive criticisms of the medical profession made by physicians who are eminent in their profession. A religious tract bearing the marks of sincerity has lately come to us. It urges sinners to seek health from Divine rather than medical sources. It quotes thirty medical authorities to show the helplessness of medical science, and the disconcerting point about it all is that many of the authorities were in reality eminent. Dr. Oliver Wendell Holmes is quoted as saying "I fairly believe that if the whole *materia medica* could be sunk to the bottom of the sea, it would be all the better for mankind and all the worse for the fishes." This is a sample of extravagant statements actually made by prominent physicians, giving the impression that the practice of medicine rests on a foundation of untruth. If the medical writers had thought about the effect of their statements, they would have been more careful to express their meaning accurately.

The newspapers of New York City have given wide publicity to the remarks by an eminent public health worker before a two day conference of public health workers in which he criticized the medical profession for not giving proper attention to public health. The *Herald-Tribune*, November 21, says that this doctor "regretted that no medical organization of New York had co-operated with the six health bodies which were responsible for the conference," and that

he admitted that there had been encroachments on the part of health workers on the medical field, but rebuked the physicians for jealousy and ignorance of public health needs."

It is to the credit of the metropolitan newspapers that they generally printed this as news with little or no comment. The editorial writer of the *Patchogue Advance*, November 27th, takes up the active defense of the doctors and says

"We are fond of thinking how modern science is wiping out plagues and extending the field of preventive medicine. It is then with something of a shock that one reads that too many physicians look with coldness on modern discoveries. In consequence, only a limited number of people are receiving the best that science can afford."

"It is to be hoped that the doctor in his zeal to have his profession do its utmost for mankind, makes too sweeping statements and thus discredits some worthy doctors who are above the criticism he offers. But his warning will not do any harm. A physician should be a student to the end of his days, and should be able to employ every form of diagnosis and every remedy that has got beyond the purely experimental stage."

To physicians the statements of their eminent critic sound like scolding, and to unfriendly critics of the medical profession they appear to be indictments of doctors generally. This question is further discussed in our editorial pages.

## BACTERIOPHAGES

The *Brooklyn Daily Eagle*, November 13, has an editorial on "The Elusive Bacteriophage." How many readers of the *Eagle* will know what a "bacteriophage" is? The more thoughtful will turn to the English dictionaries,—Webster's, or *The Standard*, or *The Century*,—and they will not find the word listed.

Doctors are accused of using long technical words, but they seldom use the word "bacteriophage" even in their technical writings. There are a few medical words, such as "*streptococcus*" and "*poliomyelitis*," which have come into common use because no every-day words existed to denote the popular meanings of those words. Physicians to-day are using familiar terms as much as possible. It is the dressmakers and carpenters rather than the doctors who are given to the use of unfamiliar technical terms.

The editorial writer uses the term "bacteriophage" to denote a universal destroyer of internal parasites in the human body. The principal point which he makes is that American investigators are too cold toward alleged foreign discoveries for the prevention of disease. He cites two examples of what he calls "American indifference." First he mentions "A lytic principle got from sewage-filled water," which is "efficient as against the dysentery, the typhoid, and the paratyphoid bacteria, and therefore of inestimable value to the physician." It is of course difficult to know just what the lay editorial writer had in mind, but he probably read something about the details of an investigation into the exact cause of the well-known fact that virulent disease germs in sewage usually die and disappear in the course of putrefaction and decay in a

cesspool or disposal plant. Their disappearance from sewage under natural conditions is of great public health importance, but that phenomenon has no bearing on the destruction of the germs inside the human body.

The second example of "American indifference" quoted by the editorial writer is an alleged cure of cancer by injections of lead. The writer remarks that a prominent American investigator in cancer says "coldly" — "I have experimented with it extensively, and found nothing in it that offered any definite hope in the treatment of cancer."

The writer then comments — "The layman is inclined to wonder if the healing science would not be more advanced in this country if more of enthusiasm and less of skepticism greeted the discover of other scientists in other lands."

The point of view of the lay editorial writer is that of reports which come to him through newspaper channels. Whenever a foreign investigator makes an apparent discovery, he tries to exploit it in America,—the land of free thought and money. Turtle serum for tuberculosis and artificial pleuritic pus from rabbits for empyema, are two alleged German "discoveries" which were exploited in America until laws were passed forbidding the sale of any serum containing living disease germs unless it was manufactured under the strict supervision of the United States Public

Health Service. America is entirely too hospitable toward investigators who have advertising press agents.

The fact that American investigators welcome information from whatever source,—German, French, Japanese, or otherwise,—leads the self-advertisers to come to this country. American physicians have given enthusiastic support to Behring for his diphtheria antitoxin, to Wasserman for his test for lues, to Ehrlich for his salvarsan, and to Schick for his toxin-antitoxin protection against diphtheria.

Science knows no nationality, and the methods and results of investigations are fully revealed in technical journals which have a world-wide circulation among scientists. Journals published in German, French, Japanese, and Spanish are found in every American research laboratory, and their volume exceeds that of the Journals published in the English language.

The greatest amount of complaint of the coldness of Americans toward outside workers comes from those foreigners who are denied admission to the scientific journals of their own countries. When these incompetent workers complain to the lay press, they entirely misjudge the attitude of American investigators whose unselfish ideals, modesty, and honesty are as high as those of any other nation. To complain to the newspapers is the surest way to ruin the reputation and standing of an aspiring scientific worker.

## QUARANTINE ON NARCISSUS BULBS

Physicians can appreciate the motives of the Federal Horticultural Board of the Department of Agriculture in placing a quarantine on the importation of narcissus bulbs, on the ground that they are likely to be infested with larvæ of a fly which might threaten onion and alfalfa plants as well as narcissus bulbs. The Garden Club of America is protesting against the quarantine, according to an editorial in the *Brooklyn Eagle* of November 18th, on the grounds that there is no evidence of an emergency, that the Holland growers are taking "the most intelligent precaution that long experience can offer", and that the immediate money loss will be great if the bulbs cannot be imported.

Doctors know how difficult it is to prevent the admission of human diseases. It is still more difficult to prevent the admission of insect pests. Most of our noxious insects and weeds are imported foreigners, which do little damage in their home lands because their natural enemies keep them in subjection. The gypsy moth which threatens the shade trees of New England and Eastern New York is harmless in Europe because its natural enemies keep it in check. A few escaped from a Boston entomologist who

kept them for study. He informed the authorities who considered that, since they were harmless in Europe, they would also be harmless here. They multiplied enormously, and all efforts to find their natural enemies have failed. The only way to eliminate them from a district is that of epidemiology—to find every moth nest and destroy it.

More fortunate was the measure taken against the Japanese orange scale that was introduced into California. A ladybug was found that preyed upon the young insects in Japan, and when this was introduced into California, it quickly destroyed most of the scale insects, and then itself died because it found too few scales on which to feed. The Government now grows the ladybugs, in order to release them wherever the scale appears.

If the narcissus fly is introduced into America, there is no assurance that it will not multiply to a dangerous extent, unless its natural enemy, or antitoxin, is brought with it. The Department of Agriculture is to be commended for adopting a plant quarantine that is as effective as the rat quarantine of the United States Public Health Service.



# BOOKS RECEIVED



Acknowledgment of all books received will be made in this column and this will be deemed by us a full equivalent to those sending them. A selection from this columns will be made for review, as dictated by their merits or in the interest of our readers.

**THE RADIOLOGICAL EXAMINATION OF THE MALE URETHRA** By G. L. S. KOHNSTAM, M.R.C.S. (Eng.), L.R.C.P. (Lond.). Preface by SIR JOHN THOMSON-WALKER O.B.E., M.B., F.R.C.S. William Wood & Co., New York. Price \$5.50

**SOME ENCOURAGEMENTS IN CANCER SURGERY** By G. GREY TURNER, F.R.C.S. (Eng.), Honorary Surgeon Royal Infirmary, Newcastle-upon-Tyne. William Wood & Co., New York, 1925. Price \$3.50

**AIDS TO SURGICAL DIAGNOSIS** By CECIL P. G. WAKELEY, F.R.C.S., Assistant Surgeon, King's College Hospital. William Wood & Co., New York, 1925. Price \$1.50

**DISEASES OF INFANTS AND CHILDREN** By HENRY DWIGHT CHAPIN, A.M., M.D., Consulting Physician New York Post Graduate and Willard Parker Hospitals, and Lawrence Thomas Royster, M.D., Professor Pediatrics, Pediatric Department of the University of Virginia. Fifth revised edition. William Wood & Co., New York, 1925. Price \$6.00

**THE THERAPY OF PUERPERAL FEVER.** By Privatdozent Dr ROBERT KOEHLER, formerly Assistant Genecological Department Krankenhaus Wieden, Vienna, Austria. American edition prepared by HUGO EHRENFEST, M.D., F.A.C.S., Associate in Obstetrics, Washington University School of Medicine, twenty-seven illustrations. The C. V. Mosby Co., St. Louis, Mo., 1925. Price \$4.00

**A TEXTBOOK OF PHYSIOLOGY** By WILLIAM D. ZOETHOUT, Ph.D., Professor of Physiology in the Chicago College of Dental Surgery (Loyola University). Second edition. The C. V. Mosby Co., St. Louis, Mo., 1925. Price, \$4.50

**PSYCHOLOGICAL HEALING** A Historical and Clinical Study by PIERRE JANET, Professor of Psychology, College of France. Translated from the French by Eden and Cedar Paul. Two volumes. The Macmillan Company, New York, 1925. Price per set, \$14.00

**A HISTORY OF THE MASSACHUSETTS MEDICAL SOCIETY WITH BRIEF BIOGRAPHIES OF THE FOUNDERS AND CHIEF OFFICERS** By WALTER L. BURRAGE A.M., M.D., Secretary of the Society. Illustrated with views of some of the meeting places, reproductions of old documents and portraits of important officers

**INTRAVENOUS THERAPY—ITS APPLICATION IN THE MODERN PRACTICE OF MEDICINE.** By WALTER FOREST DUTTON M.D., Visiting Physician to the Northwest Texas Hospital. 64 half-tones and line engravings, some in colors. Second revised and enlarged edition. F. A. Davis Company, Philadelphia, 1925. Price \$6.00

**THE MEDICAL FOLLIES** An Analysis of the Foibles of Some Healing Cults, Including Osteopathy, Homeopathy, Chiropractic, and the Electronic Reactions of Abrams with Essays on The Antivivisectionists Health Legislation, Physical Culture, Birth Control, and Rejuvenation. By MORRIS FISHBAIN, M.D., Editor of the Journal of the American Medical Association. Boni & Liveright, New York, 1925

**TREATMENT OF KIDNEY DISEASES AND HIGH BLOOD PRESSURE.** By FREDERICK M. ALLEN, M.D. Part I, Practical Manual for Physicians and Patients. The Physiatric Institute, Morristown, N. J.

**THE HEALING GODS OF ANCIENT CIVILIZATIONS.** By WALTER ADDISON JAYNE, M.D. Emeritus Professor of Gynecology and Abdominal Surgery, University of Colorado. Yale University Press, New Haven, Conn., 1925. Price \$5.00

**ALLERGY, ASTHMA, HAY FEVER, URTICARIA AND ALLIED MANIFESTATIONS OF REACTION** By WILLIAM W. DUKE, Ph.B., M.D., Kansas City, Mo. With 75 Illustrations. The C. V. Mosby Co., St. Louis, 1925. Price \$5.50

**EYE, EAR, NOSE AND THROAT MANUAL FOR NURSES.** By ROY H. PARKINSON, M.D., Visiting Oculist and Aurist to St. Joseph's Hospital, San Francisco, California. Illustrated. The C. V. Mosby Co., St. Louis, 1925. Price \$2.25

**OCULAR THERAPEUTICS** A Manual for the Student and the Practitioner. By ERNST FRANKKE, M.D. Translated by CLARENCE LOEB, A.M., M.D. Oculist to The Michael Reese Hospital, Chicago, Ill. The C. V. Mosby Co., St. Louis, 1925. Price \$3.50

**A SYNOPSIS OF SURGERY** Illustrated. By ERNEST W. HEY GROVES, M.S., M.D., B.Sc. (Lond.), F.R.C.S. (Eng.). Seventh Edition. William Wood and Co., New York, 1925. Price \$5.00

**SYNOPSIS OF MIDWIFERY AND GYNECOLOGY** By ALECK W. BOURNE, B.A., M.B., B.Ch. (Camb.), F.R.C.S. (Eng.). Third Edition, Revised and Enlarged, with numerous Diagrams. William Wood and Co., New York, 1925. Price \$4.50

**PHYSIOLOGICAL CHEMISTRY** A Text Book and Manual for Students. By ALBERT P. MATHEWS, Ph.D., Professor of Biochemistry The University of Cincinnati, O. Fourth Edition. Illustrated. William Wood and Co., New York, 1925. Price \$6.50

**MODERN OPERATIVE SURGERY** Edited by H. W. CARSON, F.R.C.S., Eng., Senior Surgeon, Prince of Wales's General Hospital, Tottenham, Lecturer on Abdominal Surgery, North-East London Post-Graduate College. In Two Volumes, with 735 Figures and 6 Plates. William Wood and Company, New York, 1925. Price \$20.00 set.

**OPOTHÉRAPIE, ENDOCRINIENNE, BASES PHYSIOLOGIQUES SYNDROMES, POSOLOGIE, DE L'OPOTHÉRAPIE PAR LES GLANDES A SÉCRÉTION INTERNE.** Masson et Cie, Paris.

**MANSON'S TROPICAL DISEASES** A Manual of the Diseases of Warm Climates. Edited by PHILIP H. MANSON-BAHR, D.S.O., M.A., M.D., D.T.M., and H. CANTAB, F.R.C.P., Lond. Physician Hospital Tropical Diseases, London, Eighth Edition, Revised. 20 color plates 7 half-tone, 387 figures, maps and charts. William Wood and Co., New York, 1925. Price, \$11.00

**THE NATIONAL HEALTH SERIES** Edited by the National Health Council. Published in 20 volumes by the Funk and Wagnalls Company, New York City. 1924. 16mo. Bound in flexible fabrikoid. Price per set, \$6.00 net, per volume, 30c net.

**PHYSICAL DIAGNOSIS OF DISEASES OF THE CHEST** By JOSEPH H. PRATT A.M., M.D., and GEORGE E. BUSHNELL, Ph.D., M.D. Octavo of 522 pages with 166 illustrations. Phila. and London, W. B. Saunders Co. 1925. Cloth, \$5.00

**SURGICAL CLINICS OF NORTH AMERICA.** Volume 5, Number 3, June, 1925 (Mayo Clinic Number). Published every other month by the W. B. Saunders Co. Phila. and London. Per Clinic Year (6 issues) Cloth, \$16.00, Paper, \$12.00

**MEDICAL CLINICS OF NORTH AMERICA.** Volume 9, Number 1, July, 1925. (St. Louis Number). Published every other month by the W. B. Saunders Co., Phila. and London. Per Clinic Year (6 issues) Cloth, \$16.00, Paper, \$12.00

cesspool or disposal plant. Their disappearance from sewage under natural conditions is of great public health importance, but that phenomenon has no bearing on the destruction of the germs inside the human body.

The second example of "American indifference" quoted by the editorial writer is an alleged cure of cancer by injections of lead. The writer remarks that a prominent American investigator in cancer says "coldly" — "I have experimented with it extensively, and found nothing in it that offered any definite hope in the treatment of cancer."

The writer then comments — "The layman is inclined to wonder if the healing science would not be more advanced in this country if more of enthusiasm and less of skepticism greeted the discover of other scientists in other lands."

The point of view of the lay editorial writer is that of reports which come to him through newspaper channels. Whenever a foreign investigator makes an apparent discovery, he tries to exploit it in America,—the land of free thought and money. Turtle serum for tuberculosis and artificial pleuritic pus from rabbits for empyema, are two alleged German "discoveries" which were exploited in America until laws were passed forbidding the sale of any serum containing living disease germs unless it was manufactured under the strict supervision of the United States Public

Health Service. America is entirely too hospitable toward investigators who have advertising press agents.

The fact that American investigators welcome information from whatever source,—German, French, Japanese, or otherwise,—leads the self-advertisers to come to this country. American physicians have given enthusiastic support to Behring for his diphtheria antitoxin, to Wasserman for his test for lues, to Ehrlich for his salvarsan, and to Schick for his toxin-antitoxin protection against diphtheria.

Science knows no nationality, and the methods and results of investigations are fully revealed in technical journals which have a world-wide circulation among scientists. Journals published in German, French, Japanese, and Spanish are found in every American research laboratory, and their volume exceeds that of the Journals published in the English language.

The greatest amount of complaint of the coldness of Americans toward outside workers comes from those foreigners who are denied admission to the scientific journals of their own countries. When these incompetent workers complain to the lay press, they entirely misjudge the attitude of American investigators whose unselfish ideals, modesty, and honesty are as high as those of any other nation. To complain to the newspapers is the surest way to ruin the reputation and standing of an aspiring scientific worker.

## QUARANTINE ON NARCISSUS BULBS

Physicians can appreciate the motives of the Federal Horticultural Board of the Department of Agriculture in placing a quarantine on the importation of narcissus bulbs, on the ground that they are likely to be infested with larvæ of a fly which might threaten onion and alfalfa plants as well as narcissus bulbs. The Garden Club of America is protesting against the quarantine, according to an editorial in the *Brooklyn Eagle* of November 18th, on the grounds that there is no evidence of an emergency, that the Holland growers are taking "the most intelligent precaution that long experience can offer", and that the immediate money loss will be great if the bulbs cannot be imported.

Doctors know how difficult it is to prevent the admission of human diseases. It is still more difficult to prevent the admission of insect pests. Most of our noxious insects and weeds are imported foreigners, which do little damage in their home lands because their natural enemies keep them in subjection. The gypsy moth which threatens the shade trees of New England and Eastern New York is harmless in Europe because its natural enemies keep it in check. A few escaped from a Boston entomologist who

kept them for study. He informed the authorities who considered that, since they were harmless in Europe, they would also be harmless here. They multiplied enormously, and all efforts to find their natural enemies have failed. The only way to eliminate them from a district is that of epidemiology—to find every moth nest and destroy it.

More fortunate was the measure taken against the Japanese orange scale that was introduced into California. A ladybug was found that preyed upon the young insects in Japan, and when this was introduced into California, it quickly destroyed most of the scale insects, and then itself died because it found too few scales on which to feed. The Government now grows the ladybugs, in order to release them wherever the scale appears.

If the narcissus fly is introduced into America, there is no assurance that it will not multiply to a dangerous extent, unless its natural enemy, or antitoxin, is brought with it. The Department of Agriculture is to be commended for adopting a plant quarantine that is as effective as the rat quarantine of the United States Public Health Service.

# INDEX

NOTE.—Original articles are indexed in *italics* Editorials are marked (E) Legal Department marked (L)  
For list of authors see page 1131

	PAGE		PAGE
<i>Abdomen, Acute Surgical Diseases of</i>	599	County Medical Societies (E)	23, 620
Academy of Medicine, Laying the Corner Stone (E)	1002	— — — — — Clinical Programs (E)	742
Activities of the Journal (E)	485	— — — — — Ideals of (E)	215
<i>Address Conference Health Officers in Public Health Nurses</i>	861	— — — — — Interests in Meetings (E)	818
Advertising and the Journal (E)	868	— — — — — Meetings in February (E)	169
Alleged Failure to Have X-Ray Taken (L)	122	— — — — — Meeting of Secretaries	762
— Negligence with Resultant Loss of Ovary (L)	662	— — — — — Relation to the Community	159
Alopecia as a Result of X-Ray Therapy (L)	661	— — — — — Reporting (E)	119
Alsever, W. Dewey (E)	120	County Society Meetings	40, 189, 242, 405, 460, 504, 590, 630, 670, 706, 749, 847, 884, 916, 948, 975, 1015, 1048, 1086, 1121
American Medical Association Convention 1925	819-821	Crippled Children, Survey of	36
Anemia, Pernicious	147	Cult Bills, Unalterably Opposed to So-called Before Legislature (E)	431
Annual Dinner	762	<i>Cystic Ovary, Etiology of</i>	713
Annual Meeting (E)	167, 431, 572	<i>Cystoscopic Points in Urological Diagnosis</i>	637
— — — — — One Hundred and Nineteenth	760	Daily Press	44, 141, 192, 244, 299, 350, 409, 467, 508, 548, 595, 633, 672, 709, 752, 851, 887, 917, 950, 977, 1016, 1052, 1088
— — — — — Tuberculosis Day (E)	657, 669, 818	Death, Ether Anesthesia at Delivery (L)	624
<i>Appendicitis, Gram Positive Anaerobes in</i>	1	Deaths	140, 263, 428, 571, 656, 833, 934, 1001, 1073
— — — — — in Asthma and Other Cases of Allergy	368	<i>Deformities, Treatment of Congenital</i>	686
Arthritis, Chronic	422	Destructive Criticism (E)	1113
Automobile Accidents, Treatment of	313	<i>Diabetes Mellitus, Neglected Phases of Coma In</i>	200
Blood Pressure Treated with Sensitized Colon Vaccine	419	District Branches (E)	834, 905, 1003
Books Received,	46, 143, 194, 246, 510, 554, 635, 853, 919, 1053, 1090	— — — — — Meetings for 1925 ,	912
Book Reviews,	47, 144, 246, 352, 411, 550, 597, 636, 674	First	1011
711, 754, 854, 920, 951, 979, 1017, 1054, 1091, 1126		Second	945, 1011
Bran Tumors, Ocular Signs of	103	Third	912, 947
Breast Feeding	653	Fourth	913, 1012
— — — — — Demonstration in Hornell	831	Fifth	945, 1013
Burn from Hot Sandbag (L)	1083	Sixth	946, 974
Caduceus Post	139	Seventh	913, 946
Cancer Present Status of Treatment of	1022	Eighth	913, 1014
— — — — — Surgical Treatment of	1019	<i>Doctor of the Future</i>	758
— — — — — Therapy, X-Ray in	1025	Doctors Fees in Olden Times	507
<i>Carcinoma of the Cervix Uteri Treated with Radium</i>	855	Drugless Therapy (E)	371
Cardiac Clinic, Organization of	995	<i>Ectopia Lentis</i>	117
— — — — — Cripple, Problem of the Chronic	983	<i>Endocrine Therapy in Sterility</i>	305
— — — — — Procedure in Problem of	991	— — — — — Treatment of Menstrual Disorders	1099
Case Histories (E)	1004	<i>Ethmoiditis Acute</i>	114
Childbirth, Causes of Death at	555	Feet and Back (E)	697
Child Welfare Clinics in Yates Co	243	<i>Femur Fractures of the Neck of</i>	966
Christmas (E)	1112	Five Thousand Physicians Should Think This Over (L)	577
Chiropractic Literature (E)	698	Floating Hospital, Health Teaching On	914
Chiropractors, an Experience with	545	— — — — — of St. Johns Guild	914
— — — — — Licensing (E)	429	<i>Foot Strain</i>	519
<i>Cholecystography, Recent Advances in</i>	825	Fractures of both Femurs, Delayed Union, Etc. (L)	534
<i>Cisternal Puncture, Clinical Uses of</i>	568	Fundamentalism in Medicine (E)	868
Claimed Breach of Contract to Cure (L)	624	<i>Gastro-Intestinal Tract, Recurrent Vomiting and Abnormalities</i>	301
— — — — — Dislocation of Femur by Forceps Delivery (L)	870	General Session (E)	742
— — — — — Infections from Retained Placenta (L)	700	<i>Gouty Endemia as a Public Health Problem</i>	207
— — — — — Improper Administration of Chloroform (L)	871	Gorgas Memorial	401 466 506, 547 593 632 671, 708
— — — — — Negligent Operation Resulting in Loss of Kidney (L)	1006	Government as a Profession (L)	1005, 1035, 1119
— — — — — Wrong Diagnosis and Improper Advice (L)	268	Governor's Message	36
Clinical Programs of the Orange County Society	846	— — — — — Smith's Special Message	588
Community Nurse	319	Graduate Education	875, 1037
Compensation Law and the Physician	210	Graduate Medical Courses (E)	573
Conference Chairman Co Legislative Committees	463	— — — — — Education, Principles of (E)	658
Consultants Fee (E)	576	— — — — — Plans State Medical Society (E)	936
Council Meetings	458 839 1047	— — — — — Instruction (E)	835
		— — — — — Studies in New York	587
		<i>Gynecological Infection From Injections</i>	1108
		<i>Gynecology Four Years' Work with Radium in</i>	195
		Harrison Narcotic Law conviction under and effect upon Physicians License (I)	216



# BOOK REVIEWS



**OLD AND NEW VIEWPOINTS IN PSYCHOLOGY** Some Interpretations and Applications of Psychological Principles By KNIGHT DUNLAP, Professor of Experimental Psychology, Johns Hopkins University The C. V. Mosby Co., St. Louis \$1.50 net.

This is a delightful book of five chapters. The style is clear, and forceful. This seems to be the era for the publication of books on psychology, and on all sides lectures are being given on the subject. The word is frequently heard in all sorts of conversations. The author will isolate the value of many of the arguments on this subject, if the reader will follow him. The value and real basis of the various schools is given in a few easily understood paragraphs. Freud receives the credit, which to our mind is his due.

Observation is a part of clinical medicine. A help on this subject is given in this book. The book is of value for this purpose alone.

We recommend this book to anyone, and am sure that a few hours will be spent with pleasure as well as benefit while reading it. J ARTHUR BUCHANAN

**A COMPEND OF GYNECOLOGY** By WILLIAM HUGHES WELLS, M.D. 5th Edition, revised and enlarged, by WILLIAM B. HARER, M.D. 12mo 371 pages, 167 illustrations. Phila., P. Blakiston's Son & Co 1925 Cloth, \$2.00

This compend is as clear and concise as it is possible for a compend to be. Because of the limited space, statements are made as though final, thus oftentimes leaving the wrong impression. Again space is devoted to a discussion of implements and practices that are in truth obsolete, thus using needed space.

For one who has a good working knowledge of gynecology this little book offers an easy method of review. G W P

**A LABORATORY MANUAL OF PHYSIOLOGICAL CHEMISTRY** By ELBERT W. ROCKWOOD, M.D., and PAUL REED ROCKWOOD, M.D. Fifth Edition, revised and enlarged. Four colored plates, forty-three text engravings. F. A. Davis Co., Philadelphia, 1924. Price, \$4.00 net.

As a Laboratory Manual of Physiological Chemistry this Fifth Revised and Enlarged Edition presents all the valuable features of the earlier ones and has an air of being up-to-date that is refreshing. Special consideration of colloids in relation to metabolism, the ionic theory and hydrogen ion concentration acknowledge the importance of those subjects in the study of Physiological Chemistry as a part of modern medical education.

Its treatment of micro-methods in blood-chemistry, acid-base equilibrium, insulin and vitamins, place it abreast with progress in medical science. The questions asked at the conclusion of each series of related procedures, promote observation and thought on the part of the student who otherwise is so prone to perform his experiments mechanically without appreciating their significance.

The subject-matter is complete and the elaboration of theory in opportune places makes this a well-rounded work. G H R.

**BOOK OF PHYSIOLOGY FOR MEDICAL STUDENTS AND PHYSICIANS** By WILLIAM H. HOWELL, Ph.D., M.D., Sc.D., LL.D. Ninth Edition, thoroughly revised. Octavo of 1069 pages with 308 illustrations. Phila and London, W. B. Saunders Co., 1924. Cloth, \$6.50

As a Text-book of Physiology for medical students this work has, for many years, enjoyed a place second

to none. It is concise, to the point and follows a logical sequence. At the same time, it is sufficiently complete to provide for the student a comprehensive, and yet not burdensomely detailed, source of information. It is a book of science and yet easy to read.

This recent edition as also the others, simply confirms the apparent intention of the author to present a work which has all of the wealth of its forerunners, eliminates that which time has shown to be untenable or irrelevant, and presents that part of the newer matter which safely may be accepted as fact or which is compatible with those of the newer theories and points of view which are most generally acceptable.

The medical student's most bitter complaint is that he has too much to read. The busy physician certainly cannot wade through a mass of material for the information which he must have if he is to keep abreast of the advance in medical science or to review, as he should, its fundamentals. Such a text as this provides a ready source of all that is necessary and the author is to be congratulated in that while he has revised and rewritten, he has not materially added to the length of the book.

While knowledge of the chemistry of muscle contraction is still far from complete, the author has given the student the benefit of the more recent light on that subject, and he has recognized the fact that endocrinology is still whirling in the vortex of a whirlpool of uncertainty, by rewriting large parts of that chapter.

This Ninth Edition is, then, at once concise, in good order, readable, up-to-date and sufficiently comprehensive to make it immeasurably useful to the book-burdened medical student and the all-too-busy physician, as a text-book of physiology. G H R.

**LIFE INSURANCE EXAMINATION** Edited by FRANK W. FOXWORTHY, Ph.D., M.D. Octavo of 738 pages with 156 illustrations. St. Louis, C. V. Mosby Co., 1924

Life insurance examining may almost be considered an essential part of post graduate medical education. A great majority of the physicians of the United States indulge in it at one time or another. Some utilizing it as a crutch to tide them over the first lean years of practice, to be given up as soon as finances permit, others continuing to examine throughout their entire active practice, and a certain few making it a life work. To these physicians this book is dedicated.

It is a collection of monographs contributed by recognized authorities on the various phases of life insurance of interest to the medical examiners. The numerous subjects are excellently presented and the illustrations are profuse. The first part of the book is devoted to a history of life insurance, and to the internal organization of the companies. This is followed by detailed instruction to the examiner, as to his duty to the company, for which he is examining.

Nearly one-half of the work is devoted to the subject of physical diagnosis from a somewhat different point of view. Indeed, this portion of the volume is in itself an elementary text-book on this subject, and is excellently presented.

On the whole "Life Insurance Examination" is a noteworthy and valuable addition to a reference library. It is to be hoped that the editor will present a condensed volume with the inevitable overlappings and repetitions eliminated, which one feels will be even more valuable to the medical examiner. W V M



# INDEX

NOTE.—Original articles are indexed in *italics* Editorials are marked (E) Legal Department marked (L)  
For list of authors see page 1131

	PAGE		PAGE
<i>Abdomen, Acute Surgical Diseases of</i>	599	County Medical Societies (E)	23, 620
Academy of Medicine, Laying the Corner Stone	1002	Clinical Programs (E)	742
(E)	485	Ideals of (E)	215
Activities of the Journal (E)	—	Interests in Meetings (E)	818
<i>Address Conference Health Officers in Public Health</i>	861	Meetings in February (E)	169
Nurses	868	Meeting of Secretaries	762
Advertising and the Journal (E)	122	Relation to the Community	159
Alleged Failure to Have X-Ray Taken (L)	—	Reporting (E)	119
— Negligence with Resultant Loss of Ovary	662	County Society Meetings	40, 189, 242, 405, 460, 504, 590, 630, 670, 706, 749, 847, 884, 916, 948, 975, 1015, 1048, 1086, 1121
(L)	661	Crippled Children, Survey of	36
Alopecia as a Result of X-Ray Therapy (L)	120	Cult Bills, Unalterably Opposed to So-called Before	431
Alsever, W. Dewey (E)	819-821	Legislature (E)	713
American Medical Association Convention 1925	147	Cystic Ovary, Etiology of	637
Anemia, Pernicious	762	Cystoscopic Points in Urological Diagnosis	467
Annual Dinner	167, 431, 572	Daily Press	44, 141, 192, 244, 299, 350, 409, 467, 508, 548, 595, 633, 672, 709, 752, 851, 887, 917, 950, 977, 1016, 1052, 1088, 1121
Annual Meeting (E)	760	Death Ether Anesthesia at Delivery (L)	624
— One Hundred and Nineteenth	657, 669, 818	Deaths	140, 263, 428, 571, 656, 833, 934, 1001, 1073
<i>Appendicitis, Gram Positive Anaerobes in</i>	1	Deformities, Treatment of Congenital	686
— in Asthma and Other Cases of Allergy	368	Destructive Criticism (E)	1113
Arthritis, Chronic	422	Diabetes Mellitus, Neglected Phases of Coma In	200
Automobile Accidents, Treatment of	313	District Branches (E)	834, 905, 1003
Blood Pressure Treated with Sensitized Colon	419	— Meetings for 1925	912
Vaccine	—	First	1011
Books Received,	46, 143, 194, 246, 510, 554, 635, 853, 919, 1053, 1090, 1125	Second	945, 1011
Book Reviews,	47, 144, 246, 352, 411, 550, 597, 636, 674	Third	912, 947
711, 754, 854, 920, 951, 979, 1017, 1054, 1091, 1126	103	Fourth	913, 1012
Bran Tumors, Ocular Signs of	653	Fifth	945, 1013
Breast Feeding	831	Sixth	946, 974
— Demonstration in Hornell	1083	Seventh	913, 946
Burn from Hot Sandbag (L)	139	Eighth	913, 1014
Caduceus Post	1022	Doctor of the Future	758
Cancer Present Status of Treatment of	1019	Doctors Fees in Olden Times	507
— Surgical Treatment of	1025	Drugless Therapy (E)	371
— Therapy, X-Ray in	855	Ectopia Lentis	117
Carcinoma of the Cervix Uteri Treated with Radium	995	Endocrine Therapy in Sterility	305
Cardiac Clinic, Organization of	983	— Treatment of Menstrual Disorders	1099
— Cripple, Problem of the Chronic	991	Ethmoiditis Acute	114
— Procedure in Problem of	1004	Feet and Back (E)	697
Case Histories (E)	555	Femur Fractures of the Neck of	966
Childbirth, Causes of Death at	243	Five Thousand Physicians Should Think This Over	577
Child Welfare Clinics in Yates Co	1112	(L)	914
Christmas (E)	698	Floating Hospital, Health Teaching On	914
Chiropractic Literature (E)	545	— of St. Johns Guild	519
Chiropractors, an Experience with	429	Foot Strain	534
— Licensing (E)	825	Fractures of both Femurs, Delayed Union, Etc. (L)	568
Cholecystography, Recent Advances in	568	Fundamentalism in Medicine (E)	868
Cutaneous Puncture, Clinical Uses of	624	Gastro-Intestinal Tract Recurrent Vomiting and	301
Claimed Breach of Contract to Cure (L)	—	Abnormalities	742
— Dislocation of Femur by Forceps Delivery	870	General Session (E)	207
(L)	700	Gouty Endemic as a Public Health Problem	708
— Infections from Retained Placenta (L)	871	Gorgas Memorial	401, 466, 506, 547, 593, 632, 671, 708
— Improper Administration of Chloroform	—	Government as a Profession (L)	1005, 1035, 1119
(L)	1006	Governor's Message	36
— Negligent Operation Resulting in Loss of	—	— Smith's Special Message	588
Kidney (L)	263	Graduate Education	875, 1037
— Wrong Diagnosis and Improper Advice	846	Graduate Medical Courses (E)	573
Clinical Programs of the Orange County Society	319	— Education, Principles of (E)	658
Community Nurse	210	— Plans State Medical Society (E)	936
Compensation Law and the Physician	463	— Instruction (E)	835
Conference Chairman Co. Legislative Committees	576	— Studies in New York	587
Consultants Fee (E)	458, 839, 1047	Gynecological Infection, Proton Injections	1108
Course	—	Gynecology Four Years' Work with Radium in	195
		Harrison Narcotic Law, conviction under and effect	216
		upon Physicians License (L)	—

	PAGE
<i>Headache of Nasal Origin</i> . . . . .	616
<i>Health Examination, Periodic (E)</i> . . . . .	1028
— <i>Officers Conference</i> . . . . .	872
— <i>Courses in Albany, Jefferson and St. Lawrence Counties</i> . . . . .	877
— <i>and Public Health Nurses Conference</i> . . . . .	824
— <i>and Public Health Nurses Address at the</i> . . . . .	861
— <i>Structure, Building the (E)</i> . . . . .	1077
<i>Hearing Before Committees on Public Health Senate and Assembly</i> . . . . .	432
<i>Heart Disease, Problem of Organic</i> . . . . .	986
<i>Hemorrhage, Tonsillar</i> . . . . .	11
<i>High Blood Pressure Treated with Sensitized Colon Vaccine</i> . . . . .	419
<i>Honesty in Medicine (E)</i> . . . . .	869
<i>Humerus, Fractures of the</i> . . . . .	606
— <i>Fracture of the Upper End</i> . . . . .	691
— <i>Volkmanns Paralysis (L)</i> . . . . .	1082
<i>Hypodermoclysis, Needle Breaking in (L)</i> . . . . .	744
<i>Hysteria</i> . . . . .	560
<i>Industrial Hygiene, Policy N Y State Labor Department</i> . . . . .	426
<i>Infantile Paralysis, Do Elderly People Have It</i> . . . . .	118
<i>Infant Feeding</i> . . . . .	688
<i>Infants Stools, Factors in Acidity of</i> . . . . .	152
<i>Infected Finger (L)</i> . . . . .	837
<i>Injured Ankle, Subsequent Infection (L)</i> . . . . .	908
<i>Insane, Chronic Otorrhea in</i> . . . . .	684
— <i>Provision for Temporary Care</i> . . . . .	1111
<i>Insulin Therapy, Present Status</i> . . . . .	901
<i>Jaundice, Infections</i> . . . . .	19
<i>Journal, The during 1924 (E)</i> . . . . .	20
— <i>The Weekly (E)</i> . . . . .	696
<i>Journals, Preserve Yours (E)</i> . . . . .	1030
<i>Kala-Azar in Infant</i> . . . . .	413
<i>Karle-Dunmore Bill, Registration and Other Features of (L)</i> . . . . .	324
<i>Keep the Old Secretary (E)</i> . . . . .	22
<i>Keuka Lake Medical Society</i> . . . . .	916
<i>Kings County Against Medical Practice Bill</i> . . . . .	403
— <i>Society, December Bulletin</i> . . . . .	37
— <i>Report of Legislation Committee</i> . . . . .	349
<i>Labor Department Division of Industrial Hygiene</i> . . . . .	426
<i>Labor, Relief Measures During</i> . . . . .	254
<i>Laboratory Demands Clinical Data or Will Charge Fee for Supplies (E)</i> . . . . .	323
<i>Laceration of Wrist with Resultant Cellulitis (L)</i> . . . . .	433
<i>Legal Department</i> 24, 121, 170, 216 267, 324, 373, 432, 487, 534, 577, 624, 699, 743, 836, 870, 907, 937, 1005, 1035	
<i>Legislative Department</i> 26, 79, 123, 172, 218 269, 327, 376, 434, 489, 536, 579	
<i>Legislation, Bills Introduced 1925</i> . . . . .	
To Repeal Section 37 Chapter 206 of the Laws of 1818 relating to Appointment of Censors State Medical Society . . . . .	445
To amend charities law in relation to physically handicapped persons . . . . .	288
To define and regulate the practice of chiropractic . . . . .	236
To create a temporary commission to inquire and report on condition of crippled children throughout the State . . . . .	225
To amend the civil practice act, in relation to testimony of physicians in certain cases . . . . .	186
To amend the Code of Criminal Procedure in relation to jurisdiction of courts of special session . . . . .	238
To amend the code of Criminal Procedure in relation to jurisdiction of Courts of Special Sessions . . . . .	228

	PAGE
To amend the county law, in relation to public health nurses . . . . .	183
To amend the Education Law in relation to the education of children with retarded mental development . . . . .	237
To amend the education law, relative to medical inspection of cities . . . . .	272
To amend the education law, relative to medical inspection and health service in the public schools . . . . .	176
To amend the Education Law in Relation to Medical Services in the Schools of the State . . . . .	86
To establish City Court in Buffalo and defining its powers in relation to jurisdiction of Drug Addicts . . . . .	540
To amend the insanity law in relation to qualifications of examiners in lunacy . . . . .	174
To amend the Insanity Law in Relation to Licensing Private Institutions for the Treatment of Narcotic Drug Addiction . . . . .	84
To amend the insanity law in relation to qualifications of examiners in lunacy . . . . .	227
To amend the Labor Law, in Relation to Furnishing Nursing and First Aid Service in Factories, Etc. . . . .	85
To amend the mental deficiency law, generally . . . . .	333
To provide for the establishing of a clinic for mental diseases in the state prison at Ossining . . . . .	334
To amend the penal law, in relation to physician's instruments . . . . .	343
To amend the penal law in relation to the name, sale, use and labeling of methanol . . . . .	294
To amend the penal law in regard to intoxicating liquors . . . . .	221
To amend the Penal Law, in Relation to Experiments Upon Living Dogs . . . . .	46
To amend Public Health Law in relation to practice of systems, methods or sciences for treatment of disease except the practice of medicine, osteopathy and Christian Science . . . . .	232
To amend Prison Law in relation to removal of sick prisoners from jails . . . . .	239
To amend the Public Health Law in relation to powers of Board of Health . . . . .	228-230
To amend section three hundred and sixteen of the public health law, in relation to cadavers . . . . .	340
To amend the public health law, in relation to the supervision and control by the state department of health of the New York state hospital for the care of crippled and deformed children . . . . .	334
To amend the public health law creating a board of chiropractic examiners and regulating the practice of chiropractic . . . . .	495
To amend the Public Health Law, in relation to the Practice of Chiropractic and Podiatry . . . . .	445
To amend the Tax Law in relation to Deductions from Income of Expenses Paid or Incurred for Medical, Surgical or Dental Services . . . . .	86
To amend the State Charities Law in relation to duties of superintendent . . . . .	237
To amend the Public Health Law in relation to Habit Forming Drugs etc . . . . .	80
To amend the Public Health Law in relation to district laboratory supply stations . . . . .	343
To amend the public health law, in relation to the revocation of licenses . . . . .	276
To amend the public health law, in relation to the fiscal management of the state institute for the study of malignant disease . . . . .	335
To amend the public health law, in relation to the conduct of pharmacies by corporations . . . . .	273
To amend the public health law, in relation to the Practice of the Healing Art . . . . .	447

	PAGE		PAGE
To amend the Public Health Law, in relation to practice of medicine	278	Should not the Profession Discourage Baseless Ones (L)	661
To amend Public Health Law, in relation to practice of medicine (Chiropractic Bill)	386	March Fourth in Albany (L)	267
To amend the Public Health Law, in relation to the qualification of licenses to practice medicine	294	Medical Bills—Hearings	464
To amend the Public Health Law, in relation to establishing a division of rural hygiene, and making an appropriation therefor	332	— <i>Education, 25 Years Progress in</i>	675
To amend the Public Health Law, in relation to sales of Spectacles, Eye Glasses and Lenses	446	— Economics	942, 1007
To amend the Public Health Law, in relation to Sanitation in factories, stores and shops engaged in selling food	395	— Field Service at Carlisle	884
To amend the Public Health Law in regard to vaccination	231	— Instruction, Psychology of (E)	1004
To amend the Public Health Law, in relation to violations of rules or orders of local boards of health	186	— Language (E)	698
To amend the Public Health Law, in relation to vital statistics	396	— Legislation (E)	264
To amend section thirteen of the Workmen's compensation act	183	— Legislative Machinery (E)	320
To amend the workmen's compensation law, in relation to maximum and minimum compensation for disability	179	— News What Is It (E)	1113
To amend the workmen's compensation law, in relation to compensation for occupational diseases	178	— Officer of the World War, Reunion	751
To amend the workmen's compensation law, in relation to fibroid phthisis (Silicosis)	183	— Practice Act Adopted by Special Committee, October, 1925	1039
To amend the workmen's compensation law, in relation to presumptions	179	— Practice Act 1924 Bill to Amend	123
To amend the workmen's compensation law, in relation to medical attendance and surgical treatment for an injured employee	177	— Progress	1031, 1078, 1115
To amend the workmen's compensation law, in relation to medical procedure	448	— — — Evidences of (E)	935
To amend the workmen's compensation law, in relation to compensation for occupational diseases	180, 181, 182	— — — Waivers in (E)	430
Briefs In favor of Assembly Bill Int. No 1351 Supervision and treatment of injured employees	491	— Reserve Corps	864
In Support of Assembly Bill Int 1348 Censors of the State Medical Society	494	— Service from Standpoint of Rural Physician	483
In support of Assembly Bill Int. No 678 Sanitation in Factories and Stores Selling Food	495	— Society Salesmanship (E)	969
In favor of Senate Int. No 115 Habit forming drugs	492	Medical Society of the State of New York	
In favor of Senate Int. No 851 Concerning cadavers	492	— Annual Meeting (E)	167, 431, 572
In support of Senate Bill Int. No 380 Injured employees	493	— — — Report of	760
In opposition to Assembly Bill Int No 127 Medical Services in Public Schools	494	— Annual Dinner	762
In opposition to Senate Bill Int No 647 Physical examination and practical tests of claimants for workmen's compensation	493	— Meeting of the House of Delegates	802
In opposition to Senate Int 632 Conduct of Pharmacies by Corporations	493	— Adjourned Meeting of the House of Delegates	813
Legislators and Petitions (E)	1076	— President's Address	755
Legislative Department of the Journal (E)	214	— Scientific Sessions Preliminary Program	455, 583
— Notes	123, 172, 218, 269, 327, 376 434 489, 536	— Report of the Speaker	764
Legislation of 1925 (E)	532	— — — President	766
— Disposition of Bills introduced in	579	— — — Treasurer	768
— History of 1925 (E)	574	— — — Secretary	770
— 1925 Season Closes (E)	575	— — — Council	771
Leg Contraction Due to Burn (L)	938	— — — Committee on Publication	771
Leukemia and Mononucleosis	525	— — — Committee on Arrangements	773
Libraries, State Medical (E)	23	— — — Committee on Scientific Work	774
Lumbar Puncture, Paralysis, Death (L)	937	— — — Committee on Public Health and Medical Education	774
Malpractice Suits, Protection Therefrom (L)	836	— — — Committee on Legislation	775
		— — — Committee on Medical Research	781
		— — — Committee on Nurse Problem	782
		— — — Committee on Medical Economics	788
		— — — Committee on Post-Graduate Medical Instruction	793
		— — — Counsel	794
		— — — District Branch Councillors	800
		Medical Surveys (E)	658
		— Cattaraugus County	943
		— Cayuga County	972
		— Fulton County	1014
		— Hamilton County	1014
		— Jefferson County	910
		— Kings County	664
		— Lewis County	911
		— Long Island	702
		— New York County	626
		— Montgomery County	1009
		— Orange County	747
		— Rockland County	747
		— Saratoga County	873
		— Seneca County	973
		— Steuben County	843
		— Tompkins County	29
		— Testimony (L)	24
		— Meetings (E)	905
		Medicine, Fundamentalism in (E)	868
		— Honesty in (E)	869
		— New Procedures in (E)	660
		— Present Day Tendencies in Practice of	608
		— Problems of Organized (E)	1030
		— and Psychology	247
		— Standards of Practice of (E)	530

	PAGE		PAGE
<i>Headache of Nasal Origin</i>	616	To amend the county law, in relation to public health nurses	185
<i>Health Examination, Periodic (E)</i>	1028	To amend the Education Law in relation to the education of children with retarded mental development	237
— Officers Conference	872	To amend the education law, relative to medical inspection of cities	272
— Courses in Albany, Jefferson and St. Lawrence Counties	877	To amend the education law, relative to medical inspection and health service in the public schools	176
— and Public Health Nurses Conference	824	To amend the Education Law in Relation to Medical Services in the Schools of the State	86
— and Public Health Nurses Address at the	861	To establish City Court in Buffalo and defining its powers in relation to jurisdiction of Drug Addicts	540
— Structure, Building the (E)	1077	To amend the insanity law in relation to qualifications of examiners in lunacy	174
<i>Hearing Before Committees on Public Health Senate and Assembly</i>	432	To amend the Insanity Law in Relation to Licensing Private Institutions for the Treatment of Narcotic Drug Addiction	84
<i>Heart Disease, Problem of Organic</i>	986	To amend the insanity law in relation to qualifications of examiners in lunacy	227
<i>Hemorrhage, Tonsillar</i>	11	To amend the Labor Law, in Relation to Furnishing Nursing and First Aid Service in Factories, Etc.	85
<i>High Blood Pressure Treated with Sensitized Colon Vaccine</i>	419	To amend the mental deficiency law, generally	333
<i>Honesty in Medicine (E)</i>	869	To provide for the establishing of a clinic for mental diseases in the state prison at Ossining	334
<i>Humerus, Fractures of the</i>	606	To amend the penal law, in relation to physician's instruments	343
— Fracture of the Upper End	691	To amend the penal law, in relation to the name, sale, use and labeling of methanol	294
— Volkmanns Paralysis (L)	1082	To amend the penal law in regard to intoxicating liquors	221
<i>Hypodermoclysis, Needle Breaking in (L)</i>	744	To amend the Penal Law, in Relation to Experiments Upon Living Dogs	445
<i>Hysteria</i>	560	To amend Public Health Law in relation to practice of systems, methods or sciences for treatment of disease except the practice of medicine, osteopathy and Christian Science	232
<i>Industrial Hygiene, Policy N Y State Labor Department</i>	426	To amend Prison Law in relation to removal of sick prisoners from jails	239
<i>Infantile Paralysis, Do Elderly People Have It</i>	118	To amend the Public Health Law in relation to powers of Board of Health	228-230
<i>Infant Feeding</i>	688	To amend section three hundred and sixteen of the public health law, in relation to cadavers	340
<i>Infants Stools, Factors in Acidity of</i>	152	To amend the public health law, in relation to the supervision and control by the state department of health of the New York state hospital for the care of crippled and deformed children	334
<i>Infected Finger (L)</i>	837	To amend the public health law creating a board of chiropractic examiners and regulating the practice of chiropractic	495
<i>Injured Ankle, Subsequent Infection (L)</i>	908	To amend the Public Health Law, in relation to the Practice of Chiropody and Podiatry	445
<i>Insane, Chronic Otorrhea in</i>	684	To amend the Tax Law in relation to Deductions from Income of Expenses Paid or Incurred for Medical, Surgical or Dental Services	86
— Provision for Temporary Care	1111	To amend the State Charities Law in relation to duties of superintendent	237
<i>Insulin Therapy, Present Status</i>	901	To amend the Public Health Law in relation to Habit Forming Drugs etc	80
<i>Jaundice, Infections</i>	19	To amend the Public Health Law in relation to district laboratory supply stations	343
<i>Journal, The during 1924 (E)</i>	20	To amend the public health law, in relation to the revocation of licenses	276
— The Weekly (E)	696	To amend the public health law, in relation to the fiscal management of the state institute for the study of malignant disease	335
<i>Journals, Preserve Yours (E)</i>	1030	To amend the public health law, in relation to the conduct of pharmacies by corporations	273
<i>Kala-Asar in Infant</i>	413	To amend the public health law, in relation to the Practice of the Healing Art	447
<i>Karle-Dunmore Bill, Registration and Other Features of (L)</i>	324		
<i>Keep the Old Secretary (E)</i>	22		
<i>Keuka Lake Medical Society</i>	916		
<i>Kings County Against Medical Practice Bill</i>	403		
— Society, December Bulletin	37		
— Report of Legislation Committee	349		
<i>Labor Department Division of Industrial Hygiene</i>	426		
<i>Labor, Relief Measures During</i>	254		
<i>Laboratory Demands Clinical Data or Will Charge Fee for Supplies (E)</i>	323		
<i>Laceration of Wrist with Resultant Cellulitis (L)</i>	433		
<i>Legal Department</i> 24, 121, 170, 216 267, 324, 373, 432, 487, 534, 577, 624, 699, 743, 836, 870, 907, 937, 1005, 1035			
<i>Legislative Department</i> 26, 79, 123, 172, 218, 269, 327, 376, 434, 489, 536, 579			
<i>Legislature, Bills Introduced 1925</i>			
To Repeal Section 37 Chapter 206 of the Laws of 1818 relating to Appointment of Censors State Medical Society	445		
To amend charities law in relation to physically handicapped persons	288		
To define and regulate the practice of chiropractic	236		
To create a temporary commission to inquire and report on condition of crippled children throughout the State	225		
To amend the civil practice act, in relation to testimony of physicians in certain cases	186		
To amend the Code of Criminal Procedure in relation to jurisdiction of courts of special session	233		
To amend the code of Criminal Procedure in relation to jurisdiction of Courts of Special Sessions	228		

	PAGE
C ARTHUR ABT—Diseases and Fate of Twins	511
ERICK M. ALLEN—Hypertension and Treatment of Nephritis	726
T FORREST BARBER—The Varicose Disease	162
IS FRANKLIN BARKER—Psychic Factors in General Medical Diagnosis	1058
HUR JOSEPH BEDELL—The Ocular Signs of Some Brain Tumors	103
SEPH FRANCIS BICAK—High Blood Pressure Treated with Sensitized Colou Vaccine	419
ALFRED L. BINGER—Therapeutic Value of Oxygen in Pneumonia	953
ANCIS GILMAN BLAKE—Observations of the Therapeutic Value of Scarlatinal Antitoxin	1093
RIED BLOCK—Hysteria	560
MUEL W. BOORSTEIN—Foot Strain	519
AN GOWANS BROWN—Factors Involved in the Acidity of the Stools of Infants	152
RY G. BUGBEE—Infections of the Urinary Tract in Children	1063
ESSELL BURTON-OPITZ—Simple Auscultatory Method of Physical Diagnosis	18
SEPH ALMARIN CAPPS—Origin and Radiation of Pain in the Serous Membranes	418
ELIAM WESLEY CARTER—Correction of Nasal Deformities	1070
ESSELL LAFAYETTE CECIL—Lobar Pneumonia Treated with Pneumococcus Antibody Solution	355
THUR S. CHITTENDEN—The Clinical Uses of Cisternal Puncture	568
WARD COBB—Educating and Placing Out Mental Defectives	252
LAND E. COFER—The Policy of the New York State Labor Department's Division of Industrial Hygiene	420
ORGE KIRBY COLLIER—Psycho Therapy	250
WARD NEWTON COOPER—Laboratory Aids in Diagnosing and Treating Nephritis	640
ESTER CHARLES COTT—Atrophic Rhinitis	112
WARD HUTCHISON COX—The Etiology and Treatment of Tonsillar Hemorrhage	11
Headache of Nasal Origin	616
ORGE WASHINGTON CRILE—Results of Surgical Treatment of Cancer	1019
WOHY F. DONOVAN—Endocrine Therapy in Sterility	305
The Endocrine Treatment of Menstrual Disorders	1099
GEORGE DRAPER—The Influence of Sex Upon the Constitutional Factor in Disease	1065
LOUIS I. DUBLIN—Statistical Aspects of the Problem of Organic Heart Disease	986
JOHN L. ECKEL—The Early Neurological Manifestations of Syphilis	63
WITO R. EICHEL—Results of Investigations of Causes of Death at Childbirth	555
MAX EINHORN—Recent Advancements in Cholecystography	825
THOMAS P. FARMER—Review of Four Years' Work With Radium in Gynecology	195
LILIAN K. P. FARRAR—Preliminary Report of Primary Carcinoma of the Cervix Uteri Treated with Radium in the Woman's Hospital in the State of New York	855
GEORGE MERRILL GELSER—Functional Abnormalities of Menstruation	1105
HARRY GOLEMBE—Early Diagnosis of Pulmonary Tuberculosis	612
ALBERT L. HALL—Do Elderly People Have Infantile Paralysis?	118
RAYMOND WILLARD HAWKINS—Infections in the Tonsils and Paranasal Sinuses in a Series of Cardiac Patients	566
WILLIAM P. HEALY—Idiopathic Uterine Bleeding from the Clinical Standpoint	964
ALFRED M. HELLMAN—A Contribution to the Etiology of the Cystic Ovary	713
JAMES BRYAN HERRICK—The Problem of the Chronic Cardiac Cripple	983
DAVID EDWARD HOAG—Nervous and Mental States Following Injuries to the Head	260
ALEXANDER C. HOWE—Broncho-Mycosis X-Ray	60
EDWARD LIVINGSTON HUNT—Polymyelitis	722
JOHN EDWARD JENNINGS—The Gram-Positive Anaerobes in Appendicitis and Its Complications	1
ELLIOTT PROCTOR JOSLIN—The Present Status of Insulin Therapy	901
ALBERT DAVID KAISER—The Incidence of Infections in Tonsillectomized Children	469
ELDRRED WESTON KENNEDY—Complete Ectopia Lentis—Report of Case	117
CHARLES GILMORE KERLEY—Recurrent Vomiting in Its Relation to Abnormalities of the Gastro-Intestinal Tract	301
FRANK KIERNAN—Provisions for Temporary Care of the Insane Pending Commitment	1111
OLIVER PERRY KIMBALL—Endemic Goitre as a Public Health Problem	207
AMES HALL MASON KNOX, JR.—Prevention in Pediatric Practice	921
AMUEL JOSEPH KOPETZKY—The Relationship of County Medical Society to the Community	159
WILLIAM ANDREW KRIEGER—Nasal Infection, Exclusive of Diphtheria in Children	203
AMUEL WALDRON LAMBERT—Twenty-Five Years' Progress in Medical Education in Internal Medicine and the Medical Specialties	675
JACZY LEVI LERNER—Thrombosis of the Retinal Veins	365
CLARENCE WILLIAM LIEB—Intestinal Toxæmia Control through Bio-Dietetic Methods	475
WILLIAM LINTZ—Appendicitis in 300 Cases of Asthma and Other Forms of Allergy	368
OSWALD SWINNEY LOWSLEY—Inhalation vs. Regional Anesthesia for Prostatectomy	893
Kidney and Prostate	70
Under Regional Anesthesia	200
WILLIAM S. McCANN—Some Neglected Phases of Co	19
ED DOWELL—A Case of Infectious Ja	

	PAGE		PAGE
<i>Mental Defectives, Educating and Placing Out</i>	252	and Medical Education, Commit-	875
— <i>Hygiene of the Child, Relation to Medicine</i>	924	tee on	
— — — — — <i>Relation to Develop-</i>		Joint Meeting of Committee on	940
— — — — — <i>ment of Character</i>	926	Medical Education	940
— <i>Illness, Community Provision for</i>	570	Nursing, Code of Ethics for (E)	322
Menstrual Disorders, Endocrine Treatment	1099	— — — — — <i>Work, Newspaper Aid in</i>	933
Menstruation, Functional Abnormalities of	1105	<i>Puerperal Infection, What Types Require Surgical</i>	
Money Raising (E)	697	<i>Treatment</i>	358
Nasal Deformities, Correction of	1070	Quacks (E)	865
— Hump, Removal of (L)	170	Radium in Gynecology	193
— Ganglion, Surgical Aspect of	929	Rash on Face, Negligent Treatment of (L)	1033
— Infection, 101 Cases Exclusive of Diphtheria		Recommendations for 1925	2
in Children	203	Referendum Vote Medical Practice Act	347-50
— Operation Claimed Without Consent of		Reregistration and the Karle-Dunmore Bill (L)	324
Parent (L)	326	— — — — — Objections Considered (L)	37
Neighbors—Our	880, 1084	Retained Placenta, Puerperal Septicæmia—Death	
Nephritis, Hypertension and Treatment	726	(L)	12
— <i>Laboratory Aids in Diagnosing</i>	646	Retinal Veins, Thrombosis of	76
Nervous and Mental States Following Head In-		Rhinitis, Atrophied	11
juries	260	Salpingitis Claimed Due from Insertion of Stem	
New Department (E)	1029	Pessary (L)	21
Nicoll Bill, Drop in Legislative Slot and Receive		Scarlatinal Antitoxin, Therapeutic Value of	109
Doctor's Degree (L)	170	Schistosoma Hematobium Infection Relation to	
Non-Pregnancy, Leucorrhœal Discharge (L)	578	Urmay Sinus	64
Nurse Education (E)	622	School Medical Inspectors	82
— Register (E)	659	Secretarial Conference in Chicago (E)	107
Nurses Duty (E)	576	Serous Membrane, Origin and Radiation of Pam	41
Nursing, Scientific (E)	621	Sex, Influence of Upon Constitutional Factors in	
— Situation (E)	533	Disease	106
Obstetrics, Course in	876	Smallpox—Vaccination in	68
Ocular Signs of Brain Tumors	103	Specialists and General Practitioner	85
Operation Without Consent (L)	216	Spokesman for the Medical Society of the State of	
Opportunities (E)	741	New York (E)	48
Organization (E)	22	State Department of Health,	
Organized Medicine, Mission of Today (L)	487	28, 134, 187, 240, 296, 345, 400, 461, 50	
Otorrhea in the Insane	684	543, 582, 625, 663, 701, 745, 838, 872, 909, 9	
Oysters and Typhoid Fever (E)	120	— — — — — Medical Libraries (E)	2
Pediatric Practice Prevention in	921	— — — — — Society's Activities (E)	73
Pediatrics, Teaching Clinics in	587	Sterility, Endocrine Therapy in	36
Pediatrician and Preventive Pediatrics	109	Teaching Clinics (E)	65
Perforations, Important Symptom with Free Fluid		— — — — — Hospitals (E)	111
in Abdomen	472	Therapeutic Standards (E)	97
Periodic Health Examination in New York County		Thrombosis of the Retinal Veins	36
32, 135, 188, 241, 297, 348, 402, 462,	629	Tonsil Problem	82
— — — — — Endocrinology in	629	Tonsils and Paranasal Sinuses, Infections in Cardiac	
— — — — — Progress in (E)	168	Patients	56
— — — — — How to Make a (E)	531	Tonsillar Hemorrhage, Etiology and Treatment of	1
Phillips Wendell C., President-Elect A M A (E)	816	Tonsillectomized Children, Infection in	46
Physical Diagnosis Auscultatory Method of	18	Torax, Intestinal Control Through Bio-Dietetic	
Physician Can Aid Legislator (E)	266	Methods	47
— in Civic Affairs (E)	1076	Trial by Jury Shall Remain Inviolable Forever (L)	9
— in Medical Bills (E)	265	Tuberculosis Day (E)	657-669-81
— in Public Health (E)	321	— — — — — Early Diagnosis of Pulmonary	61
— and Public Health Nurse (E)	372	— — — — — Problems of (E)	62
Physicians Seek Rural Practice	38	— — — — — and Public Health State Committee	70
Pity of It (E)	970	— — — — — Teaching in Suffolk County	87
Pneumonia Lobar Treated with Pneumococcus		Twins Diseases and Fate of	51
Antibody Solution	355	Ulcer of Stomach and Duodenum, Surgery for Be-	
— Serum Therapy in N Y State	528	lign	105
— Therapeutic Value of Oxygen in	953	Undergraduate Deficiencies and Post-Graduate Re-	
Pohomvelitis	722	quirements	65
Post Graduate Lectures Tangible Results from (E)	1029	Ureters Importance and Technic in Palpation of	
Pregnancy Convulsive Toxemia of	6	Female	95
Prinatal Care	735	Urinary Tract in Children Infections of	106
President Our (E)	695	Urine Report Fallacies of a Negative Preoperative	73
President's Address—119th Annual Meeting	755	Urological Diagnosis Cystoscopic Points in	63
Prize Essays	39	Uterine Bleeding, Curettage in Idiopathic	96
Prolapsed Uterus (L)	488	— — — — — Idiopathic from Clinical Stand-	
In Prospect (E)	817	point	964
Prostatectomy Present Day Factors	889	— — — — — Tumors—X-Ray Burns (L)	1006
— — — — — Inhalation vs Regional Anesthesia	893	Uvula Removed in Tonsillectomy (L)	171
Protection Against Law Suits (L)	699	Vacation Time (E)	867
Psychiatry in Relation to Public Schools	480	Vaccination in Smallpox	681
Psychic Factors in General Medical Diagnosis	1058	Varicose Disease	162
Psychology and Medicine	247	Version Modern Application of	362
Psycho-Therapy	250	X-Ray Apparatus Breaking (L)	1006
Public Health Laboratories Associated Annual	706-823	Years Progress (E)	740



HUGH C McDOWELL—A Modern Application of Version	
FREDERICK F McGAULEY—Important Symptom of Perforation with Free Fluid in Abdomen	
ROSS McPHERSON—The Convulsive Toxemia of Pregnancy and Its Treatment	
ALBERT S MAN—The Physician and the Compensation Law	
HERMAN G MATZINGER—Medicine and Psychology	
FREDERICK GEORGE METZGER—The Success or Failure of the Community Nurse	
JOHN J MOORHEAD—The Treatment in Automobile Accidents	
HOMER L. NELMS—The Fallacies of a Negative Preoperative Urine Report	
MATTHIAS NICOLL, JR.—The Specialist and the General Practitioner	
EMIL NOVAK—Diagnostic Curettage in So-called Idiopathic Uterine Bleeding	
FREDERICK W PARSONS—Community Provision for Mental Illnesses	
CHARLES H PECK—The Present Status of Surgery for Benign Ulcer of the Stomach and Duodenum	1059
JOHN OSBORNE POLAK—Prenatal Care	739
— — — — — What Types of Puerperal Infection require Surgical Treatment	358
WINFIELD SCOTT PUGH—Schistosoma Hematobium Infection and Its Relation to Urinary Sinus	643
JAMES KNIGHT QUIGLEY—"The Low Cervical Cesarean Section—Its Advantages"	49
REGINALD M RAWLS—Protein (Milk) Injections in Gynecological Infections	1108
EDWARD CONRAD REIFENSTEIN—Some Present-Day Tendencies of the Practice of Medicine	608
CHARLES R. REYNOLDS—The Medical Reserve Corps	864
FRANK HOWARD RICHARDSON—Breast Feeding	653
BENJAMIN PRICE RILEY—The Chronic Arthritides—Special Reference to Relief of Pain	422
H EARL ROGERS—Inhalation vs Regional Anesthesia for Prostatectomy	893
GEORGE LOUIS ROHDENBURG—A Contribution to the Etiology of the Cystic Ovary	713
ALBERT M ROOKER—The Tonsil Problem	828
HENRY ROTH—The Diagnosis of Acute Surgical Diseases of the Abdomen	599
SIMON L. RUSKIN—The Surgical Aspect of the Nasal Ganglion	929
NELSON G RUSSELL—Acute Leukemia and Mononucleosis	525
ERIC J RYAN—Recent Advancements in Cholecystography	825
HAROLD ELMORE SANTEE—Fractures of the Humerus	606
LEO FRANCIS SCHIFF—The Newspaper as an Aid in Public Health Work	933
JAMES M SCHMIDT—Broncho-Mycosis X-Ray	60
HENRY WILLIAM SCHOENECK—Relief Measures During Labor	254
BERNARD FRANCIS SCHREINER—X-Ray in Cancer Therapy	1025
FREDERICK W SEARS—Vaccination and Smallpox	681
FUAD I SHATARA—The Varicose Disease	162
HENRY LARNED KEITH SHAW—The Pediatrician and Preventive Pediatrics	109
RALPH SHELDON—Infant Feeding	688
ALBERT B SIEWERS—Psychiatry in Relation to the Public Schools	480
BURTON THORNE SIMPSON—The Present Status of the Treatment of Cancer	1022
— — — — — X-Ray in Cancer Therapy	1025
E E SMITH—The Chronic Arthritis; Special Reference to Relief of Pain	422
LAWRENCE EMERSON SPROUT—Medical Service Problem from the Standpoint of a Rural Physician	483
RICHMOND STEPHENS—The Treatment of Congenital Deformities	686
WILLIAM H STEWART—Recent Advancements in Cholecystography	825
EDWARD RHODES STITT—Undergraduate Deficiencies and Post-Graduate Requirements	650
FRANK MALCOLM SULZMAN—Acute Ethmoiditis	114
HOMER FORDYCE SWIFT—A Program of Procedure in the Problem of the Cardiac Cripple	991
PARKER SYMS—Prostatectomy, Emphasizing the Present Day Factors of Safety	889
DOUGLAS ARMOUR THOM—Mental Hygiene of the Child and Its Relation to Medicine	924
FREDERICK F TISDALL—Factors Involved in the Acidity of the Stools of Infants	152
DAVID WILLIAM TOVEY—Importance and Technique of Palpation of the Female Ureters	958
JAMES DOWLING TRASK—Observations of the Therapeutic Value of Scarletinal Antitoxin	1093
NATHAN B VAN ETEN—Address at the Annual Conference of Health Officers and Public Health	
Nurses	861
GEORGE E VINCENT—The Doctor of the Future	758
AUGUSTUS WADSWORTH—Serum Therapy of Pneumonia in New York State	528
BERTIS RUPERT WAKEMAN—Hornell Breast Feeding Demonstration	831
LOUIS M WARFIELD—How Can We Best Treat Pernicious Anemia?	147
WILLIAM CRAWFORD WHITE—Treatment of Fractures of the Neck of the Femur	966
IAY DASHIEL WHITHAM—Observations in Chronic Otorrhea in the Insane.	684
IRA S WILE—Mental Hygiene of the Child and Its Relation to the Development of Character	926
MARTHA WALLSTIIN—A Case of Kala-Azar in an Infant	413
JAMES N WORCES.ER—Fractures of the Upper End of the Humerus	691
JOHN WYCKOFF—Organization of the Cardiac Clinic	995
JOHN VAN DOREN—A Further Study of Aspiration in Gynecology	54
MAXIMILIAN ZIGLI—Practical Clinical and Cystoscopic Points in Urological	637



